ACCOUNTABILITY IN THE GLOBAL HEALTH REGIME: A CRITICAL EXAMINATION OF THE INSTITUTIONAL POLICY AND PRACTICE OF THE GLOBAL FUND TO FIGHT HIV/AIDS, TUBERCULOSIS AND MALARIA PARTNERSHIP PROGRAMME IN GHANA

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Abstract

The overarching objective of this thesis is to undertake a critical examination of the institutional accountability policy and practice of the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) in the context of its partnership programme in Ghana. The Global Fund is a global public-private partnership (GPPP) in health engaged in public health policy processes worldwide. As a GPPP, the policy mandate that underpins its global response to fight the aforementioned diseases requires it to enter into partnerships with recipient countries to finance their national health policy responses and strategies to tackle these diseases. Situating accountability within the context of the shift from an international health to a global health regime, the study argues that the emergence of GPPPs in health and the formal policy mandate and decision-making powers they exercise have had knock-on consequences for understanding accountability in the global health regime. This is because while the understanding of accountability for public health policy processes in the international health regime revolved solely around state-based and state-led accountability processes, it is no longer so in current global health regime. Since these GPPPs are not states, they derive their understanding of accountability from the nature and character of their individual policy and practice arrangements. However, despite contestation around the Global Fund's accountability in global health literature, this literature has little to say on the question of how the Global Fund itself (as a partnership organisation) understands accountability in policy and how this understanding informs its practice in specific settings of global health.

Thus, this study contributes to literature on GPPPs' accountability in global health by specifically exploring how the Global Fund understands accountability in policy and how this understanding informs its accountability in practice, in particular in relationship to its implications for country ownership of health policy in Ghana. Drawing on fieldwork undertaken in Ghana, and guided by a critical political economy approach, this study will demonstrate how: 1) the Global Fund's institutional policy and practice arrangements undermine accountability to the government and to those affected by their activities; 2) the Global Fund's practice of country ownership is reflective of conditional ownership despite the fact that the Global Fund claims to promote country ownership as a core principle of its accountability practice in aid recipient countries; and 3) the accountability policy and practice instruments of the Global Fund are not politically neutral, but are rather a function of relations of power. To improve the ability of Ghana (and other recipient countries) to own their developmental policies, a reordering of global economic relations is needed, with a renewed emphasis and focus on economic justice and human rights. Such a reordering will improve the material capabilities (control of and access to global centres of production, finance and technology) of aid recipient countries. This will empower Ghana (and other recipient countries) to play a more dominant, rather than a subsidiary role in how the global health landscape is organised and financed and in policy processes undertaken by global health policy institutions like the Global Fund. In this way, Ghana (and other developing countries) will be able to limit and mitigate the dominance and influence of powerful donors who shape the institutional policy and practice arrangements of global health policy institutions like the Global Fund.

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John Onokwai

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Abbreviations

AAA	Accra Agenda for Action
ADRA	Adventist Development and Relief Agency of Ghana
AGMAL	AngloGold Ashanti (Ghana) Malaria Control Limited
AIDS	Acquired Immune Deficiency Syndrome
AM	Alternative Medicine
AP	Associated Press
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral Drug
BCC	Behaviour Change Communication
BMGF	Bill and Melinda Gates Foundation
BP	Bloomberg Philanthropies
BRICS	Brazil, Russia, India, China and South Africa
CBO	Community-Based Organisations
CCM	Country Coordinating Mechanism
CDC	Center for Disease Control
CDF	Comprehensive Development Framework
CEDEP	Centre for Development of People
CF	Clinton Foundation
CHAG	Christian Health Association of Ghana
CHI	Carso Health Institute
CHPS	Community-based Health Planning and Services
CMA	Common Management Agreement
CMH	Commission on Macroeconomics and Health (of the WHO)
CSO	Civil Society Organisation
DAC	Development Assistance Committee of the OECD
DAC	District AIDS Committee of the Ghana AIDS Commission
DALY	Disability Adjusted Life Year
DANIDA	Danish International Development Agency
DFID	Department for International Development
DHIMS	District-wide Health Information Management System

DOTS	Directly Observed Treatment Short-Course (for tuberculosis)
E.U	European Union
ECB	European Central Bank
EPR	Economic Recovery Programme
ETF	Exchange-Traded Funds
FMOU	Framework Memorandum of Understanding
FPM	Fund Portfolio Manager
GAC	Ghana AIDS Commission
GAIN	Global Alliance for Improved Nutrition
GAO	U.S. Government Accountability Office
GATT	General Agreement on Trade and Tariffs
GAVI	Global Alliance for Vaccines and Immunization (now officially Gavi, the Vaccine Alliance
GBS	General Budget Support
GDP	Gross Domestic Product
GF	Global Fund to Fight AIDS, Tuberculosis and Malaria
GHS	Ghana Health Services
GPPPH	Global Public-Private Partnership in Health
GTZ	German Agency for Technical Cooperation
HCT	HIV Testing and Counselling
HIPC	Heavily Indebted Poor Countries Initiative
HIV	Human Immune Deficiency Virus
HLP	High Level Independent Review Panel (of the Global Fund)
HSS	Health Systems Strengthening
HSSP	Health Sector Support Programme (of the World Bank)
HSWG	Health Sector Working Group
IACC	Inter-Agency Coordinating Committees
IALC	Inter-Agency Leadership Committee
IAVI	International AIDS Vaccine Initiative
IFI	International Financial Institution
IHR	International Health Regulations

IMF	International Monetary Fund
INGO	International Nongovernmental Organisations
IPM	International Partnership for Microbicides
KAP	Key Affected Populations
KPIs	Key Performance Indicators
LFA	Local Fund Agent
M&E	Monitoring and Evaluation
MAP	Multi-country AIDS Program
MCC	Millennium Challenge Corporation
MDBS	Multi Donor Budget Support
MDG	Millennium Development Goal
MMV	Medicines for Malaria Venture
MOH	Ministry of Health, Ghana
MSM	Men who have Sex with Men
NACP	National AIDS/STD Control Programme
NAFTA	North Atlantic Free Trade Area
NASA	National AIDS Spending Assessment
NFM	New Funding Model (of the Global Fund)
NGO	Non-governmental organisation
NHS	National Health System
NIC	National Intelligence Council (USA)
NMCP	National Malaria Control Program
NTCP	National Tuberculosis Control Program
OECD	Organisation for Economic Co-operation and Development
OIG	Office of the Inspector General of the Global Fund
OIHP	Office International d'Hygiène Publique
OPEC	Organisation of Petroleum Exporting Countries
PASB	Pan American Sanitary Bureau
PBF	Performance-Based Funding
PD	Paris Declaration on Aid Effectiveness
PEPFAR	President‘s Emergency Plan for AIDS Relief

PHMHB	Private Hospitals and Maternity Homes Board
PLWA	People living with HIV/AIDS
PMTCT	Prevention of Mother-to-Child Transmission
PMU	Project Management Unit
PNDC	Provisional National Defence Council
POW	Programme of Work
PPAG	Planned Parenthood Association of Ghana
PR	Principal Recipient
PRSP	Poverty Reduction Strategy Paper
QGIH	Quasi-Government Institution Hospitals
RBM	Roll Back Malaria Partnership
RMU	Resource Mobilisation Unit
SAPRI	Structural Adjustment Participatory Review Initiative
SAPRIN	Structural Adjustment Participatory Review International Network
SAP	Structural Adjustment Programme
SBS	Sector Budget Support
SCF	Save the Children Fund (United Kingdom)
SRs	Sub-Recipients
Stop TB	Stop Tuberculosis Partnership
SWAp	Sector-Wide Approach
TB	Tuberculosis
TFM	Transitional Funding Mechanism (of the Global Fund)
THB	Teaching Hospital Board
TMP	Traditional Medical Providers
TRIPS	The Agreement on Trade-Related Aspects of Intellectual Property Rights
TRP	Technical Review Panel (of the Global Fund)
TWG	Transitional Working Group (of the Global Fund)
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Programme
UNGA	United Nations General Assembly

UNICEF	United Nations Children‘s Fund
UNPF	United Nations Population Fund
UNSC	United Nations Security Council
USA	United States of America
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing Centres
WAPCAS	West African Programme to Combat AIDS and STIs
WB	World Bank
WDR	World Development Report
WHA	World Health Assembly
WHO	World Health Organisation
WTO	World Trade Organisation

CHAPTER ONE
INTRODUCTION

1.1. Background to the Study

Neoliberal economic globalisation has enabled a shift from an international health regime (that was basically state-centric in nature and character) to a multi-actor global health regime (Koplan et al., 2009; Aginam, 2010; Brown et al., 2006; Brown, 2012; Lee, 2000, 2003, 2006, 2009; Rushton and Williams, 2011; Bunyavanich, and Walkup, 2001; Biehl and Petryna, 2013; Buse et al., 2009; Buse and Walt, 2002a; Yach and Bettchet, 1998a, 1998b; Ruebi, 2016, 2018; King, 2002; Schneider, 2009; Brown and MacLean, 2009; Moran, 2009). This is with regards to both the many health issues that now exceed the territorial limits of states and the approaches to resolving these health issues which are now formally multi-actor in orientation (Brown, 2012; Lee, 2006). The multi-actor orientation speaks to the rise of global public-private partnerships (GPPPs) in health and the increased prominence of other non-state actors in the global health regime. The increased prominence of these other non-state actors is due to their formal incorporation into health policy processes and decision-making structures in the global health regime (Bruen et al., 2014). Such non-state actors include non-governmental organisations, philanthropic organisations and private business interests (e.g. pharmaceutical companies).

Global public-private partnerships (GPPPs) in health are prime examples of organisations that incorporate these non-state actors (alongside state actors) into health policy processes and decision-making structures in global health. As will be elaborated in Chapter 2.5 and 2.7.1, these GPPPs which started emerging from the late 1970s, entail more complex forms of partnerships in global health in contrast to other historical forms of interaction between the public and private sectors. These GPPPs are mainly concentrated in the areas of drug and vaccine development and the prevention and treatement of infectious diseases (Buse and Walt, 2000a). However, GPPPs are also prominent in a number of health-related fields, such as tobacco dependence and contraceptive technology development (Buse and Walt, 2000a). As Bruen et al. (2014), Buse and Walt (2000a) and Buse et al. (2009) further explain, these GPPPs in health bring together a broad gamut of state and non-state actors under various partnership frameworks to undertake and proffer solutions for the resolution of prevailing global health policy challenges. Based on the roles and responsibilities undertaken by these GPPPs in global health, Buse and Harmer, (2007,

2009) and Kapilashrami and McPake (2013) note that they have become pervasive and widely recognised governance mechanisms set up to tackle and resolve specific global health challenges.

The Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (Global Fund) is emblematic of GPPPs that encapsulate state and non-state actors into health policy processes and decision-making structures in global health to undertake and proffer solutions for the resolution of specific global health policy challenges. GPPPs (like the Global Fund) are now imbued with formal mandates, legitimate and authoritative policy and decision-making powers in the global health regime. This is different from the operation of the earlier international health regime which was dominated by state and inter-state institutions that were the main policy actors imbued with formal mandates, legitimate and authoritative policy and decision-making powers. As such, Bruen et al. (2014) aver that global health has witnessed a paradigm shift from vertical levels of state representation reminiscent of the World Health Organisation (WHO) and the United Nations (UN) structure in general to more horizontal models of public-private partnerships that embed multi-actor representation and involvement.

In distinguishing between the international and global health regime, Brown (2012) aptly articulates that the shift from international health to global health 'imputes responsibility for its management on a multi-layer authority structure' (2012:4). This implies that formal mandate and decision-making powers for health policy processes are no longer the exclusive preserve of states and inter-state institutions (as in the international health regime), but are now also exercised by non-state actors and institutions operating alongside states and inter-state structures such as the World Health Organisation and the United Nations system (Brown, 2012:3). Lee et al. (2011) further postulate that global health can be differentiated from international health in three main ways. Unlike international health and the predominant focus of governments with the health of their domestic populations and infectious disease surveillance, global health focuses on addressing the factors or processes shaping the broad determinants of health such as water and sanitation, employment, education, housing, and agriculture and food production. Secondly, it places emphasis on health challenges that transcend the territorial limits of states in terms of their geographic scope and impact. For example, tackling a disease like severe acute respiratory syndrome (SARS) and multi-drug resistant tuberculosis necessitates paying attention to patterns

of population movement within and across countries such as migrant workers, migration, refugee or displaced populations and tourism. Thirdly, the regulatory frameworks and institutions that govern health policy and practice extend beyond state and inter-state actors to encompass non-state actors (Lee et al., 2011).

The advent of GPPPs (such as the Global Fund,) suggests changes in the ways in which accountability for public health policy processes is currently understood and practised in global health relative to how they were understood and practised in the international health regime. Accountability is a pervasive concept in contemporary discussions about health policy processes in the global health regime and is commonly ascribed to different types of activities and relations. Broadly defined, accountability refers to individuals, organisations, or states assuming or taking responsibility for their actions and being answerable for performance, finance or political activities assessed against a set of standards (Brinkerhoff, 2004). As observed by Bruen et al. (2014), how accountability is conceptualised, understood and practised in the global health regime is a function of the worldview or perspective of the actor involved. In other words, its meaning and application are dependent on the actor who uses or applies the term (Bruen et al., 2014: 1-2). Thus the global health regime is a space where various kinds and forms of accountability understandings and practice now battle for recognition and legitimacy (Bruen et al., 2014).

The central and overarching concern of this study is to critically examine the Global Fund's institutional policy understanding and practice of accountability. The Global Fund was established in early 2002 as a global health partnership engaged in public health policy processes worldwide. This is because the policy mandate that underpins its global response to fight AIDS, Tuberculosis and Malaria requires it to enter into partnerships with aid recipient countries to finance their national public health policy responses and strategies to tackle these diseases. The extensive role that the Global Fund undertakes, due to the volume of funding it provides for the fight against these diseases, in specific settings of global health has led to questions and concerns regarding its accountability. Accountability of the Global Fund matters because human lives are affected by its policy and practice arrangements. The promoters of the Fund promised that the Global Fund in its partnership policy and practice of accountability would 'exhibit a level of substantive accountability that's unheard of in international development assistance' (United

States government official, cited in McGill, 2014). Therefore, it is important to place its accountability policy and practices under careful scrutiny.

Given the pervasiveness of the term 'accountability' in the global health literature, it would be reasonable to expect sustained scholarly interests in how these global public-private partnerships (GPPPs) in health understand and practice accountability. However, there is little reflection or consideration on how accountability is understood in policy by these GPPPs in health. Neither has sufficient attention been given to how such policy understanding of accountability is received and applied in practice on the ground in specific settings of global health. For instance, despite contestation around the Global Fund's accountability, the literature has little to say on the question of how the Global Fund itself (as a partnership) understands accountability in policy and how this informs and affects its accountability practices on the ground in specific settings of global health. This study aims to address this gap in the literature.

1.2. Context of the Study

The shift from an international to a global health regime provides the backdrop for the analysis of accountability in this study. This shift is broadly detailed in different sections of Chapter Two (which outlines the conceptual and theoretical basis of this study). However, it is germane to provide at this point a synopsis of these broader discussions in order to clearly contextualise the study.

Prior to the advent of neoliberal globalisation and the subsequent transformations that took place in the organisation of social, political and economic life particularly from the 1970s onward, the health relationship between states and the World Health Organisation (WHO) made up the structure of what was referred to as the international health regime. States and the WHO coordinated formal public health policy responses to international health disease outbreaks and challenges. There was little collaboration between private and public sectors within the United Nations in particular or the international health regime in general (Buse and Walt, 2000a). Partnerships that existed were generally limited to public sector collaborations and relations between donor agencies and governments of recipient countries (Buse and Walt, 2000a). Although the UN Charter facilitated cooperation with NGOs and non-profit entities, the relationship between the UN agencies and NGOs and non-profit entities were rarely referred to

as partnerships as NGOs were often regarded simply as pressure, interest or advocacy groups (Buse and Walt, 2000a).

Several international NGOs and private foundations, such as the Rockefeller and Ford Foundations were prominent in this regard (Kapilashrami, 2010; Schneider, 2009). Also, organisations such as the Rotary International, the International Red Cross and volunteer groups of missionaries, journalists, religious leaders and teachers also undertook immunisation and disease control programs in the developing world (Schneider, 2009). A significant percentage of the budget of the then League of Nations Health Organisation (LNHO) (a forerunner to the World Health Organisation) came from the Rockefeller Foundation (Schneider, 2009). However, formal mandate and decision-making power for public health policy processes remained in the hands of states and inter-state institutions such as the WHO and the broader United Nations system despite the influence of foundations such as the Rockefeller and Ford Foundations (Kapilashrami 2010).

In relation to the understanding and practice of accountability in the international health regime, accountability for public health policy processes revolved around state-based and state-led accountability processes. In line with this regime, states are responsible for the health of their people and are accountable to them for health issues within their borders (Bruen et al., 2014; Loughlin and Berridge, 2002; Dodgson et al., 2002). States are held accountable by their citizens through elections and parliamentary oversights and representations. While states are perceived to be accountable for the management of public health policy processes within their territorial boundaries, inter-state organisations like the WHO manage health issues on behalf of states at the international level (Bruen et al., 2014; Brown et al., 2006; Ng and Ruger, 2011; Kelly and Berridge 2002; Dodgson et al., 2002). In this relationship structure, member governments hold the World Health Organisation (WHO) accountable for its activities through the World Health Assembly (Bruen et al., 2014). The World Health Assembly (WHA) is the governing decision-making body of the WHO (Irwin and Smith, 2019; Bruen, et al., 2014). States are deemed accountable to their citizens for their activities in the WHO. This relationship pattern implies a democratic accountability relationship between citizens, states and the WHO. Citizens are represented in the WHO through their member states who sit in the WHA (Bruen et al., 2014).

With regards to global health, the global health regime emerged through the process of neoliberal globalisation. Inherent in these processes of globalisation were new forms of risks to human health (Ruebi, 2016; Brown, 2012; Dodgson et al., 2002). Therefore, Dodgson et al. (2002) posit that globalisation has increased transborder health risks to human health such as emerging and reemerging infectious diseases which transcend the territorial boundaries of states with regards to their origin and impacts the health of the world's populations (Dodgson et al., 2002:7). These risks arose due to the rapid proliferation of infections across transnational boundaries enabled by affordable air travel, growing global population movement and global economic interdependency of all nations (Brown, 2012; Altman, 1999; Yach and Bettchet 1998a, Yach and Bettchet 1998b; Ruebi, 2016; Collin and Lee 2003; Lee, 2000, 2003; Tatem et al., 2006; Gubler, 2011; Buse, 2004; Koplan et al., 2009; Aginam, 2010, 2004, 2016; Buse 2004; Frenk and Moon 2013).

Furthermore, as Lee (2006) argues, in an increasingly globalised world with its many health risks, the influencing of status, outcomes and health determinants is no longer the sole prerogative of states. The rapidity, spatial dimension and speed with which these transborder health risks occurred necessitated a reconsideration of the regulations and institutions that govern health policy and practice (Lee 2006). The transnational nature of these new types of threats meant that they were immune to the efforts of individual states and that the state-centric international health regime was insufficient to deal with these threats (Dodgson et al., 2002; Ruebi, 2018; Yach and Bettchet 1998a, Yach and Bettchet 1998b; Aginam, 2010, 2004; Lee, 2006). Additional or new forms of health relations or actions were thus considered necessary (Dodgson et al., 2002; Ruebi, 2018; Schneider, 2009; Aginam, 2010, 2004; Frenk, and Moon, 2013; Lee, 2006).

Therefore, to meet the challenges of these emerging new health threats and to advance broader UN objectives in the context of the Millennium Development Goals (MDGs), the WHO and the UN system began to seek partnerships with the private business sector, non-governmental organisations, and civil society organisations for the resolution of global health challenges (Bruen et al., 2014; Bartsch, 2007b, 2011; Biehl and Petryna, 2013; Frenk and Moon, 2013; Ng and Rudger, 2011; Van de Pas and Van Schaikl, 2014; Fidler, 2007 and 2010; Drager and Sunderland, 2007). In order to formalise its desire for public-private partnerships, the UN and the WHO, initiated the passage of resolutions via the United Nations General Assembly (UNGA)

calling on non-state actors such as private business players and civil society actors to participate officially in global health policy processes. As noted by Brown (2012), this signalled the rise of global public-private partnerships (GPPPs) into the global health sector to undertake and resolve prevailing global health challenges. This move bestowed recognition on GPPPs in health as formally recognised and legitimate actors in global health governance (Brown, 2012).

Unlike in the international health regime where the understanding of accountability for public health policy processes was derived from state-based or state-led accountability processes, the understanding of accountability for public health policy processes in the global health regime is no longer limited to state-based or state-led accountability processes due to the emergence of GPPPs in health. These GPPPs in health derive their understanding of accountability from the nature and character of their individual health policy and practice agendas or arrangements. Also, in contrast to the vertical structure of relationships in the international health regime (which is characterized by hierarchical and bureaucratic relations between states and the WHO because states have formal authority over the WHO), accountability is more horizontally structured in today's global health regime. For example, multi-stakeholder partnerships can demand accountability from those they fund.

But such GPPPs are expected to be accountable not only to the governing boards that have formal authority over them (just like in a vertical, bureaucratic relationship), but also to health sector regulators (read: government) as well as to those affected by their operations in specific settings of global health. Scholars refer to these patterns of partnerships' horizontal accountability relationships as 'multiple accountabilities' (Bruen et al., 2014; Weisband and Ebrahim, 2007; Bartsch, 2007a; Blagescu and Young, 2005; Newell and Bellour, 2002). Multiple accountabilities mean that who is demanding accountability and who is being held to account demands careful consideration and is dependent on the context in which this accountability relationship takes place. As such, Bruen et al. (2014) note that the understanding and practice of accountability in global health has become flexible with connotations, meanings and inferences that change depending on the context, agenda and perspectives of the actors involved. Thus the global health regime is a space where various kinds and forms of accountability understandings and practice now battle for recognition and legitimacy (Bruen, et al., 2014).

As stated earlier, GPPPs in health derive their understanding of accountability from the nature and character of their individual health policy and practice agendas or arrangements. Policy provides the regulatory framework that guides practice in specific settings of global health (Barnes, 2011; Bruen, et al., 2014). So how does the Global Fund as a GPPP in health understand accountability in policy and how does this understanding inform its practice when it undertakes public health policy processes in specific settings of global health? Despite contestation around the Global Fund's accountability, the literature has little to say on the question of how the Global Fund itself understands accountability in policy and how this understanding informs its accountability practices on the ground with regards to public health policy processes in specific settings of global health. This study aims to bridge this gap.

Ghana is a specific setting of global health in which the Global Fund is engaged in public health policy processes. The Global Fund entered Ghana in 2002 as a donor in the national response to the outbreak of the HIV/AIDS epidemic in the country. However, the participation of donors generally in the national HIV/AIDS response and the methods they employ gave rise to questions over the country ownership of the national HIV/AIDS response in Ghana and its attendant accountability implications. Country ownership is a phrase which is intended to represent a paradigm shift into a post-conditionality era away from what had been an era of International Financial Institutions ownership (that is the World Bank and International Monetary Fund) through failed structural adjustment policies (Walker, 2012). It represents efforts to increase the involvement of recipient countries (government and its citizens) in the design of externally funded programmes (Walker, 2012).

The Global Fund describes country ownership as a core principle of its accountability policy which informs its practice in aid recipient countries (Global Fund, 2012a). However, there has been a significant lack of scholarship investigating the Global Fund's accountability practice in specific settings of global health, particularly in relationship to its implications for country ownership of health policy. So, rather than take the Global Fund's claim that it promotes country ownership at face value, it is necessary to investigate the practices of the Global Fund. In sum, in order to examine the Global Fund's institutional policy and practice of accountability, there is the need to respond to and understand what accountability translates to in policy by the Global Fund and how this informs its accountability in practice in particular in relationship to its implications

for country ownership of health policy in Ghana, specifically the national HIV/AIDS response policy.

1.3. Research Objectives of the Study

As discussed in the opening section of this chapter, the central objective of this thesis is to interrogate the institutional accountability policy and practice of the Global Fund in the global public health regime. The specific focus of the study is on the way in which accountability is understood and practised by the Global Fund in Ghana, in particular in relation to its implications for country ownership of the HIV/ AIDS response policy. In order to achieve this overarching objective, this thesis has two specific objectives. These are:

(a) To determine how the Global Fund understands accountability in its policy documentation and what structures and procedures it has put in place to address accountability concerns.

(b) To investigate how the Global Fund's policy understanding of accountability works itself out in practice in Ghana, in particular in relation to its implications for country ownership of the national HIV/AIDS response policy.

1.4. Conceptual and Theoretical Approach

Analysis in the thesis is embedded in a critical political economy approach. An approach rooted in the critical political economy tradition enables the researcher to understand that the shift from an international to a global health regime is a complex and historically mediated developmental process conditioned by social relations. Global public-private partnership and the question of partnership policy understanding of accountability and how it informs and affects their accountability practice, are situated in the context of these relations. In view of the fact that accountability refers fundamentally to how policy and practice relations are structured, driven and managed, accountability in relation to global public-private partnership in health is therefore about who is accountable to whom, how and why in the developmental space. In other words, it is about relations of power. The conceptual and theoretical approach of this study will be discussed in broader detail in the next chapter which is Chapter Two. That Chapter outlines the theoretical and conceptual basis of the study.

1.5. Justification for the Study

This thesis makes important contributions to understanding the functioning of the Global Fund and, more generally, to understanding accountability in global health. Firstly, it makes a contribution to the literature in the field by enriching our understanding of the challenges of institutionalising accountability and country ownership, with a particular focus on the Global Fund. In so doing, the thesis shows that notions of accountability and country ownership do not materialise or find practical application merely because an organization, such as the Global Fund, has a stated commitment to realizing them. As such, there is the constant need for a critical approach and a careful interrogation of words such as accountability and country ownership to determine how they are used in policy documentation and whether and how they are translated into practice. Such an interrogation will alert us to the role of power and the deeply political and politicised nature of the global aid industry and the ways in which this industry continually reinforces global inequalities.

Secondly, the adoption of a critical political economy approach widens the analytical net by offering alternative insights in political science and international relations literature on global public-private partnership in health scholarship. As noted in Section 1.4 above, an approach rooted in the critical political economy tradition enables the researcher to understand that the global health regime emerged through a complex and historically mediated developmental process conditioned by social relations. Therefore, while some discussions of global health are insufficiently attentive to questions of relations of power, this study, rooted as it is in the tradition of critical political economy, pays close attention to power. Hence, this research aligns with other studies that are sufficiently attentive to questions of history and power relations with regards to the emergence of global public-private partnerships in health by contributing from a critical political economy perspective.

1.6. Limitations of the Study

The research process faced some challenges. It was difficult getting access to different organisations to conduct interviews. In order to drive the interview process, the researcher had to meet often with respondents at any location conducive for them and not limited to their official institutional spaces. Furthermore, due to time constraints that arose with some respondents (in relation to their job demands), it became expedient that the researcher focused on the salient

questions first during interviews. Some respondents also asked for interviews to be rescheduled. To achieve my research objectives, I always willingly adjusted my time to accommodate such requests as they arose. Also, documentary evidence was used to complement and safeguard the robustness and quality of interview data where possible.

Still on the interview process, it would have been desirable to have a higher number of state respondents involved in the research. However, I had difficulty meeting with public officials. Some of those contacted did not reply or respond to communication requesting interviews. There were others who asserted that they would be travelling, felt overextended because of outstanding commitments still pending or were just generally, reluctant to participate. Although I interviewed respondents from 11 government and public sector agencies, it would have been better to interview more participants from this respondent group. This is because the bulk of Global Fund grants go to government agencies, and they play major roles in the Global Fund practice (both as managers and implementers) within the response process. However, the lack of a greater level of government and public sector agencies perspectives in the interview process was moderated by relying on other primary sources embedding state involvement in the Global Fund operations in the response process. For example, the official Ghana country page on the Global Fund website and other country reports focus on Ghana and include perspectives from state officials.

Also, greater observation of important processes such as the meetings of the Ghana country level secretariat of the Fund referred to as the country coordinating mechanism (CCM) and the visitation of the Global Fund secretariat country team for Ghana (during my fieldwork activities) would also have benefitted the research process. I was in the Ghana AIDS Commission (GAC) on the day of the meeting, but could not meet with any of the officials due to issues of protocol. However, most of these processes are documented in official reports and publications (accessible from official organisational websites).

1.7. Research Methodology

This section presents the methodology chosen to answer the research questions. I started this section by engaging in an explanation of the philosophical assumptions that guide the research. Furthermore, I describe in detail the research design, the choice of Ghana as a good social context to study the Global Fund accountability practice, and the methods employed for data

collection and data analysis. Data collection included both primary and secondary data sources. The section concludes by discussing the research analysis process.

1.7.1. Explaining the philosophical assumptions that guide the research process

All research studies are founded on some basic assumptions about what can be regarded as valid research and the research methods suitable for achieving it (Myers 1997; Pozzebon, 2004). These views and standards in research have been referred to as paradigms of inquiry, theoretical traditions or simply, orientations (Pozzebon, 2004). Each tradition has a particular understanding of ontology and epistemology (Scotland, 2012; Mack, 2010; Gialdino, 2009; Ritchie et al., 2013). The concept of ontology speaks to how researchers perceive, understand and examine the world in which they live (Scotland, 2012; Mack, 2010; Gialdino, 2009; Ritchie et al., 2013; Orlikowski and Baroudi 1990). The three often used or mentioned ontological positions are positivist, interpretive, and critical (Orlikowski and Baroudi 1990; Scotland 2012).

Ontologically, positivist studies are premised on controlled scientific experimentation (Orlikowski and Baroudi 1990). Positivists believe that whatever exists can be verified through experiments, observation, and mathematical/logical proof. A positivist approach is built upon values such as quantification, generalisation, measurability and objectivity (Riley, 2007; Aliyu, 2014; Orlikowski and Baroudi 1990). Interpretivists, on the other hand, view reality as socially constructed and therefore examine phenomena through the understandings or interpretations assigned to them by people as they undertake activities in the social world (Orlikowski and Baroudi 1990; Gialdino, 2009). Critical theorists, like interpretivists, believe that reality is socially constructed, but pay particular attention to the undercurrents of power relations and ideology that surround social relations and practices (Pozzebon, 2004). They adopt an approach which seeks to reveal the underlying power relations or ideologies that inform or affect a phenomenon (Orlikowski and Baroudi 1990).

Following from the above, this study adopts a critical political economy approach and its underlying ontological underpinnings. In articulating the underlying ontological underpinnings of the critical political economy approach, Cox (1995:31) posits that ‘first of all, there is no theory in itself, no theory independent of a concrete historical context. Theory is the way the mind works to understand the reality it confronts. It is the self-consciousness of that mind, the awareness of how facts experienced are perceived and organized so as to be understood. Theory

thus follows reality in the sense that it is shaped by the world of experience'. This implies that theory (knowledge) building is a function of how an individual or people experience and understand the world they live in at any given time. In other words, theory is how they construct, interpret and understand the reality of their existence at any point in history. As this study is rooted in critical political economy, the approach taken is attentive to the historical power relations and underlying ideological orientation which informs and shapes the Global Fund's policy understanding of accountability. The Fund's policy understanding of accountability informs and affects its accountability practice in specific settings of global health.

Closely associated to ontological concerns are epistemological issues. Epistemology examines the nature of knowledge and how it is captured, particularly in relation to its methods, scope or justification and validity (Bryman, 2016; Potter, 2013; Ritchie et al., 2013; Denzin and Lincoln, 2011; Scotland, 2012; Mack, 2010; Gialdino, 2009; Hofer and Pintrich, 1997; Myers 1997; Orlikowski and Baroudi 1990; Bryman and Bell, 2007; Bhattacherjee, 2012; Pozzebon, 2004). Many epistemological approaches have been documented and referenced in literature. The three often used or cited approaches are positivist, interpretive, and critical approaches (Harrison et al., 2017; Potter, 2013; Ritchie et al., 2013; Bryman, 2016; Scotland 2012; Gialdino, 2009; Bryman and Bell, 2007; Orlikowski and Baroudi, 1990; Pozzebon, 2004; Potter, 2013; Guba and Lincoln, 2005). These three epistemological approaches are reflective of the three ontological approaches in research methodology literature. This suggests that a clear relationship exists between the ontological and epistemological views of a researcher and the methods employed in the research process.

Auguste Comte (1798–1857), often considered the architect of positivism, believed that we can study the social world through direct observations from which universal and invariant laws of human behaviour can be identified (Comte cited in Ritchie et al., 2013; Scotland, 2012; Bryman and Bell, 2007). The positivist approach is similar to the position of the natural scientists with their preoccupation with facts. Knowledge discovered in accordance with this approach is considered value-free and devoid of political or historic context or interference (Scotland, 2012). Thus, positivists see the researcher and the phenomenon under research as separate entities independent of the other (Scotland, 2012; Ritchie et al., 2013). Knowledge is captured under the positivist approach using precise measurement techniques, verifiable through experiments,

observation, and mathematical/logical proof. As such, certain values such as quantification, generalisation, highly structured methodological procedures, standardized tests, hypothesis testing, statistical correlations and analysis, measurability, objectivity, and cause and effect are common attributes of this approach (Riley, 2007; Aliyu, 2014; Orlikowski and Baroudi 1990; Harrison et al., 2017; Scotland, 2012; Ritchie et al., 2013; Denzin and Lincoln, 2011).

In contrast to positivist inclined researchers and their preference for quantitative and measurement-oriented methods, interpretive researchers favour meaning-oriented methods (Pozzebon, 2004). Interpretive researchers believe that people and their social institutions are different from the subject matter investigated by positivist researchers in the natural sciences. They propose that an approach is needed that is more sensitive to the specific qualities of people and the social institutions that impact on their existence (Potter, 2013; Ritchie et al., 2013; Bryman, 2016; Scotland 2012; Gialdino, 2009; Bryman and Bell, 2007; Orlikowski and Baroudi, 1990; Pozzebon, 2004; Potter, 2013). Interpretive epistemology embraces the understanding of phenomenon from an individual's perspective and also from the social contexts which people occupy (Scotland 2012; Potter, 2013; Ritchie et al., 2013). In other words, the social world can be analysed or understood from the perspective of individuals who inhabit it. As such, there are multiple realities because diverse people can assign different interpretations and understandings to a specific phenomenon. The interpretive epistemology is thus one of subjectivism derived from real world phenomena (Scotland 2012; Bryman and Bell, 2007; Pozzebon, 2004; Potter, 2013; Ritchie et al., 2013; Klein and Myers, 1999).

While critical researchers share the underlying epistemological assumptions of interpretivist researchers, critical research epistemology pays specific attention to power relations and ideology (Scotland 2012; Pozzebon, 2004; Harvey, 1990). As Scotland (2012) explains, the focus on power relations and ideology enables the researcher to understand that knowledge is a function of social construction and shaped within society by power relations and ideology. He goes further to explain that 'what counts as knowledge is determined by the social and positional power of the advocates of that knowledge' (Scotland 2012: 13). Thus, Pozzebon (2004) concludes that the critical interpretive epistemology emphasises the dynamics of ideology, power, and knowledge that informs social practices.

In this vein, this study adopts a critical interpretative epistemology. I concur with the position of Pozzebon (2004) that research may be both interpretive and critical. This is because to be critical and interpretive can be viewed as intrinsically related because both search and look for meaning-oriented methods. For example, interpretivist (or constructivist) approaches emphasise the way in which a specific social reality is constructed and the understanding or interpretation assigned to it. Likewise, the critical interpretative epistemology also assume that social reality is socially constructed and focus on the underlying socio-relational forces of power and ideology that affect social practices (Pozzebon, 2004). This position is sustained by Phillips and Hardy (2002), Alvesson and Skoldberg (2000). Pozzebon (2004) further posits that it is difficult (if not impossible) to be interpretative without being critical. In other words, critical analysis is embedded in interpretive research.

Therefore, the critical interpretative approach can be conceptualised as encompassing the following: qualitative methods that pay attention to underlying socio-relational forces of power and ideology that affect social practices. Qualitative research employs flexible collection methods derived from the social context under investigation. Put clearly, such qualitative methods seek to explore, gain understanding, and establish the meaning of experiences from the perceptions of those involved. Thus, qualitative data research methods focus on real life circumstances and practice, driven by an interactive research process involving both the researcher and the social actors involved (Myers and Klein, 2011; Pozzebon, 2004). In this way, data collection drives theory building (Scotland, 2012).

On the whole, qualitative researchers can employ a wide gamut of data methods and interpretative practices in any given study. Such methods and practices include interviewing, critical interpretive method, non-participant or participant observation, document analysis or reviews, in-depth case study, historical analysis, textual analysis, etc. This study also draws on some of these methods. Therefore, multiple ways of undertaking research are prevalent among researchers and is a function of their philosophical orientation.

1.7.2. Research design: A 'single case study'

In conducting this study, I adopted a qualitative case study research design (Yin, 2003). Yin (2009) explains that a research design 'is the logical sequence that connects the empirical data to a study's initial research questions and, ultimately, to its conclusions' (Yin, 2009:26). This is

because such a design offers a logical way to gather data, analyse the data, and present the findings, and therefore understand a specific phenomenon, issue, or problem in great depth (Yin, 2009; Thomas, 2003). With regards to the Global Fund, a critical interpretive case study approach assumes that the Global Fund's accountability policy and practice are socially constructed. Therefore, this approach is employed to examine how the Global Fund understands accountability in its policy documentation and how such policy understanding of accountability works itself out in practice in Ghana, in particular in relation to its implications for country ownership of health policy.

A critical interpretive case study approach was also embraced because its flexibility allowed the researcher to analyse phenomena by applying various types of data collection and analysis methods such as interviews, observations and documentary evidence. Furthermore, a case study approach supports detailed examination of a subject of study and the social context in which it exists (Hancock, 1998; Devine, 2002). Yin (1994) further argued that the case study method is relevant for the examination of social phenomena in its objective conditions of existence when boundaries between phenomena and its social context are not apparent. Put succinctly, the detailed investigation of social phenomena in its objective conditions of existence is the key concern of the case study approach (Creswell, 1998; De Vaus, 2001; Diefenbach, 2009; Yin, 2009, 1994; Flyvbjerg, 2006; Coast; 1999; Harrison, 2017; Luck et al., 2006; Ritchie et al., 2013; Bhattacherjee, 2012). The objective conditions are important because country characteristics of specific settings of global health differ due to political, social and economic reasons which all impact in one way or the other on Global Fund accountability practices.

Therefore, each case study offers unique characteristics relative to it. Ghana was selected as the real life context of this study's single case study research design for a variety of reasons. First, it was selected because its government depends on donor support for health system financing (including its national HIV/AIDS response). In a 2007 National AIDS Spending Assessment (NASA) report, donor funds comprised 71% of overall expenditure on HIV and AIDS (Asante et al, 2007) and in a more recent study, donor contribution accounted for roughly 80% of the entire HIV/AIDS budget in Ghana (Zakaria, 2015). The Global Fund is the foremost financier of Ghana's national HIV/AIDS response. While the World Bank funds the Ghana AIDS

Commission (GAC) through its Multi AIDS Programme (MAP), the Global Fund remains by far the dominant actor in the national HIV/AIDS response in Ghana.

Second, HIV/AIDS is implicated as a key cause of death in Ghana's health sector. Thus the government and its allies are determined to reverse this trend. One of the key indicators of obtaining Global Fund support for HIV/AIDS financing is the degree of disease morbidity and mortality within a specific country and the efforts and progress made to ameliorate the situation (Armstrong, 2019). In 2019, Ghana ranked 13th in relation to global Malaria incidence, in contrast to the 11th position it occupied in 2015 (Global Fund Ghana Audit, 2019). With regards to HIV/AIDS, a measure of the global HIV/AIDS prevalence ranks Ghana in the 33rd position (Global Fund Ghana Audit, 2019). HIV/AIDS prevalence is reported particularly in major urban centres and in roughly more than half of the ten regions in the country (Global Fund Ghana Audit, 2019). Ghana is not ranked among the 30 countries with the highest global high burden of tuberculosis (TB) as a disease on its own. However, it is one of the 30 countries with high levels of TB/HIV co-infections (Global Fund Ghana Audit, 2019). TB/HIV co-infections refer to situations where those affected by HIV/AIDS also have active or latent TB.

Third, Ghana is a bastion of democracy in Africa. In this vein, its determination to address its HIV/AIDS epidemic can be reasonably evaluated because the national HIV/AIDS response has not been impacted on by adverse social conditions such as political instability, conflict and migration that blight the political economy of some sub-Saharan African countries. Finally, English is the medium of communication in Ghana. This made it easy to examine relevant documents and also to communicate with research participants.

1.7.3. Methods of data collection and analysis

Following the adoption of a qualitative case study research design in this study, it is important to clearly explain the methods of data collection and analysis. As has been articulated by scholars, there is no standard procedure for engaging in qualitative research as findings can be informed by various methods of data collection and data analysis (De Vaus, 2001; Devine, 2002; Harrison, 2017; Luck et al., 2006; Diefenbach, 2009; Flyvbjerg, 2006; Ritchie et al., 2013). In this vein and following the structure of the research objectives, different research methods were needed in this study to analyse the accountability policy and practice of the Global Fund.

1.7.3.1. Interpreting accountability in policy: critical interpretative analysis

As discussed in preceding sections, this study adopts a critical interpretive case study approach or research design. The critical interpretive epistemology assumes that knowledge is socially constructed and shaped within society by power relations and ideology (Pozzebon, 2004; Phillips and Hardy, 2002; Alvesson and Skoldberg, 2000; Scotland, 2012). Therefore, the critical interpretive epistemology places emphasis on the dynamics of ideology, power, and knowledge that informs social practices in any specific context (Pozzebon, 2004).

The first research objective of this study is to determine how the Global Fund understands accountability in its policy documentation and what structures and procedures it has put in place to address accountability concerns. In order to achieve this objective, the official Global Fund website functioned as the key source of reference (data collection) for the Fund's policy documentation and other publications (McGill, 2014). The Global Fund makes public most of its documents online, thereby creating access to examine its policy documentation. The single most important policy document of the Global Fund is its foundational partnership policy framework document (Global Fund, 2012a). This partnership framework document not only encapsulates the Fund's principles, mission and vision as a global organisation established to fight HIV/AIDS, tuberculosis and malaria, but also details its institutional policy and practice arrangements.

Chapter Five is the chapter that engages with this first research objective of this study, while Chapter Three (on the origin of the Global Fund) will provide a backdrop for the analysis in Chapter Five. In addition to the documents provided by the Global Fund itself, other supporting literature to aid the analysis in Chapter Five was identified through the lens of critical political economy and was located through academic databases (e.g. Springer Nature, ProQuest Academic Complete, Oxford Scholarship Online, PubMed) and online search engines (such as Google Scholar).

1.7.3.2. Interpreting accountability in practice: qualitative fieldwork in Ghana's health sector

The second research objective of the study is to investigate how the Global Fund's understanding of accountability works itself out in practice in Ghana, in particular in relation to its implications for country ownership of national HIV/AIDS response policy. Qualitative fieldwork was undertaken in the health sector in Ghana in order to fulfil this second research objective. In

conducting this fieldwork, my interest was in exploring how various actors in practice appropriate and interpret the Global Fund's understanding of accountability particular in relation to its implications for country ownership of health policy.

The field study was undertaken in Ghana between February and May 2018. Fieldwork was primarily concentrated in Ghana's capital city, Accra. The Global Fund country level secretariat known as the country coordinating mechanism (CCM) is domiciled the capital city. The capital city is the seat of government and its agencies involved with the Global Fund and the majority of the civil society organisations undertaking Global Fund programmes are also based in this city. However, I also visited Kumasi, the second largest city in Ghana, in order to gather data from a wider constituency of actors involved with the Fund. The duration of the fieldwork was the function of a gamut of factors such as transportation, accommodation and other ancillary costs and availability of key stakeholders such as public authorities at particular times in the fieldwork process as they frequently changed and rescheduled dates. Before undertaking interviews, respondents were alerted to the ethical implications of participating in the study. Every interview respondent was asked to read the informed consent form which contained and described the objectives of the research (See Appendix A for Informed Consent Form).

As explained earlier, different research methods were needed in this study to analyse the accountability practice of the Global Fund. The deployment of different research methods was important as it availed different insights into the Global Fund's accountability practice in Ghana, which would not have been possible applying a single research method. The different data sources and methods used during my fieldwork are analysis of documentary evidence, the observation of meetings and interviews. These methods are discussed in greater detail below.

Documentary evidence

Documentary evidence was adduced to support the field research. Documentation was located and accessed in multiple ways. For example, I visited public libraries in Accra, and also solicited help from research participants in obtaining relevant documents where possible. Documents collected included for example government level reports on the health sector more broadly and on HIV/AIDS in particular, award letters and funding agreements between the Global Fund and its aid recipients, the HIV/AIDS coordinating secretariat meeting minutes and agendas, and

various official monitoring and evaluation reports relating to the activities of the government, donors and civil society organisations (CSO's) alike. For instance, a civil society organisation like Aidspan provide information on Global Fund activities in Ghana and other counties, and on CSOs and other actors operating in the global health landscape across countries. The Global Fund website functioned as the key source of reference (data collection) for the Fund's policy documentation and other publications. The Global Fund documentation is easily accessible online. Taken together, these documents acted as a basis for gaining insights and perspectives into how the Global Fund's understanding of accountability works itself out in practice in Ghana, in particular in relation to its implications for country ownership of health policy.

Observation of meetings

Kawulich (2005) argues that when events and behaviour in the social context chosen for study are systematically described or appraised, then observation has taken place. It affords the context for the development of sampling guidelines or interview guides. Baker (2006) notes that the value of observation is that it permits researchers to study phenomena in their natural context in order to understand its nature, character and behaviour. Observing formal meetings as a participant was considerably difficult, though opportunities as a non-participant observer arose a number of times that offered insight into Global Fund activities. Non-participant observation entails observing participants without taking an active part in the events in which they are observing. Put clearly, this option is applied to observe and understand a phenomenon by being in the same social context in which the phenomenon is located, while keeping a distance from the activities under observation (Liu and Maitlis 2010; Cooper et al, 2004). Non-participant observation is often used together with other data collection methods and can provide a contextual appreciation of situations not easily apprehended through other approaches (Liu and Maitlis 2010; Cooper et al., 2004).

Through contacts made by friends who knew people involved in the response, I had the opportunity to visit such people at different times in their offices on friendly calls and observed them as they engaged in their activities. Such visits were to government, donor agencies and civil society organisations. Furthermore, a number of informal visitations to sites to observe HIV/AIDS programme implementation in action were also arranged. These were to some civil society organisations directly involved in programme implementation to see how programmes

are undertaken daily and also to two hospitals in Accra and one in Kumasi. At times during such visits, I got to hear people discuss, policy matters related to the governance and organisational structure of the Global Fund and their programmatic/financial challenges as actors in the response. These observatory activities provided contextual insights into the national response in action. Germane to successful non-participant observation is the gathering of detailed field notes (Liu and Maitlis, 2010; Cooper et al., 2004; Baker, 2006). In this context, detailed notes of informal discussions, and their dates and times as well as follow up actions, were written down at the earliest possible time in a notebook reserved for such interactions. These interactions enhanced the richness of my interview guide as it provided insights to follow up and to inform the questions that I put to my respondents in interviews.

Interviews

Interviews have been described as a critical tool for gathering data in qualitative research (Creswell, 2007; Jamshed, 2014; Sutton and Zubin, 2015; Crotty, 1998; DiCicco-Bloom and Crabtree, 2006). Kapilashrami (2010) reiterate the elastic and interactive character of the interview process which endows it with the capacity to engender new insights, thoughts or knowledge at any stage in the interview process. As such, the development of the case narratives with regards to the second research question under investigation was dependent on interviews as the primary source of information. Before undertaking the fieldwork in Ghana, I drew up an interview guide (see Appendix B). The interview guide assisted me in asking respondents the right questions in order to address my research objectives. Although the guide was developed before the interviews, it was subject to revisions during the interview process as the need arose. I conducted 65 semi-structured interviews. Some were repeat interviews to clarify respondent views as the need arises. Internet and documentary review, and snowball technique were applied to identify respondents.

Interviews took place at settings acceptable to the respondent and that guaranteed confidentiality. Interviews lasted an average of one hour or more depending on the disposition of the respondent. Those interviewed were chosen on the basis of their position as CCM members, health sector leaders, grant recipients, civil society leaders, activists, knowledgeable observers such as in the academia, media commentators, donor partners and also participation in the national response. Therefore the choice of the respondents was informed by their leadership positions, their

participation as stakeholders in the implementation of the national response and the possibilities that these create for their extensive knowledge of issues to be covered. I also made efforts to capture key contextual characteristics of the national response by making sure the views of both men and women were captured, as well as those of People living with HIV/AIDS (PLWA) and representatives from key affected populations (KAP). Key affected populations in the Ghanaian context include sexually active groups who are not legally recognised under state laws in Ghana. They include Women having Sex with Women (WSW), Men having Sex with Men (MSM) and Sex Workers (SW). They are represented in the national response by proxy through advocacy groups such as the West African Program to Combat AIDS and STI (WAPCAS), and other proxy groups. Beyond involvement in the national response, questions related to respondents' health status were not asked.

The majority of respondents preferred not to be recorded. Instead, I took down notes and made sure to capture details carefully during each interview session. The reluctance of respondents to be recorded is linked to the sensitivity of the subject matter (accountability) in Ghana, and potential concerns about the implications that may arise should they be quoted directly in the study. This sensitivity is heightened due to the various accountability audit probes that the Global Fund has commissioned into its operations in Ghana over time. For example, there have been several occasions where local actors have been found guilty of financial mismanagement and have had to pay back money and, consequently, many respondents were nervous that if their interviews were recorded they may likewise face sanctions for speaking without official authorisation or approval on such sensitive financial issues in particular and the Global Fund operation more broadly.

To address respondents' concerns, their identities will not be revealed in this study and their responses will be used in a way that does not make any respondent identifiable. Anonymity and non-disclosure are essential so as not to embarrass or endanger in any way the jobs or livelihoods of the research participants. Rather than be identified by name, respondents were each given a number. Respondents cut across different partnership constituencies in Ghana such as government, civil society, donor aid agencies, academia and also the private business sector. In other words, government respondents are a respondent group. Same for civil society respondents, donor aid agency respondents and so on. Each organisation (or individual) within a group is

tagged with a number depending on the number of organisations (or individuals) within a respondent group. This helps to secure respondent anonymity and non-disclosure. The system is detailed and explained in Table 1.1 below.

Table 1-1: Interview respondents' group affliations and their identification numbers

Broad Respondent Group Affiliation	Organisations or Individuals that Make Up Broad Respondent Groups and their Identification Numbers
Government Respondents	Ministry of Health – 1 Ghana Health Service – 2 National AIDS Control Programme – 3 National TB Control Programme – 4 Ghana AIDS Commission – 5 Ministry of Finance and Economic Planning – 6 Nurses and Midwives Council of Ghana – 7 District Officials – 8 National Malaria Control Programme – 9 Ministry of Local Government and Rural Development – 10 Ministry of Education – 11
Civil Society Respondents	Africare – 1 Forum for Youth Organisations – 2 West Africa Aids Foundation – 3 Wisdom Association – 4 Christian Council of Churches – 5 Muslim Council of Ghana – 6 Traditional Healers Association of Ghana – 7 Network of People Living with HIV/AIDS – 8 Ghana Social Marketing Foundation – 9

	Family Health International – 10
	Care International – 11
	West African Programme to Combat HIV/AIDS – 12
	Planned Parenthood Association of Ghana – 13
	Adventist Development and Relief Agency of Ghana – 14
	Centre for Development of People – 15
	Stop the Killer AIDS – 16
	Population Service International – 17
	Ghana Coalition of NGOs in Health – 18
Private Business Sector Respondents	Anglo Ashanti (Ghana) Malaria Control Limited – 1
	Ghana Business Coalition on Employee Wellbeing – 2
	Association of Building and Civil Engineering Contractors of Ghana – 3
Aid Agency Respondents	World Health Organisation – 1
	United Nations Development Programme – 2
	United Nations Children's Education Fund – 3
	United Nations Joint Agency for HIV/AIDS – 4
	British Department for International Development – 5
	United States Agency for International Development - 6
Academic Respondents	University of Ghana, Legon – 1

University of Education, Winneba – 2

University of Cape Coast – 3

Kwame Nkrumah University of Science and Technology – 4

From Table 1.1 above, each organisation (or individual) within a group is tagged according to the number of organisations or persons) within a group of respondents. For example, organisations such as the Ministry of Health, Ghana Health Service, National AIDS Control Program and so on are part of the Government respondent community. Under this category, the Ministry of Health is named government respondent 1, Ghana Health Service is classified as government respondent 2 and government respondent 3 is designated as the National AIDS Management Programme. If I interview one respondent under the Ministry of Health, that respondent will be government respondent 1a. If under the Ministry I have more than one respondent, the subsequent respondents will be listed as government respondent 1b, 1c, 1d and so on. Ghana Health Service, for example, is also listed as government respondent 2. The first respondent under the service is simply government respondent 2a. Subsequent respondents under the health service will be reflected as government respondents, 2b, 2c, and so on.

With regards to interview data analysis, I read the interviews carefully in order to identify themes. Identification of themes is employed as a means to arrange the data and reduce it to a convenient proportion. The theme identification process has been extensively researched in a wide gamut of qualitative methods research guides such as Welsh (2002), Basit (2003), and Elliott (2018). The process of theme identification can be reflective of a researcher's bias or subjectivity. Therefore, in this process, the onus is on the researcher to interpret the data in a way that is consistent with the views of the respondents. The theme identification process can be manual or computer-driven. Both are widely applicable in the qualitative research process (Strauss and Corbin, 1998; Krippendorf, 2004; Rodwell, 1998; Lacy et al., 2015; Matthes and Kohring, 2008; Conway, 2006; Lewis et al., 2013). With regards to computer-based theme identification processes, Coffey et al. (1996), Denzin and Lincoln (2008) and Lewis et al. (2013) observe that there is a prevailing attitude among some researchers to adopt micro-computing devices and strategies for qualitative data analysis. Such researchers believe that the use of

computer-based analysis signposts an emphasis on logical procedures and systemic methodology to drive data analysis in the qualitative research process (Coffey et al. 1996; Riffe et al., 2005). However, Krippendorf (2004) pointed out the problems associated with using computer text in the analysis process. He argued that computer text analysis is an input and output mechanism that is reliant on computational algorithms that decontextualise data or sections of data into isolated categories independent of their contextual meanings (2004:14–15). Lewis et al. (2013) also argue that computer-driven analysis lacks the capacity to consider and interpret contextual meanings and the nuances of human language. It is in this context that Conway (2006), Strauss and Corbin (1998), Matthes and Kohring (2008), and Rodwell (1998), argue that the manual method of data analysis is best suited for interpretive research because data cannot be interpreted and understood independent from the context from which it derives its meaning.

Thus, this study aligns with the observations of the scholars discussed immediately above because a computer-based analysis process would not be compatible with the ontological and epistemological assumptions informing a critical interpretivist approach as adopted in this study. In this vein, I employed a manual theme identification process in order to analyse the data representing the views of respondents in its original context. In undertaking this process, I transcribed the interviews and filed all interviews with an interview identification number. By means of Microsoft Word and Excel, I arranged the data by probing for words, connotations and specific contextual phrases that repeatedly appeared in the text, thus creating room for clarity and an understanding of the data. The transcribed data were revised and organised into common themes in order to gain insights and interprets the perspectives of the respondents involved in the research process. These themes were regularly reexamined to search for definite linkages, patterns and meanings. From this process, I derived a set of coherent analytical categories. These analytical categories were then used to develop the narrative that was relevant in addressing the second research objective of the study on the accountability practice of the Global Fund in the practice chapters (six and seven).

1.7.4. Analysis of practice data: an inductive or deductive process?

The study embraces both an inductive and deductive process. This study embraces an inductive approach to analysis in which the researcher approaches data analysis and derives the analytical categories from examining the transcribed data embedding the views and understandings

expressed by respondents in the interview process. In this context, the analytic categories (or units) applied to describe and explain the research phenomenon under examination arise from the fieldwork data set instead of being determined beforehand through prior studies (Kapilashrami, 2010). Therefore, these analytical categories are a function of the reflections, views and opinions of respondents as to how the Global Fund's understanding of accountability works itself out in practice in Ghana, in particular with regard to its implications for country ownership of health policy.

Deductively, the critical political economy theoretical insights (highlighted in section 1.4 and to be discussed more broadly in Chapter Two) guided the entire research process and acted as the basis for drawing up the research questions and the initial interview guide (which underwent adjustment and revisions as the need arose) in the interview process. The initial interview topic guide was thus a reflection of relevant literature and prior studies by the researcher. Therefore, rather than as a framework to assess or examine accountability in practice, theoretical insights were employed to provide systemic guidance and to help interpret field data in order to understand the views and perspectives of the actors involved in the national response in Ghana. Kapilashrami (2010) proposes a blend of these two methods in the research process because they complement and strengthen each other.

Yin (1994), therefore posits that a case study is more convincing and accurate when its sources for evidence corroborate each other. Ultimately, the triangulation of observations, primary document analysis and interview records offered extensive data collection which could be matched with secondary literature to ensure reliability and validity. It created the 'thick' single case (Barnes, 2012) which forms the basis for a detailed narrative of the Global Fund's accountability practice, particularly in relation to country ownership of health policy (national HIV/AIDS response) in Ghana in forthcoming chapters (six and seven).

1.8. Structure of the Thesis

Chapter Two will proceed by explaining the basic theoretical tenets of the critical political economy approach. It then goes further to argue that the paradigm shift to a global from an international health regime, the emergence of global public-private partnerships (GPPPs) in health and the attendant changes in the way in which accountability for public health policy processes is understood and practiced in global health relative to international health are not

ordinary (circumstantial) occurrences or manifestations. Rather, they are structural and normative consequences of globalisation processes underpinned by a neoliberal world order.

Chapter Three reflects on the origin of the Global Fund. The rationale behind the chapter was to capture the historical circumstances within the context of globalisation that can account for the emergence of the Global Fund as a global public-private partnership. Chapter Four examines the effects of globalisation on the political economy of Ghana, particularly its health sector. Globalisation intersected with the outbreak of the HIV/AIDS epidemic in Ghana. Donors entered the health sector in support of government effort to combat the epidemic. However, donor participation generally in the national HIV/AIDS response and the practice methods they employ gave rise to questions of accountability in relation to the ownership of the national response. The Global Fund is a donor participating in the national HIV/AIDS response.

In order to examine the Global Fund accountability practice as a donor in the national HIV/AIDS response, there is the need to understand and respond to what accountability translates to in policy by the Global Fund and how such informs its accountability practice in the Ghanaian health sector. In this context, Chapter Five critically explores how the Global Fund understands accountability in its policy documentation and what structures and procedures it has put in place to address accountability concerns. Chapters Six and Seven are the two chapters that provide the examination of the Global Fund's accountability in practice in the Ghanaian health sector. Chapter Eight concludes the thesis by offering an overall summary of the thesis findings and arguments.

CHAPTER TWO
CONCEPTUAL AND THEORETICAL CONSIDERATIONS

2.1. Introduction

In Chapter One, I provided an introductory background and rationalisation for exploring accountability in the global health regime. I also noted in Chapter One that this study proceeds from the position that globalisation (underpinned by neoliberalism) in the post-World War Two order has enabled a paradigm shift from a state-centric international to a multi-actor global health regime. This shift also suggests changes in the ways in which global public-private partnerships (GPPPs) in health understand and practice accountability for public health policy processes in the global health regime relative to the international health regime. In order to explain and defend the position adopted by this study as articulated above, in this second chapter, I will examine historical and socio-relational trends in global political economy and their theoretical implications. The chapter provides a broad overview of neoliberal induced transformations in the political economy of health in states and discusses how this transformations has impacted on the understanding of accountability in the global health regime with specific regards to global public-private partnerships (GPPPs). In so doing, this chapter provides the conceptual and theoretical basis of the study. I will argue that the shift from an international to a global health regime and the attendant changes in the way in which accountability for public health policy processes is understood and practiced in global health are not ordinary (circumstantial) occurrences or manifestations. Rather, they are structural and normative consequences of globalisation processes underpinned by a neoliberal world order.

Based on the foregoing, the chapter proceeds in eight sections. Section 2.2 begins by reviewing the literature on GPPPs to identify divergent perspectives on their emergence in the global health regime. Section 2.3 advances the justification for the choice of a critical political economy approach in conceptualising the rise of public-private partnerships in particular and to guide this study in general. In line with this approach, Sections 2.4 describe and analyse the structural and normative transformations in the global political economy, while Section 2.5 takes this analysis further by articulating how these structural and normative transformations in the global political economy engendered a shift from an international health to a global health regime. Section 2.6 engages with a brief discourse on the decline or end of the neoliberal world order. While a

detailed and broader discussion of the decline or end of the neoliberal world order is outside the purview of this study, it is germane to demonstrate my awareness of this discourse because my study and its conceptual and theoretical approach is rooted in the context of a globalised neoliberal world order. Section 2.7 discusses the conceptualisation of global public-private partnerships in the global health regime. The analysis of the shift in the understanding of accountability in the international health regime relative to the global health regime is presented in sections 2.8 and 2.9 respectively. Section 2.10 contextualises the linkage between power and accountability in relation to global public-private partnerships operating in the global health regime and Section 2.11 summarises and concludes this chapter.

2.2. Divergent Perspectives on the Rise of Public-Private Partnerships in Global Health

There are divergent perspectives in the literature regarding the emergence of public-private partnerships in the global health landscape. Some of these perspectives argue that public-private partnerships emerged to fill various governance gaps and failures and to provide efficiency and solutions in addressing such gaps and failures. In this vein, Bäckstrand (2005) for instance, argues that regardless of the perspective from which the partnership phenomenon is viewed, it is reasonable to conclude that such partnerships emerged in response to the restrictions of multilateralism in that intergovernmental diplomacy alone does not appear to be able to grapple with the pressing problems and complex dimensions of sustainable development. Picking up on the theme of complexity identified by Backstrand (2005), Benner et al. (2004) argue that state failure in the arena of unilateralism or multilateralism has given rise to new forms of networked governance (conceptualised as public-private partnerships). They noted that these new forms of networked governance are necessities to plug state operational governance asymmetries and gaps.

In contrast to Bäckstrand (2005) and Benner et al. (2004), other scholars explain the emergence of public-private partnerships by referring to the relationship between democratic practices and such partnerships. These scholars suggest that public-private partnerships help strengthen democracy by bolstering the realm of social life where public opinion can be formed freely and in this way expanding democratic participation. In this context, Borzel and Risse (2002) posit that public-private partnerships promote efficiency (through increased problem-solving capacity) and democratic participation and accountability in democratic societies. Also adopting this

perspective, Nanz and Steffek (2004) and Walter (2014) assert that cooperative arrangements (public-private partnerships) generate citizen empowerment and involvement by encouraging greater levels of participation and political deliberation in democratic societies.

Still on the value-addition and problem-solving capabilities of public-private partnerships, some other scholars are of the belief that public-private partnerships materialised to promote public-private cooperation in the provision of global public goods. Rosielloa and Smith (2008) argue that public-private partnerships are an innovative mechanism to improve the efficiency of the distribution of health services and medical products in developing countries. Kaul and Faust (2001), Kaul et al. (2003), and Kaul and Conceicao (2006) postulate that the provision of global public goods (goods that are beneficial to humanity as a whole such as essential medicines) is no longer a function limited to state authorities. Rather, the provision of global public goods is a collective venture or process that requires new organisational frameworks to take advantage of the opportunities engendered by the processes of globalisation and also to mitigate the risks inherent in the globalisation process such as emerging infectious disease. Also in articulating his conceptualisation of global public goods, Ruggie (2004) speaks of a 'global public domain' beyond the confines of the nation-state that associated the 'public' with only states and the interstate realm (by embracing the private sector) that drives the creation of global public goods. Ruggie's (2004) assertion does not imply that the state has lost its authority in the provision of public goods, but that such efforts are now necessarily complemented by private sector efforts.

Still on global public goods, Buse (2003), Buse and Walt (2000a, 2000b, 2002) argue that the logic behind public-private partnerships is that emerging health problems necessitated cooperation between the public and private sectors that will leverage on the technical know-how efficiency and resource base of the private sector. Mahoney (2005) asserts that public-private partnerships presented a framework for aggregating resources between the public and private sector to achieve intended results (such as in the provision of vaccines in developing countries). This view is also sustained by Meier et al. (2013), Sinanovic and Kumaranayake (2006), Reinicke et al. (2000), Widdus (2001), Reich (2000), Nelson, (2002), Wheeler and Berkley (2001). Implicit in the conception of public-private partnerships as global public goods is that it is a positive innovation that builds mutual trust and presents a win-win situation for the parties involved. For example, it provides public authorities with additional resources and technical

knowledge from the private sector, while also allowing the private sector to participate in public health policy processes, all for the public interest.

While the scholars discussed above examined the establishment of public-private partnerships in terms of global public goods, there are scholars that stressed their belief that public-private partnerships arose to address governance gaps and failure in the provision of rules, standards and norms in international governance arrangements (Finnemore and Sikkink, 1998; Shiffman, 2016; Holzscheiter et al, 2016; Keck and Sikkink, 1999). Finnemore and Sikkink conceptualise a norm 'as a standard of appropriate behaviour for actors with a given identity' (Finnemore and Sikkink, 1998: 891). Picking up on norms in relation to public-private cooperations, Keck and Sikkink (1999) articulated the concept of 'transnational advocacy networks' and placed emphasis on the 'centrality of principled ideas or values in motivating their formation' (1999: 89). In other words, the construction of transnational networks (such as public-private partnerships) varies depending on the principled ideas or values that underpin their creation. For example, global public policy networks pay attention to policy consequences and the provision of public goods, epistemic communities and knowledge networks emphasize knowledge generation and identification of causal relationships and transnational advocacy networks concentrate on advocacy (Shiffman et al., 2016). As further articulated by Shiffman et al. (2016) and Shiffman (2016), central to all network building is the attribute of problem-solving. Thus, problem and solution finding are fundamental components of deliberate social construction (Shiffman et al., 2016, Shiffman, 2016).

While the narrative in the preceding paragraphs generally places more emphasis on efficiency advantages, problem-solving and other value-addition capabilities as factors that can account for the emergence of public-private partnerships in global health, there are scholars who place more weight on history and power in conceptualising the rise of these partnerships. Barnett and Duvall (2005) postulate that power relations govern the nature and character of institutions in the global health regime and implicitly, its legitimacy. Brown (2012) argues that power approaches examine power relations inside and outside social institutions, while historical approaches locate public-private partnerships in a broader systemic context by considering systemic trends, events and transformations that has taken place over time in the global political economy.

Richter (2004a) traces the global spread of public-private partnerships in the global health arena to the 1992 United Nations (UN) Conference on Environment and Development (UNCED), dubbed the Earth Summit. This summit placed emphasis on the need for the United Nations to work closely with the commercial sector in the name of partnership. The summit was chaired by Gro Harlem Brundlandt who later became the Director-General of the World Health Organisation (WHO). Richter (2004a) argues that the focus on public-private partnership should not fundamentally be on the type of interactions (value-added utilities they promote), but on 'the framework of thought underlying this policy paradigm' (2004a:43). In explaining her conception of 'the framework of thought underlying this policy paradigm', she notes that what differentiates these partnerships from other types of historical relations between the public and private sector in the international and global health landscape is the emphasis on 'shared processes'of decision-making power' (2004a:45). This view is also shared by Nelson (2002). This implies that the incorporation of non-state actors into these partnerships, alongside state actors has given non-state actors a formal mandate in public health policy processes and decision-making hitherto the exclusive preserve of states. In this context, partnerships promote a shared process of decision-making power between state and non-state actors.

However, Richter (2004a) proceeds to point out the implications in adoption of public-private partnerships as a governance mechanism. She avers that such partnerships implicitly reduce the role of governments and interstate institutions and elevate the political status of private actors, specifically that of the multinational business corporations (Richter, 2004a). She also notes that partnerships and their promotion of private interests (based on a business paradigm) endanger the core mandate of states in the global health arena which is to promote the fundamental right of their citizens to adequate and affordable healthcare. She thus advocates that public-private partnerships and their business orientation should be discarded in favour of new policy paradigms centred on the promotion of public-interest (Richter, 2001, 2003, 2004a, 20004b).

Bartsch (2006, 2007a), and Bartsch and Kohlmorgen (2007) explore the historical determinants of the rise of actors such as public-private partnerships. They note that the rise of partnerships has necessitated a need for governance discourse on global health to take into consideration the governance structures and power relations underpinning their activities. They categorised power in terms of discursive power, decision-making power and legal power (Bartsch and Kohlmorgen,

2007:9). Discursive power refers to the capacity to frame and influence discourses, resource-based power speaks to power arising from monetary, knowledge and information capabilities, decision-making power encompasses power to set agenda and participate in decision-making, while legal power involves the capability to exert power founded on legal structures and laws(Bartsch and Kohlmorgen, 2007:9). They argue that the application of these kinds of powers and how it is deployed is determined by how the governance system is configured and the roles actors undertake within them. Implicit in the views of these scholars is that the possession of various components of power by an actor can shape the balance of power relations in favour of that actor in specific public-private partnership governance systems. This focus on power relations with regards to public-private partnerships and non-state actors more broadly also runs through other works of Bartsch (see Bartsch, 2007a, 2009, 2011).

Barnes and Brown (2011) argue that public-private partnerships are by-products of globalisation configured to address the inadequacies of multilateral state-centric efforts in global health. The involvement of non-state actors in such partnerships is thus intended to expand participation and redress the power imbalances of state-focused multilateral politics. Such politics had hitherto excluded non-state actors from authoritative decision making spaces of global health. Picking up on the theme of multilateralism identified by Barnes and Brown (2011), Bartsch (2011) however notes that the historical rise of these partnerships affect discourse and practice in global health, erodes the decision making power of states and undermines the United Nations system. Addressing similar concerns, Faubion et al. (2011) aver that there is a need to explore the activities of these entities because they remake and influence the global health agenda in various ways and advance a neoliberal agenda. Similarly, Moran (2011, 2009) and Utting and Zammit (2009) argue that the historical development of public-private partnerships as policy responses to complex global health challenges has given rise to critical concerns around the entrenchment of private sector power within global health institutional arrangements.

Taking into consideration the views expressed by scholars above with regards to the inclusion of non-state actors in global health policy processes, Hesselmann (2011) states that wherever these actors exercise governance power, questions are raised with regard to how such power is exercised or how to keep it under control. In this context, she posits that it becomes imperative to investigate the activities of these entities because they exercise power in different ways

(Hesselmann, 2011). For example, 'in a material sense, they spend huge amounts of money and at an ideational level, they make policies, shape agendas and claim legitimacy' (Hesselmann, 2011:228). Rushton and Williams (2011), therefore conclude that there is a necessity to advance beyond descriptive accounts of public-private partnerships in the global health landscape to investigate more broadly critical questions of power relations with regards to their emergence and activities.

2.3. Conceptual Approach and Justification for Choice of Approach

This study, rooted as it is in the tradition of critical political economy, pays close attention to history and to questions of power relations. As such, this study broadly aligns with the position of the studies (discussed immediately above) which place more weight on history and power in conceptualising the rise of public-private partnerships. In this context, this study takes the position that the emergence of public-private partnerships is a complex and historically mediated developmental process conditioned by social relations. Therefore, the rise of the Global Fund as a public-private partnership and the question of its understanding of accountability which informs its practice are situated in the context of these relations. This approach insists on locating and analysing phenomena within the context of the socio-historical circumstances and processes of change that determine its nature and character.

Critical political economy pays careful attention to the underlying historical configuration of social relations and the hegemonic ideational arrangements that underpin a political system such as a world order (Cox, 1981, 1983, 1987, Cox and Sinclair 1996, Cox, 2002). In other words, critical political economy is concerned with investigating the historical evolution and progression of a political system (e.g. the neoliberal induced shift from international to global health) instead of paying attention solely to the present system as the basis and unit of analysis (Cox, 1981, 1983; Gill 1991, 1995 1995). Also, the utility of this framework for analysis is that it pays attention to both agency and structure when seeking to understand and explain the social (Bieler and Morton, 2001.). This approach is also critical because 'it does not take the institutions and social relations for granted, but calls them into question by concerning itself with their origins' (Cox, 1981: 129; Bieler and Morton, 1982: 86).

In articulating the theoretical basis of the critical political economy approach, Cox (1995) argues that 'first of all, there is no theory in itself, no theory independent of a concrete historical

context. Theory is the way the mind works to understand the reality it confronts. It is the self-consciousness of that mind, the awareness of how facts experienced are perceived and organized so as to be understood. Theory thus follows reality in the sense that it is shaped by the world of experience' (1995:31). Recognising this dialectical relationship between theory and history, this study proceeds to look beyond the present and go back in history to the crisis of the post-war capitalist development project. This is in relation to the advent of neoliberalism as an alternative political project in the 1970s, and the consequent transformations that took place in the organisation of social, political and economic life (Robertson et al., 2012).

2.4. Globalisation, Neoliberalism and the Restructuring of the State-Market Relations

Historically, intense economic crises were normally the turning point for the movement from one historical structure to another and usually heralded the beginning of a new global political-economic order, or 'historical structure' (Cox, 1983; Gill, 2008). After the great economic depression that preceded the Post-World War Two order (Cox, 1987), Keynesian social and economic policies became the dominant policy approach and post-war ideological consensus. Keynesian policies guided post-war rehabilitation and rebuilding activities by promoting state-regulated developmental policies in order to stop the market failures that were a feature of pre-war capitalist economies (Robertson and Verger 2012). Put clearly, Keynesianism was adopted as a response to the abuses of capitalism which led to severe economic crises in the 1930s in the developed countries of North America and Western Europe and to the challenge presented by Soviet style socialism (Pickel, 2009). The industrialised capitalist nations of Western Europe and North America were confronted with expectations from their citizenry to introduce social welfare guarantees which these countries did because they considered such guarantees as necessary to maintain social cohesion and stability (Cox, 1981, 1987).

Governments in these countries adopted an interventionist role in the economy through an increase in public sector spending and investment, nationalisation of private enterprises, overall government planning, coordination, and regulation of the market economy (Pickel, 2009; Centeno and Cohen, 2012). This amalgam of social and economic policies was referred to as Keynesianism or the Keynesian welfare state. These Keynesian policies were adopted, adapted and implemented in a variety of different institutional contexts – North America, Western Europe, East Asia, as well as many developing world countries where they formed part of a

larger development strategy (Pickel, 2009; Centeno and Cohen, 2012). The Organisation of Petroleum Exporting Countries (OPEC) oil embargo of 1973, global oil price volatility, spiralling global economic inflationary trends and attendant recession, stagnating growth rates, and balance of payments and debt repayment crises of the 1970s led to an ideological shift to neoliberalism (Gill, 1995a, 2003; Morton, 2003; Pickel, 2009; Cox, 1987).

Thus, the Keynesian policy regime lasted for three decades until the late 1970s. Liberal economists who had lost their voices under the Keynesian policy regime were quick to present the crises of the 1970s as a failure of Keynesian policies and proposed neoliberal antidotes as corrective measures to free the market from the state (Gill, 2003; Pickel, 2009; Centeno and Cohen, 2012). They contended that state-inspired Keynesian policy and state-controlled monopolies circumscribed private sector innovation, efficiency and participation in the economy. Thus, they recommended that the role of the state in the economy should be fundamentally limited to regulatory activities configured to drive market-based economic practices (Harvey, 2005:2; Robertson and Verger 2012). The emergence of neoliberal-oriented political leadership in the United States (with the Republicans under Ronald Reagan), in Canada under Brian Mulroney and in Britain (Margaret Thatcher's Conservatives) gave traction to the dispersion of neoliberalism as the new ideological consensus and global socio-political and economic architecture (Gill, 1995a, 2002b; Brown, 2012).

Cox (1981) argues that the shift from one historical framework to another (e.g. from one world order to another such as from Keynesian to neoliberalism) is driven by a confluence of material capabilities, ideas and institutions that engender a new structure of social relations. What this implies, as Gill and Law (1989) explain, is that an understanding of world orders must be rooted in the dynamics and logic of their ideological, institutional and material dimensions. Therefore and in line with Cox's (1981) observation with regards to ideas as a key element in distinguishing world orders, the rise of neoliberalism as the new ideological consensus was underpinned by an ideology of globalisation (Cox and Schechter, 2002:83). Neoliberal globalisation is defined by the ascendency, dominance and diffusion of norms such as liberalisation, competition, marketisation, restructuring, deregulation, and privatisation and the influence of international agencies such as the International Monetary Fund (IMF), the World Bank (WB) and the World Trade Organisation (WTO) (Gill, 1995a, 2003, Haque, 2008;

Siddiqui, 2012). It is also characterised by the rapid and free movement of goods, capital, culture, services, and people across transnational borders (Brown, 2012). Neoliberal globalisation also promotes the general acceptance of international competitive rules, and the hollowing out of the state in economic activities (Gill, 1995a, O'Manique, 2004; Sharma, 2013).

Ideas (ideology) have to be analysed or understood in relation to material conditions (Cox, 1981, 1983). Material conditions encompass the social relations and tangible attributes of production (Cox, 1983). Thus, in relation to material capabilities (as a function of material conditions) that define the nature and character of the neoliberal world order, Cox (1987) argues that material capabilities (power) are rooted in the social relations of production. Material capabilities refer to control and access to centres of global production, finance, knowledge and technologies (Cox, 1981: 136; Grinspun and Kreklewich, 1994). Thus, the structure of the global economy is a function of the pattern, nature and character of global production and exchange relations. In articulating how production works in a neoliberal world order, Cox (1987) and Gill (1993, 1995) postulate that production is underpinned by the coalescence of national economies into a globalised economic system and its simultaneous and spatial disaggregation into a network of regional production complexes. They thus conclude that globalised production has been brought to a point of development that exceeds the spatial and institutional bounds of the sovereign state due to the power and mobility of transnational capital (Cox, 1987; Gill, 1993, 1995).

In linking the material capabilities (power) to the position states occupy in the structure of the neoliberal world order, Cox (1987) argue that their positioning is a function of their role in the global production and exchange relations. Cox (1987) classifies states into three categories in relation to their social position in the structure of the world order. The first category is that of the advanced industralised countries of Europe and North America. These are the elites of the global economy who possess substantial material, knowledge, political and technological power and who through the activities of their transnational corporations and the power and mobility of transnational capital determine the nature and character of the global economy. The middle category of states is made up of those countries that have embraced the global economy and represent a key avenue for maintaining its smooth operations through the supply of needed labour, land and other production resources. The third category of states consists of peripheral nations that are not fully integrated into the global political economy, but remain at the periphery

as commodity producers whose commodities are attractive to the transnational enterprises investing globally for profit motives and capital accumulation. Sub-Saharan African countries mostly fall into this category. Therefore, structural inequality is a fundamental basis of the neoliberal world order.

With regards to the role of institutions in a world order, Cox (1981:136) argues that 'institutionalisation is a means of stabilizing and perpetuating a particular order'. In other words, institutions symbolise the rules which enable the extension of a world order (Cox, 1983: 171). As well as being products of that order; they ideologically propagate the values (norms) of the world order in order to maintain and sustain it (Cox, 1983: 171; Langridge, 2013). In this context, Cox and Schechter (2002), note that the IMF and the World Bank produce policy guidelines (driven by an ideology of globalisation) that are diffused to national governments and multi-national corporations as policy initiatives to guide economic activities. An example of such policy guidelines are structural adjustment programmes (Cox and Schechter, 2002; Gill, 1998a). In line with this, Germann (2006) and Langridge (2013) assert that institutions such as the International Monetary Fund (IMF) and the World Bank play a fundamental and active role as part of a 'historic bloc' of capitalist social forces linked with international finance in the neoliberal world order.

In further articulating the political economy of neoliberalism, Gill (1995a, 1998a, 2003) speaks about a 'globalising market civilisation' by which he refers to the disciplining and conditioning (transformative) effects of capitalism on a worldwide scale as it moves in search of market expansion. Gill (1995a, 1998a, 1998b, 2003) argues that a 'globalising market civilisation' embeds two attributes namely disciplinary neoliberalism and new constitutionalism. Disciplinary neoliberalism involves the exertion of market discipline over broader aspects of social life such as over economic agents, states, parties, cadres, and other forms of social organisations on a worldwide scale (Gill, 1995a, 2002b). Disciplinary neoliberalism relies on the basic principle or idea that capitalism is driven by private sector investment directly and through transnational corporations (Gill, 1995a, 1998a). Therefore, to attract private sector investment to drive economic development in states, for example, there is a need to build and sustain investor trust by governments. Thus governments are motivated to preserve their reputation in the eyes of investors by trying to build an acceptable business environment or risk losing investible capital

which may be detrimental to the achievement of state developmental policy objectives (Gill, 1995a, 1998a). This implies that domestic policy planning can be configured to meet the demands of global transnational capital. Thus disciplinary neoliberalism is a concrete type of structural and behavioural power of capital inherent in the system of global economic governance associated with a neoliberal restructuring of the global political economy (Gill, 1995a, 1998a, 2002a).

With regards to 'new constitutionalism' as an attribute of a globalised market civilisation, Gill (1995a, 1998a, 1998b) argues that it can be seen in the growing institutionalisation of neoliberal governance frameworks and policies in the global economy. He avers that these frameworks and policies aim to politically 'lock-in' neoliberal reforms in order to secure and guarantee legal private sector property rights for transnational enterprises (Gill, 1998a, 1998b). In expanding on the postulations of Gill, Brown (2012) posits that these neoliberal frameworks and policies could be quasi-constitutional, constitutional or governing agreements and frameworks. She also posits that as states sign up to these kinds of regulatory agreements and frameworks, they relinquish domestic autonomy over national policy choices and planning to the Boards of inter-state and non-state institutions (Brown, 2012). According to Brown (2012), examples of such quasi-constitutional, constitutional or governing agreements and frameworks include the conditionalities associated with the IMF and World Bank as well as multilateral trade agreements and regulatory frameworks such as the WTO (Brown 2012: 59). These regulatory frameworks and agreements were identified and described by Gill (1998) as the constitutional aspects of global restructuring due to the normative changes that they engender.

Disciplinary neoliberalism and new constitutionalism have resulted in the 'rolling back' or 'hollowing out of the state' particularly in areas such as pension, health and education via processes of privatisation and deregulation driven by conditionalities enunciated by the International Monetary Fund (IMF) and World Bank. The rolling back of the state in the areas of social service provisioning (such as the health sector) was a key demand of the World Bank in its global developmental activities in the 1980s and 1990s and it fundamentally transformed the health sector in sub-Saharan Africa (which will be discussed in Chapter Four in relation to Ghana). During this period, the World Bank (a key driver and diffuser of neoliberal norms) began to aggressively promote the need to adopt market-led principles as the basis of social

service provisioning in developing countries. The World Bank's thinking in this regard is reflected in its position papers such as 'Financing Healthcare in Developing Countries: An Agenda for Reform' (World Bank, 1987) and 'World Development Report: The State in a Changing World' (World Bank, 1997). In these reports, the Bank criticised the inability of states to ensure 'health for all' due to their inefficiency and ineffectiveness in social service provisioning. The Bank decried the centrality of the state in healthcare services and the promotion of health as a human right by the WHO. It conceptualised health from a market-driven prism whereby healthcare is viewed as a commodity, rather than as fundamental human right. It postulated that the state needs efficient and effective delivery systems. The World Bank (1997) report also advocated for states to introduce market mechanisms within the government by outsourcing public services to the private sector and to administer government agencies along business principles (Gill, 1998a).

In policy and development circles, ideas, proposals and developmental frameworks promoted by the World Bank (and also the International Monetary Fund) came to be referred to as the Washington Consensus. These institutions are products of the neoliberal world order and are therefore, ideologically attuned to espouse the values of this world order (market-led development). Using structural adjustment programmes (SAPs) as an example to show how the health sector in developing nations was impacted by the conditionalities associated with the International Monetary Fund (IMF) and World Bank, Brown (2012) notes that SAPs devastated the political economy of developing countries and left them vulnerable to ill health at the very time that the HIV/AIDS epidemic spread worldwide. The net effect of these kinds of policies and practices over time is that they undermine development and depress development on the continent (Brown, 2012:81). Gill (2011), Gill and Benatar (2016, 2017), Benatar and Brock (2011) and Benatar et al. (2009, 2011) argue that the environmental and social degradation which pervade the contemporary neoliberal world order negatively affect health and are a key driver of poverty and ill-health in developing countries.

In concluding this section, this study notes that due to this unprecedented process of globalisation and the diminishing significance of national policy independence in the current neoliberal world order, the state in Sub-Saharan Africa underwent a neoliberal transformation. This transformation reconfigured the domestic operations of the state on business lines and

resulted in the state being more influenced by domestic and international capital. This signalled a crucial watershed period in state-market relation as exemplified by the ascendency of private businesses into hitherto government monopolised public sector spaces such as health in developing countries. It is imperative to note that domestic health governance in African states has usually consisted of public actors (such as state-owned health facilities) and private actors such as mission hospitals, and private medical facilities (Brown, 2012). Therefore non-state actors have long existed alongside state actors in the health sector. However, neoliberal pressures on the state and the resulting liberalisation, privatisation and deregulation have led to the emergence of public-private partnerships between governments and foreign multinational capital in social provisioning such as in the health sectors of states. Therefore, the restructuring of state-market relations has led to public-private partnerships inhabiting the space between the state and the markets (private sector) in the provision of social services such as health.

2.5. A Globalising Neoliberal Market Civilisation and the Transition from an International Health to a Global Health Regime

Prior to the late 1970s, there was minimal engagement between private and public sectors within the United Nations or in the international health regime in the context of the kinds of global public-private partnerships (GPPPs) in health currently operating in global health (Buse and Walt, 2000a). The health relations between states and the World Health Organisation (WHO) made up the structure of what was referred to as the international health regime in the Post World War Two era. The formal membership of the WHO is limited to states. The international public health regime was configured on the basis that states were accountable for the health of their populations and was able, in collaboration with other states either at bilateral or multilateral level, to protect their populations from health risks (Dodgson et al., 2002). Also, while the UN engaged with NGOs and non-profit entities, NGOs were often identified simply as pressure, interest or advocacy groups (Buse and Walt, 2000a). Despite the influence of foundations such as the Rockefeller and Ford Foundations (Kapilashrami 2010), formal mandate and decision-making powers for public health policy processes in this regime remained in the hands of states and inter-state institutions such as the WHO and the broader United Nations system. Put clearly, emphasis in this regime was focused on the strengthening of public healthcare services based on the centrality of the state in healthcare provisioning (Kapilashrami 2010; Ng and Ruger, 2011;

Fidler, 2003, 2007; Dodgson et al.; 2002; Loughlin and Berridge, 2002; Aginam, 2002; Brown et al., 2006; Ruckert and Labonte, 2014; Biehl, and Petryna. 2013).

However, the influence of neoliberal ideology, particularly from the 1970s onward, engendered transformations in the political economy of health in states (Kapilashrami 2010). It resulted in the stagnation of public health expenditure due to its emphasis on privatisation, deregulation and the hollowing out of the state in the provision of social services. Also within this era, the World Bank began to vigorously advocate for the adoption of market-led principles as the basis of social service provisioning in developing countries. The Bank rejected the notion of the centrality of the state in healthcare services and the promotion of health as a universal human right by the WHO. As neoliberal ideology gained traction worldwide, cost-containment became the prevailing policy in healthcare systems within states, the WHO and within the UN system generally. Both institutions faced severe budgetary constraints arising from the inability and reluctance of member states to meet their financial obligations (Van de Pas and van Schaik, 2014). Furthermore, donor countries owed billions of dollars in arrears to the UN system (Brown et al, 2006; Van de Pas and van Schaik, 2014). As such, the UN system began to seek alternative sources for resources. From this period, the phenomenon of public-private partnership began to gain traction within the UN system. For example, the UN through the WHO in 1975, engaged with the private sector through pharmaceutical companies. This engagement was named the Special Program for Research and Training in Tropical Diseases (TDR) (Buse and Walt, 2002a; Van de Pas and van Schaik, 2014; Brown, 2012; Kapilashrami 2010).

As neoliberalism gathered pace and momentum through the 1980s to the 1990s, a globalising world emerged, breaking down obstacles to global movements of capital, people, information and technology, culture, goods and services. However, globalisation created new risks for human health due to the rapid proliferation of infections across transnational boundaries enabled by affordable air travel, growing global population movement and global economic interdependency of all nations (Brown, 2012; Altman, 1999; Yach and Bettchet 1998a, Yach and Bettchet 1998b; Ruebi, 2016; Collin and Lee 2003; Lee, 2000, 2003; Tatem et al., 2006; Gubler, 2011; Buse, 2004; Koplan et al., 2009; Aginam, 2010, 2004, 2016; Buse 2004; Frenk and Moon 2013). The then Director General of the WHO, Gro Harlem Brundtland (1998-2003), was convinced that the rapid speed with which these transborder types of threats occurred and the emerging

complexities of healthcare worldwide arising out of the processes of globalisation could not be managed by states and the inter-state WHO alone. Therefore, globalisation meant that the state and the WHO were constrained in their ability to undertake this role and that the international health regime was insufficient (Dodgson et al, 2002; Aginam, 2010, 2004, 2016; Lee, 2006; Frenk, and Moon, 2013; Ruebi, 2018; Yach and Bettchet 1998a, Yach and Bettchet 1998b).

Thus, additional or new forms of health relations or frameworks were considered necessary (Dodgson et al., 2002; Ruebi, 2018; Schneider, 2009; Aginam, 2010, 2004; Frenk, and Moon, 2013; Lee, 2006). In this vein, the WHO under Gro Harlem Brundtland began to seek to build holistic relations with private sector businesses and partners who possess the resources to help by introducing high tech biomedical solutions to health issues, provide financial support as and when due and also bring business management procedures to bear on global health policy processes as envisaged in the United Nations Global Compact initiative. The underlying idea of the Global Compact was to advance broader UN goals (e.g., the Millennium Development Goals) which required building partnership with non-state actors (Rasche et al., 2012). Furthermore, under the then UN Secretary-General Kofi Annan, there was a concerted focus on the market as a means and avenue of resolving long-standing financial constraints within the UN system. In 1997, and with the dire financial situation of the UN agencies (including the WHO) in mind, Kofi Annan called for building relationships and creating synergies with the business community as the core element of his UN reform proposal (Richter, 2004).

In order to give official impetus and traction to this reform process, the United Nations and the WHO, initiated the passage of resolutions via the United Nations General Assembly (UNGA) calling on non-state actors such as private business players and civil society actors (i.e. non-governmental organisations) to participate officially in global health policy processes. These resolutions include 55/215 (UNGA, 2000), 56/76 (UNGA, 2001), 58/129 (UNGA, 2003), 60/215 (UNGA, 2006), and 62/211 (UNGA, 2008). The first of these Resolutions (55/215) reaffirms the central role of the United Nations and in particular the General Assembly as key drivers of partnerships in the context of globalisation. It noted that the key rationale for the United Nations Millennium Declaration is to build strong partnerships to drive poverty eradication and promote development. The resolution also posited that partnerships would ensure that globalisation becomes beneficial to all. The other resolutions are periodic reaffirmations and confirmations of

this first resolution. As noted by Brown (2012), under the new global partnership dispensation promoted by the UN, representatives of private business interests (such as pharmaceutical firm representatives) now sit on the governance boards of a broad gamut of global public-private partnerships like the Roll Back Malaria Partnership (RBM), and the International Partnership For Microbicides (IPM global), which play influential roles in global health policy processes worldwide (Brown, 2012).

It is important to note that not all global public-private partnerships involve direct collaboration with the WHO and the broader UN system. Included here are the Global Fund, the International AIDS Vaccine Initiative (IAVI), and the Global Alliance for Improved Nutrition (GAIN). These partnerships are all influential in various forms of health policy processes globally. Furthermore, it is also imperative to note that philanthropic organisations, such as the Bill and Melinda Gates Foundation (BMGF), the Carso Health Institute (CHI), the Clinton Foundation (CF), and Bloomberg Philanthropies (BP) operating within global public-private partnerships or individually have also been extremely influential in global health policy processes. These are in areas such as financing biomedical research, launching and undertaking public health initiatives, knowledge building and innovation (Ruebi, 2018: 86). The power and influence of philanthropic foundations also permeate traditional inter-state structures such as the WHO (Bruen et al., 2014). The Bill and Melinda Gates Foundation (BMGF) and Bloomberg Philanthropies are significant financiers of the WHO (Van de Pas and van Schaik, 2014). The BMGF's prominence in global health policy processes is also reflected in its establishment of an Institute for Health Metrics and Evaluation (Buse and Walt, 2002). The institute has been tasked to undertake functions similar to the functions of the WHO (Buse and Walt, 2002).

Therefore, these global public-private partnerships (embedding philanthropic entities, nongovernmental organisations, pharmaceutical corporations alongside state and inter-state institutions) and the increased prominence of philanthropic entities in global health policy processes are shaping health responses, initiatives and interventions worldwide in unprecedented ways through disparate disease or problem-specific entry points (Biehl and Petryna, 2013; Brown,2012; Bruen et al., 2014). This has led to their recognition and acceptance as important and legitimate players (actors) in the global health regime (Bartsch, 2007b, 2011; Biehl and

Petryna, 2013; Frenk and Moon, 2013; Ng and Rudger, 2011; Van de Pas and Van Schaik, 2014; Fidler, 2007 and 2010; Drager and Sunderland, 2007; Buse and Waxman, 2001).

Following from the above, in the global health regime (in contrast to the international health regime), formal mandate and decision making power for health policy processes is no longer the sole prerogative of states or inter-state institutions within the United Nations system (UN) such as the WHO. Rather such power is also vested in and applied by non-state actors such as global public-private partnerships in health.

2.6. Has the Neoliberal World Order Come to an End?

I argue above that the global health regime came about due to neoliberal globalisation. However, some may argue that neoliberalism is on the retreat. This section provides an opportunity for the reader to engage with the discourse on the decline or end of the neoliberal world order. While a detailed and broader discussion of the decline of the neoliberal world order is outside the purview of this study, it is important to highlight my awareness of this discourse because my study and its conceptual and theoretical approach is rooted in the context of a globalised neoliberal world order.

It has been claimed that the global financial crisis of 2007–2009 heralded the end of the neoliberal world order (Kotz, 2009; Wallerstein, 2008; Soros, 2009; Helleiner, 2009; Crotty, 2009; Birch and Mykhnenko, 2010; Nesvetailova and Palan, 2010; Dadush and Stancil, 2010; Lesage and Vermeiren, 2011; Mirowski, 2014). This purported demise of neoliberalism is premised on three assumptions. Firstly, it is believed that the global financial crisis delegitimised neoliberalism (Lesage and Vermeiren, 2011). The second assumption is that emerging markets such as China, Brazil and India (or the BRICS forum) represent a new locus of power relations that threaten the neoliberal world order (Dadush and Stancil, 2010; Lesage and Vermeiren, 2011; Siddiqui, 2016). Thirdly, and from a historical dimension, it is assumed that severe economic crises (such as the global financial crises) usually herald the transformation from one global political-economic order (world order) or 'historical structure' to another (Cox, 1983; Gill, 2008; Lesage and Vermeiren, 2011).

The advent of the Trump presidency in the United States of America, the British exit (Brexit) from the European Union and the rise of authoritarian politics elsewhere (e.g. in Italy, Poland,

France, India, Brazil and Hungary) has also contributed to discourse on the decline of the neoliberal world order, particularly as these changes have resulted in the adoption of nationalistic trade policies that threaten globalised trade, underpinned by free trade agreements. As argued by Regilme (2019), Trump's America First policy negates the multilateral cooperation that drives international relations between states. Consequently, Stiglitz (2019) argues that today the world faces a retreat from globalised agreements and frameworks. Adopting a similar position to that of Stiglitz (2019) and using Brexit as an example, authors such as Peters (2018) Murray (2016), Elliott (2016) and Hauk (2020), suggest that Brexit signifies not only Britain's exit from the European Union, but also heralds the end of globalisation.

However, this study takes the position that it is too early or hasty to assume that the neoliberal order is about to give way or has given way to a new post-neoliberal age. No scholar has yet clearly defined or articulated what kind of new world order currently exists (if we accept that the neoliberal order has ended), nor is the ideological basis of this new world order and its nature and character evident. Also, all indications are that the policies of the Trump administration and Brexit will not mean that neoliberal globalisation, with its ideological and institutional dimensions, will cease to exist or simply disappear. Firstly, and in relation to its ideological dimensions, the United States and Britain still promote the principles of neoliberal free-market ideas as expressed by their desire to sign trade deals. A broad range of trade deals promoting neoliberal globalisation are still being signed globally. For example, Britain desires to maintain its economic ties with the European Union and the US, Canada, and Mexico Trade Agreement (USMCA) replaced the North American Free Trade Agreement (NAFTA) as the regional trade framework in North America. In Africa, African countries have recently activated the African Continental Free Trade Area (AfCFTA) to promote regional trade and production. The Asia Pacific Trade Agreement (APTA) is in force Asia and the European Union-Mercosur Agreement (not yet in force) will bring together the EU market together with Argentina, Brazil, Paraguay and Uruguay.

Therefore, it is too early to speak of the demise of the neoliberal order. The continuous renewal and expansion of trade deals support the assertions by Cox (1987) and Gill (1993 and 1995) (see Section 2.4) that the neoliberal worlds order is defined by the coalescence of national economies into a globalised economic system. Furthermore, the European Union remains strong under the

leadership of the Germans and the French. Also, it is imperative to understand that despite the policies of the Trump administration, a new administration, perhaps led by the Democratic Party, may well reverse Trump's nationalist policies. From an institutional perspective, forums such as BRICS (Brazil, Russia, India, China, and South Africa) and countries like China and India do not appear geared towards an overhaul of the neoliberal world order. In fact, they shape, relate and operate within it (Woods, 2010; Lesage and Vermeiren, 2011). Furthermore, the institutionalisation of neoliberal policies in the constitutions of laws, institutions and regulations drives neoliberal globalisation and underpins the resilience of the neoliberal world order. Examples of institutional arrangements at the global level (apart from the International Monetary Fund (IMF) and World Bank) include the regime of the World Trade Organisation (WTO), the group of eight industrialised nations (G8), and the various statues related to the European Union (Lesage and Vermeiren, 2011). Transnational corporations still drive and control the global production processes and financial and investment agreements underpinning capital markets and the free movement of capital and profits around the globe are enshrined in various national and international laws (Lesage and Vermeiren, 2011). These laws serve to protect property and investment rights (Lesage and Vermeiren, 2011). These arrangements lock in neoliberal policies worldwide and maintain the pace of globalisation in one way or the other.

2.7. Conceptualising Global Public-Private Partnerships (GPPP) in Health

Section 2.2 of this chapter began by examining divergent views of scholars on the emergence of global public-private partnerships in the global health regime. In so doing, this study aligned with the position of scholars who place more weight on history and power in conceptualising the rise of public-private partnerships. Following from this, Section 2.3 provided a justification for the approach adopted in this study which is rooted in critical political economy. In line with this approach, Sections 2.4 presented an analysis of the structural and normative transformations in the global political economy. Section 2.5 takes this analysis further by explaining how these structural and normative transformations in the global political economy impacted on the global health landscape and accounts for the paradigm shift from international to global health due to the emergence of global public-private partnerships in the global health regime. In concluding that section, this study posited that the roles and responsibilities global public-private partnerships undertake in the global health regime has earned them acceptance and recognition as formal and legitimate actors in global health.

In this section, this study conceptualises the nature and character of the global public-private partnerships operating in the global public health regime. The objective of this section, therefore, is to define what is meant by global public-private partnerships in health and their typological orientations.

2.7.1. Defining a Global Public-Private Partnership (GPPP) in Health

An amalgam of partnership types, variants, constructs and structures permeate the global public health regime. There is no all-inclusive widely recognised definition of public-private partnerships. This has made it difficult to define what partnership means in this context. Brinkerhoff and Brinkerhoff (2011:3) assert that the literature on public--private partnerships is replete with analytical confusion and inconclusiveness. Glasbergen et al. (2007) also posit that literature on this concept remains constrained by fragmented research agendas and inconsistent conceptualisations across various studies. Richter (2004) further notes that there are three main reasons why ambiguity, distortion and contestation underpin the analysis of public-private partnerships (PPPs). Firstly, she notes that there is no single definition of the concept despite its common usage in global health literature. Secondly, despite the preponderance of debate, there is insufficient differentiation between the concept as a policy model and as practice. A third source of ambiguity is that public-private partnerships are also referred to by various other terms in global health literature (Richter, 2004).

This study accepts that public-private partnership can refer to relationships between just two parties in the public and private sector broadly speaking. However, global public-private partnerships (GPPPs) in the health sector typically entail more complex forms of partnerships. These new forms of public-private partnerships in global health bring together a broad gamut of state and non-state actors to undertake and resolve global health policy challenges. Cognisant of this, Buse and Walt (2000a: 550) provide the most widely recognised and cited definition of GPPP in health in global health literature, conceptualising a GPPP in health to be ‘a collaborative relationship which transcends national boundaries and brings together at least three parties, among them a corporation (and/or industry association) and an intergovernmental organization, so as to achieve a shared health-creating goal on the basis of a mutually agreed division of labour’. As this definition makes clear, this kind of arrangement usually involves at least three partners, organisations or actors and usually includes parties such as governments, civil society

groups, philanthropies, for-profit and not-for-profit entities, and donor agencies (Buse and Walt 2002: 44). GPPPs also frequently include the formation of a board to channel and manage funds and/or to govern its arrangement (Buse and Walt 2002: 44).

Buse and Harmer (2004) ague that the discourse relating to GPPPs in global health literature disguises the unequal power relations between the various actors. Cairney (2016), who shares the views of Buse and Harmer (2004), went further to state that using the term 'partnership' is misleading and advocates for the use of less problematic terms such as Global Health Initiatives (GHIs). She concedes that while the use of the term GHIs does not necessarily draw attention to power differentials, it does not suggest that such differentials do not exist as does the term 'partnership'. Bartsch (2011) also notes that using the term partnership places attention on the mix of actors, while using the term GHI places attention on the global nature of the initiative.

The counter-argument to the positions of Cairney (2016) and Bartsch (2011) in the context of this study is that conceiving the Global Fund as a GPPP, rather than as a Global Health Initiative (GHI) actually helps draw attention to the concept of partnership and its connotation as a 'collaborative relationship' in the definition of Buse and Walt (2000a: 550). As noted by Moran (2009), the depoliticised discourse embedded in policy research and official partnership documentation falsely gives the impression that power relations within partnerships are equal and that partnerships represent a kind of 'win-win' situation in which all partners are beneficiaries to an absolute gain. In this context, I suggest the phrase 'specific modality of power relations' as a replacement for the term 'collaborative relationship' embedded in the partnership definition of Buse and Walt (2000a: 550). Conceptualising the Global Fund GPPP arrangement as a 'specific modality of power relations' focuses and highlights the centrality of power relations in any discourse about the Fund's policy and practice and the accountability outcomes and implications they produce.

2.7.2. Types of global public-private partnership (GPPP) in health

The preceding Section 2.7.1 focused on defining a GPPP in health. In this section, this study will place emphasis on exploring the different types of GPPPs in health operating in the global health regime. There are diverse ways to classify the different GPPPs in the global health landscape. Typically, literature on GPPPs differentiates between subtypes of this relationship based on their operational and constitutive arrangements.

From the perspective of their operational arrangements, partnerships can be generally categorised according to their purpose, or goal (Kapilashrami, 2010; Buse and Walt, 2000a, 2000b; Kickbush and Quick, 1998; Widus, 2005; Nishtar, 2004; Lob-Levyt, 2001). For example, Buse and Walt (2000a, 2000b) distinguished three types of GPPPs: product-based, product development-based, and issues/systems-based partnerships. Similarly, Kickbush and Quick (1998) also categorised GPPPs in terms of whether they are involved in product development, knowledge exchange, health services, services, systems and settings and issues. Also in this vein, Nishtar (2004) categorised GPPPs based on the purpose they serve, identifying categories like product development, improving access to healthcare products, global coordination mechanisms, strengthening health services, public advocacy and education, and regulation and quality assurance. Caines et al. (2004) also distinguish between GPPPs involved in research and development, technical assistance, advocacy and financing.

In contrast to GPPPs categorised according to purpose, it is also possible to classify GPPPs based on their constitutive arrangements. Constitutive arrangements in the context of this study refer to the complexity of their individual institutional relationships and to the hosting arrangements and legal status of each GPPP. In this context, Buse (2004) and Brown (2012) identify two broad organisational types. These are GPPPs that are hosted by another organisation (although they may be a separate legal entity) and GPPPs that are independent (i.e., possess their own legal identity and are not hosted by any organisation). The hosting arrangement can be undertaken by a multilateral organisation, non-governmental organization (NGO), independently created legal organisation or an independent non-profit scientific organisation ((Buse 2004).

GPPPs that are a separate legal entity, but are hosted by another organisation are predominant within the United Nations (UN) system. The Global Alliance to Eliminate Leprosy (GAEL), Roll Back Malaria (RBM), and Stop TB, are examples of organisations operating as separate legal entities, but are hosted by the World Health Organisation (WHO) (Buse 2004). The WHO retains some accountability oversight over the operations of partnerships that it hosts. As noted by Buse (2004), senior management of most WHO-hosted partnerships are accountable to the WHO hierarchy. Also, while registered legally as an entity outside the United Nations system, the GAVI Alliance (formerly referred to in full as the Global Alliance for Vaccines and Immunisation) is hosted by the United Nations International Children Education Fund

(UNICEF). UNICEF exercises veto power over the GAVI board operations (Forman and Segaar, 2006). Furthermore, while staff members of GAVI are accountable to the GAVI Board, UNICEF rules and regulations apply to GAVI staff and secretariat operations (Buse 2004).

In contrast, there are also GPPPs that are independently hosted and operate as separate legal entities separate from the UN system. These include the Global Fund (our case study), the International AIDS Vaccine Initiative (IAVI), the Global Alliance for Improved Nutrition (GAIN), Secure the Future, and the Medicines for Malaria Venture (MMV). These independently created and hosted partnerships are outside the UN decision-making processes (Forman and Segaar, 2006). Brown (2012) identifies a third type of hosting arrangement. That 'is a publicly or privately hosted partnership without separate legal status' (Brown, 2012:125). Examples of GPPPs that operate under this hosting arrangement are the Accelerated Access Initiative (AAI) and the Malaria Vaccine Initiative (MVI) (Brown, 2012:125). Hosting arrangements have accountability implications. For example, as shown by Buse (2004), organisations such as the AAI (hosted by UNAIDS), or the MVI (hosted by PATH), are configured in such a way that the Secretariat executives are accountable, not to the governing boards of the partnership, but to their host organisations. This hosting arrangement thus constrains the degree to which the partnership's secretariat can be held to account by the partners (Buse 2004: 236).

In Section 2.9, the study will examine how these GPPPs in health understand accountability as embedded in their individual policy documentation. It is this understanding of accountability that informs their practice when they engage in public health policy processes in specific settings of global health. However, before proceeding to Section 2.9, it will be necessary to in Section 2.8 explore in broader detail how accountability for public health policy processes is understood in the international health regime.

2.8. Understanding Accountability in the International Health Regime

Accountability refers to individuals, organisations, or states assuming or taking responsibility for their actions and being answerable for performance, finance or political activities assessed against a set of standards (Brinkerhoff, 2004). Accountability in the international health regime was based on the conviction that a state is responsible for the health of its people and is accountable for health issues within its borders. When states fail to ensure the health needs and

wellbeing of their people, they can potentially be held to account by citizens through state-based political processes such as elections and parliamentary oversight. Where health risks transcend transnational powers, the World Health Organisation (WHO) is mandated by states to take the lead in addressing international health challenges ((Heymann, 2018; Dodgson et al., 2002; Loughlin and Berridge, 2002; Fidler, 2003; Aginam, 2002; Bruen et al., 2014). It is therefore accountable to its member states. States in turn are accountable to their citizens through state-based and state-led accountability processes (Bruen et al., 2014).

Accountability relations among member states are based on the principle of the 'one state, one vote' system in the World Health Assembly (WHA) which is the principal decision-making body of the WHO (Van de Pas and Van Schaik, 2014; Bruen, et al., 2014). The WHA usually meets once a year in Geneva and regulates the policy direction of the organisation. The voting structure within this assembly undermines the WHO's effectiveness due to the fact that member states possess veto powers over its resolutions (Van de Pas and Van Schaik, 2014:54). For example, legally binding WHO agreements such as the International Health regulations and the Framework Convention on Tobacco control does not allow for external enforcement of measures against erring member states by others when disputes arise (Van de Pas and Van Schaik, 2014: 47-66). This non-interference clause was to appease states and allow the Framework Convention on Tobacco to be adopted as a legal document, rather than to be vetoed down. Ng.Y and Ruger (2011) and Van de Pas and Van Schaik (2014) note that powerful donor states have used this clause to defend corporate tobacco interests, thereby undermining international efforts to improve health.

The WHO is also perceived as vulnerable to political influence and political pressure from member states (Brown et al., 2006; Ruger and Yach 2009; Ng.Y and Ruger, 2011; Van de Pas and Van Schaik, 2014). For example, developing countries argue that the WHO acts at the behest of the industrialised nations and does not protect their interests. On the other hand, these developed countries who are the major aid donors contend that the focus of the WHO on developmental activities in Africa and the developing world negates its international norm and standards-setting roles which are crucial for setting domestic norms and standards in developed countries (Van de Pas and Van Schaik, 2014). Critics have persistently contended that power

dynamics determine accountability relations in the WHO and that it favours the interest of some states over others (Bruen et al., 2014).

Furthermore, Cold War politics impacted on accountability in relation to the health policy and decision-making process in the WHO. A reference point was the exit of the then Soviet Union and its allies from the UN system in 1949. This exit empowered the United States and its allies to influence key activities within the WHO (Brown et al., 2006; Lee, 1998). However, in 1956, the Soviet Union and its allies returned to the UN system and restored some balance of power in the activities of the WHO and WHA. This balance of power was crucial to the Cold War politics of that era, led by the then Soviet Union and the United States of America (Brown et al., 2006). Also of note in the pattern of accountability relations in the WHO was the phenomenon of extra-budgetary funding. Brown et al. (2006) and Bruen et al. (2014) argue that extra-budgetary funding was funding made to the WHO by wealthy donor nations and multilateral bodies (e.g. the World Bank) outside the regular annual budget cycle of the WHO. However, while the regular budget is under the purview of the WHA (which allows poor countries to have a say based on the principle of one state, one vote), powerful donors and multilateral agencies like the World Bank determined the use of the extra-budgetary funding which they donated (Brown et al., 2006; Bruen et al., 2014).

Although extra-budgetary funding improved the WHO's finances, it created coordination and planning difficulties because the provision of such funds was subject to the interests of particular donors at any given time and the determination for the use of the funds was not under the control of the WHO or the WHA. By implication, wealthy donors ran parallel programmes outside regular WHO programs and decision-making structure (Brown et al., 2006; Bruen et al., 2014). On the whole, it is clear that accountability in multilateral organisations such as the WHO can be subject to powerful donor forces.

2.9. Understanding Accountability in Policy by Global Public-Private Partnerships (GPPPs) in Health in the Global Health Regime

In Section 2.8 above, this study posited that the understanding of accountability in the international health regime revolves around state-based policy processes within states and state-led accountability processes in the relations between states and the World Health Organisation (WHO). However, as argued earlier (see Section 2.5), there has been a transition from an

international to a global health regime. Non-state actors, like GPPPs, play an influential role in this global health regime. Since GPPPs are not states, they derive their understanding of accountability from the nature and character of their individual policy arrangements. Their individual policy understandings of accountability inform and determine their practice when they undertake public health policy processes. Therefore, the focus of this section is to examine how GPPPs in health understand accountability in policy.

Many GPPPs in health have issued policy statements of some kind in which they state how they understand accountability and how such understanding informs their practice. An overview of GPPP policy documentation reveals that many GPPPs conceptualise accountability with reference to outcomes and measurable results. For example, GAVI, the Vaccine Alliance, articulates its policy understanding of accountability within a policy document named the 'Gavi Alliance Transparency and Accountability Policy' (TAP). An analysis of this document highlights a strong emphasis on outcomes and a results-orientation framework (GAVI, the Vaccine Alliance, 2008: 6-7). The framework calls for strict oversight of cash and vaccines provided by GAVI to beneficiary countries in order to ensure that these are used for their intended purposes to achieve intended results (GAVI, the Vaccine Alliance, 2008). The document also emphasises the importance of country ownership, noting that GAVI will ensure country ownership; and promote mutual accountability through shared responsibility of oversight (GAVI, the Vaccine Alliance, 2008: 2).

Like the GAVI Alliance, the Roll Back Malaria (RBM) partnership adopts a policy understanding of accountability that is result-focused and outcome-oriented. As explained by the RBM, the application of transparency and accountability pillars in its actions and activities is key to their business model. Such an application process would require the RBM to set up a clear accountability matrix to measure progress against the partnership's targets (RBM Partnership Strategic Plan, 2018–2020:28). This accountability matrix is referred to as 'A Common Accountability Framework' (RBM Partnership Strategic Plan, 2018–2020). With reference to accountability, the RBM posits that it would pay attention to data generation that can be used to derive the performance indicators that enable the RBM to measure the malaria phenomenon under consideration. Measurements of malaria burden can take place at global, regional, national and local levels, where possible (RBM Partnership Strategic Plan, 2018 – 2020:28).

Still with an emphasis on a result-based and evidence (data) driven theme, the Malaria Vaccine Initiative (MVI) policy understanding of accountability is evidence (data) driven. The MVI expects partner countries to generate data essential for making timely and informed decisions about malaria vaccine treatment. MVI posits that this national process must integrate the use of malaria vaccine in national health policies such as countries' multiyear strategic plans. Such policy plans must be evidence (data) driven, e.g. malaria epidemiology profile by district, malaria cases in pregnant women and HIV population and so on (MVI, 2020). The STOP TB 'Multisectoral Accountability Framework for TB' explains STOP TB's policy understanding of accountability. This understanding places emphasis on results and outcomes in terms of an increased focus on data quality and coverage to drive target setting or new or improved ways of programme reporting (STOP TB, 2019). This is expected to drive national strategies to combat TB in aid recipient countries and thus underpins TB programme implementation in these countries.

While the discussion on the understanding of accountability by preceding GPPPs have highlighted a broadly outcome or result-focused orientation, some other GPPPs, such as the Global Alliance for Improved Nutrition (GAIN), understand accountability in a way that is attentive to power relations rather than focusing only on outcomes. GAIN's accountability framework places emphasis on and promotes a programmatic gender strategy that is attentive to issues of power relations (GAIN, 2019). The overarching aim of this strategy is to ensure that all GAIN programmes promote gender-sensitive approaches (GAIN, 2019). In articulating the reasoning behind this programme strategy, GAIN posits that gender inequality and women's disempowerment are root causes of malnutrition GAIN, 2019). The focus on inequality by GAIN highlights how it drives social relations between boys and girls, women and men in communities in specific settings of global health worldwide. Thus, implicit in GAIN's approach is the view that accountability is fundamentally about shifting the balance of power in favour of the vulnerable communities where it works.

Like GAIN, the Medicines for Malaria Venture (MMV) and the International AIDS Vaccine Initiative (IAVI) also include a focus on power relations in its approach to accountability (MMV, 2020; IAVI, 2014). For example, the MMV has a child protection policy aimed at protecting children from exploitation, violence and abuse (MMV, 2020). Similarly to the MMV, the

International AIDS Vaccine Initiative (IAVI) expresses a commitment to comply with all applicable laws; particularly child welfare and protection legislation in the countries where IAVI conducts business (IAVI, 2014). When taken together, the policies of the MMV and the IAVI in relation to children and the communities where they operate implies that they seek to be accountable to all their stakeholders, particularly children and communities (MMV, 2020; IAVI, 2014).

Thus the global health regime is a space where various understandings of accountability battle for recognition and legitimacy (Bruen et al., 2014). In conceptualising their understanding of accountability, different types of GPPPs in health embrace different understandings of accountability by attaching different emphasis to specific policy elements or spheres of accountability. Their individual policy understandings of accountability inform their practice when they undertake public health policy processes in specific settings of global health.

2.10. Conceptualising Power, Accountability and Global Public-Private Partnership (GPPPs) in Health

Accountability in the global health regime has been of concern to political scientists, global governance and international relations theorists. Many have argued that accountability ensures that those who are entrusted with power on behalf of others are answerable for their conduct (Keohane and Nye, 2001; Goetz and Jenkins, 2002; Grant and Keohane, 2005; Woods, 2007; Held, 1995, 2004; Risse 2004; Zuern, 2004; Koenig-Archibugi, 2004, 2017; Hesselmann, 2011; Held and Koenig-Archibugi, 2005). As averred by Hesselmann (2011), accountability is crucial in the domain of global health where the activities of funders and donors impact on the livelihoods and wellbeing of populations in specific settings of global health. Thus, the right to demand and elicit accountability from power holders assumes relations of power (Newell and Bellour 2002).

One way to approach accountability is to talk about it in terms of stakeholders and power. Stakeholder power theorists posit that an organisation is accountable not only to its shareholders (those who have formal interest and authority over it) but also to its stakeholders (the people whom their decisions impact). Freeman (2010) states that a stakeholder is anybody who affects or is affected by the activities of an organisation. The interpretation deducible from this definition is that an organisation is obligated not only to those who affect it, but also to those

whom it affects. Scholars writing on the question of stakeholders and accountability argue that germane to the success and growth of the organisation are its stakeholders, and not just the shareowners (the funders of the organisation) (Goodpaster, 1991; Donaldson and Preston, 1995; Burall and Neligan, 2005, Kovach et al., 2003; Mitchell et al., 1997). They further postulate that these organisations must prioritize accountability to their stakeholders; both those internal and external to the organisation, to enable wider participation in decision-making. They conclude that this will increase the legitimacy of these institutions and also lead to more effective decision-making in them. Therefore, stakeholder theory justifies power on the basis of inclusion and participation of shareowners and stakeholder groups in institutional activities such as decision making.

Another way to discuss accountability is to think of it in relation to democracy. Some theorists question and challenge the current architecture of the global health regime and speak of a 'democratic deficit'. This deficit comes about because GPPPs and other non-state actors do not derive their legitimacy through state-based and state-led processes such as elections and because citizens are often not able to influence, control or have a say in their decision-making process (Bartsch, 2007). Such concerns lead scholars like Held (1995, 2004) and Koenig-Archibugi (2004, 2017) to call for reforms that will drive the accountability of transnational actors to states and their citizens affected by the practice of these actors. These theorists agree on the need to 'democratise' accountability in GPPPs and other non-state transnational actors via an inclusive approach to decision-making not limited only to those who have formal authority over them, but also extending to those affected by their decisions. Some further reflect on the need for a central authority of some sort which is able to exercise power in the 'ungoverned' global health and governance realm. However, Steets (2010) notes that while there is advocacy for the creation of a new governing instrument for the global health realm, nothing was said about what will be the role of an organisation like the United Nations in relation to such proposed governance accountability mechanisms.

Accountability can also be linked to discussions around legitimacy. The legitimacy of the wide gamut of transnational actors such as GPPP operating in the global health landscape relations has received some attention. This study will not seek to engage the vast literature on legitimacy and its many dimensions, but will locate the discussion relative to areas most useful in understanding

its relationship to accountability and GPPPs. Heywood (2015: 130) conceptualised legitimacy as 'that quality which transforms naked power to rightful authority'. Put succinctly, power is legitimate if it is willingly acknowledged by the citizens (Bartsch, 2007). Thus, in a democratic system, legitimacy is most simply understood in terms of state-citizens' relations (Walker, 2012; Bartsch, 2007; Risse, 2004). Legitimacy understood in this way is conferred on national governments by their citizenry though the representative processes of elections. This process also imbues states with legitimacy when acting at the global level (Bartsch, 2007). Woods and Narlikar (2001) and Woods (2007) raise concerns that transnational actors (such as GPPPs), whose operations transcend the spatial boundaries of sovereign states, are not accountable to anyone despite the fact that their policies and operations affect the citizens of states. Similarly, Held (1995 and 2003) posits that citizens of states are affected by decisions taking outside the confines of state authority by transnational bodies and that these bodies are routinely making decisions that constrains the powers of the state in diverse areas such as in information and communicators, health and environmental issues.

However, there are scholars who do not buy into or accept the notion of a 'democratic deficit' with regards to GPPPs and transnational organisations in general (Walker, 2012; Scholte, 2004; Bexell et al., 2010; Moravcsik, 2004). These scholars also argue that legitimacy must not necessarily be derived on the basis of state-citizen relations. Scholte (2004) and Bexell et al. (2010), for example, aver that NGOs through their advocacy work already play a role in bridging the so-called democratic deficit gap in global governance more broadly. Furthermore, Moravcsik (2004), in rejecting the notion of a democratic deficit in the global health argued that international institutions should not be compared to ideal democratic systems and that to prove the existence of democratic deficit in relation to international institutions 'requires more and different empirical analysis than has heretofore been conducted' (2004: 337).

Akogu (2012), argued that the focus on transnational non-state actors should be on how they widen the democratic space rather than talking of a democratic deficit. Walker (2012) also postulates that discussions of the legitimacy of non-state transnational organisations should transcend issues of state representation and focus on their efficiency and effectiveness. Nonetheless, the existence or denial of a 'democratic power deficit' and its relationship to the legitimacy of GPPPs remains a contentious issue and is an ongoing debate in global health.

In concluding this section, this study, rooted in the critical political economy tradition, takes the position that the democratic power deficit and stakeholder power theorists conceptualise power normatively in terms of participation, representation or inclusion in the health policy processes or decision-making process that could lead to better accountability relations and outcomes. They give the impression that accountability is simply about getting the structures and mechanisms right. For example, equal participation or representation in decision making bodies. However, this study posits that while equal participation or representation in decision making bodies is crucial to accountability, it is crucial to understand that accountability processes and mechanisms are not politically indifferent or apathetic (Bruen et al., 2014). As noted by Bruen et al. (2014), these theorists ignore unequal power relations between actors (e.g between donors and recipient countries involved in or with GPPPs) in the global health regime. For instance, this is with regards to 'who gets to decide on or design accountability interventions or creates the benchmarks for its design' (Bruen et al., 2014: 4). They also note that accountability frameworks and systems are not politically neutral, but a function of power relations. They may consolidate prevailing relations of power or act as harbingers of change (Bruen et al., 2014: 4).

Also democratic deficit and stakeholder theorists pay little or no attention to the highly political contexts in which the accountability practice of GPPPs are implemented. This is because accountability is contextual and its nature, character and outcomes are shaped and influenced by the objective conditions of the political economy context in which it operates. Since accountability refers essentially to how policy and practice relations are configured and managed, accountability in relation to GPPPs in health is therefore about who is accountable to whom, how and why in the developmental space. In other words, it is about the relations of power.

2.11. Conclusion

This study concludes that an approach rooted in the critical political economy tradition enables the researcher to understand that the shift to a global health regime from an international health regime is a consequence of a complex and historically mediated developmental process conditioned by social relations which Gill (1993, 1995) conceives as a 'globalising market civilisation'. This 'globalising market civilisation' has also transformed structures and conditioned outcomes across a broad spectrum of social spheres like in global health. The rise of

global public-private partnerships (GPPPs) in health such as the Global Fund is situated in the context of these relations. Furthermore, the emergence of these GPPPs in health also results in shifts in the way in which accountability for public health policy processes is understood in global health relative to the international health regime.

While accountability for public health policy processes in the international health regime revolves around state–based and state--led accountability processes, GPPPs in health draw their understanding of accountability from the nature and character of their individual policy arrangements. Their individual policy understandings of accountability inform and determine their practice when they undertake public health policy processes. Thus, GPPPs in health embrace different understandings of accountability by attaching different emphasis to specific policy elements or spheres of accountability. In other words, accountability is context-specific and is dependent on the approach or perspective of the GPPPs who employs or applies the term in global health.

Though many scholarly works may make reference to GPPPs' accountability in some way, there is little reflection or consideration on how accountability appears or is understood in policy by these GPPPs. Neither has sufficient attention been given to how such policy understandings of accountability is received and applied in practice on the ground in specific settings of global health when these GPPPs undertake public health policy processes. Therefore, despite contestation around the Global Fund's accountability, the literature has little to say on the question of how the Global Fund itself understands accountability in policy and how this understanding informs its accountability practices on the ground in specific settings of global public health. This study aims to bridge this gap.

Moreover, the Global Fund lays claim to country ownership as a core principle of its accountability practice in aid recipient countries (Global Fund, 2012). However, there has been a significant lack of scholarship directly exploring how the Global Fund's policy understanding of accountability works itself out in practice in specific settings of global health. This study will address this gap by presenting a sustained, reflexive and empirical analysis of the Global Fund's accountability practice in Ghana, with a specific focus on its implications for country ownership of the national HIV/AIDS response policy.

In the next chapter, this study traces the origin of the Global Fund. It does this by situating the emergence of the Global Fund in a specific historical context and providing an account as to how and why it emerged as a global public-private partnership (GPPP) in the global health regime.

CHAPTER THREE
GLOBALISATION, HIV/AIDS AND THE SPREAD OF INFECTIOUS DISEASES: TRACING THE ORIGIN OF THE GLOBAL FUND

3.1. Introduction

This chapter examines the emergence of the Global Fund as a public-private partnership (GPPP) in the global health regime. The chapter is also intended to underpin and act as a backdrop to the analysis in Chapter Five. Chapter Five is the chapter that engages with the first research objective of this study. The first research objective of this study is to determine how the Global Fund understands accountability in its policy documentation and what structures and procedures it has put in place to address accountability concerns.

This chapter will show that the emergence of the Global Fund is a function of social construction and shaped within society by power relations and ideology. The underlying ideological position informing the Global Fund's policy orientation (and as such, its understanding of accountability in its policy documentation) is a neoliberal one. Therefore, an approach rooted in the critical political economy tradition adopted in this study enables the researcher to understand that the shift to a global from an international health regime is a function of a complex and historically mediated developmental process conditioned by social relations and driven by neoliberal globalisation (see Chapter 2.5). The emergence of public-private partnerships (GPPPs) in health like the Global Fund occurs in the context of these relations. Gill (1995, 1998) conceives neoliberal globalisation as a 'globalising market civilisation' (see Chapter 2.4).

Globalisation is characterised by the unparalleled expansion and integration of capital, production and exchange relations across transnational borders (Lee and Zwi, 1996). The volume of globalised economic activities and growing population movement and mobility enabled new risks for the transborder spread of disease (Brown, 2012; Tatem et al., 2006; Collin and Lee 2003; Ruebi, 2016; Gubler, 2011; Lee, 2000, 2003; Buse, 2004). This global integration and connectedness created new public health risks and challenges, limitations, and opportunities evidenced by the intensification and swift spread of infectious diseases such as HIV/AIDS (Brown, 2012). The global morbidity and mortality related to HIV/AIDS led to the recognition of the swift and rapid globalisation of infectious diseases and generated a heightened global resolve

to tackle it. This realisation was underpinned by a confluence of neoliberal discourses that influenced the construction of the Global Fund as a GPPP in health in the global health regime.

In order to locate the Global Fund in the specific historical context that underpins its emergence, it is necessary to go back in history to examine the response to the spread and control of infectious diseases in the international health regime and then to highlight how the global health regime responds to disease control differently. Therefore, in Section 3.2 of this chapter, I discuss how infectious diseases were managed in the international health regime. In this regime, formal public health policy responses and initiatives remained the mandate of states and the World Health Organisation (WHO). In Section 3.3, I examine the intersection of a then emerging HIV/AIDS pandemic with a globalising neoliberal world order. I argue that the spatial or geographic dimension, intensity and rapidity with which the HIV/AIDS disease spread as a transborder public health risk directly challenged the existing system of disease control and management defined by state-centered management of the international health regime. Section 3.4 engages in an analysis of influential neoliberal discourses which account for the decision to establish the Global Fund as a global public-private partnership. Section 3.5 discusses the establishment of the Global Fund, while Section 3.6 presents a summary of the chapter and draws a conclusion.

3.2. Taking a step back in history: The Spread, Management and Control of Infectious Diseases in the International Health Regime

In this section, I will discuss how infectious diseases were managed in the international health regime. In this regime, formal public health policy responses and initiatives remained the mandate of states and the WHO. Historically, the control and management of infectious diseases are usually prioritised in the health agenda of states. States contended with infectious diseases through national management and control (Fidler, 2001, 2003, 2005). Dodgson et al. (2002), and Johnson et al. (2013), observe that this state-centric focus and character of the control and management of infectious diseases has been a function of the advent of states since their formation. As explained by Dodgson et al. (2002), the international health regime is configured on the belief that states (individually and cooperatively) had responsibility for the health needs of their populations within and outside national boundaries (2002: 8).

As Aginam (2002) argues, the spread of infectious diseases across transnational boundaries during the European cholera epidemics of 1830 and 1847 catalysed the beginnings of the earliest international efforts directed towards the control and management of infectious diseases. In this context, Loughlin and Berridge (2002) posit that the spread of infectious diseases in that historical period was a function of the growth in international trade and economic activities between Europe and the Middle East. Such growth facilitated the spread of diseases such as cholera and later yellow fever across international borders. Efforts to control and manage infectious diseases resulted in a series of international sanitary conferences taking place between 1851 and 1903 (Howard-Jones, 1975; Porter, 1999; Loughlin and Berridge 2002; Fidler, 2001, 2007, 2003; Tognotti, 2013). These conferences were convened to seek avenues to control the spread of these diseases. The traditional response for the infectious diseases control such as the deployment of quarantine measures and the closing of ports became inadequate in a period of growing commercial activities (Loughlin and Berridge, 2002).

These international sanitary conferences led to the development of a set of regulations known as the International Sanitary Regulations (Katz and Fischer, 2010). However, there was a lack of political will from states with regard to the implementation of these regulations. In order to encourage such political will and to formalise the implementation of these regulations such that they could achieve their intended purposes, the Office International d'Hygiène Publique (OIHP) was established at a meeting in Rome in 1907 by European countries (Loughlin and Berridge, 2002). The creation of the OIHP heralded the advent of the era of international health organisations in the international health regime (Loughlin and Berridge, 2002). These international sanitary organisations remained in force from the late 19th century until World War II (Stowman, 1952; Fidler, 1999, 2003; Aginam, 2002; Katz and Fischer, 2010).

After World War II, the World Health Organisation (WHO) emerged as the new arbiter of international health in 1948 under the purview of the United Nations (UN) systems. The WHO was established as the key coordinating health agency of the UN on behalf of states. The WHO adopted the earlier International Sanitary Regulations and renamed them the International Health Regulations (IHR) in 1969 (Schneider, 2009; Aginam, 2002; Fidler, 2004, 2005; WHO, 2005; Katz and Fischer, 2010). The IHRs were modified slightly in 1973 and in 1981 (Aginam, 2002; Fidler, 2004, 2005; WHO, 2005; Katz and Fischer, 2010). The IHRs provide the legal basis and

guidance for the control and management of infectious diseases worldwide (Aginam, 2002; WHO, 2005; Katz and Fischer, 2010). The regulations lay out binding obligations on member states of the WHO to inform the WHO of any outbreaks of diseases in their jurisdictions. As further explained by Aginam (2002), the highest level of health procedures permitted in situations of disease outbreak is enforced in order to protect the state that suffers an outbreak against the risk of attracting economic and other embargoes, which could be imposed by neighbouring states, trading partners, and other countries.

In summing up this section, the international health regime was configured with the idea of protecting the national borders of states. The key objective of states was to safeguard their national populations from transborder health risks that transcend national boundaries (Dodgson et al., 2002). Thus, the defining feature of the international health regime was the focus on the state for the control and management of infectious diseases within their borders and through the state-centric World Health Organisation (WHO) at the international level.

3.3. Globalisation, HIV/AIDS, and the Spread of Infectious Diseases

In Section 3.2 above, I discussed the state-centric focused nature of infectious disease management and control in the international health regime. In this section, I will examine the intersection of a then emerging HIV/AIDS pandemic as a public health risk in a globalising neoliberal world order. I argue that the spatial or geographic dimension, intensity and rapidity with which HIV/AIDS spread challenged the existing system of disease control and management defined by state-centred management of the international health regime.

HIV/AIDS was first noticed in the United States of America (USA) in 1981 (Simms, 2012; Fourie, 2009). In that year, the United States Center for Disease Control (CDC) recorded cases of a virulent and aggressive cancer called Kaposi's sarcoma (KS) and a rare lung infection. Increasing numbers of patients diagnosed with this condition which leads to severe immune deficiency had died by the end of 1981 (AVERT 2019). In September of 1982, the CDC for the first time identified it as the 'Acquired Immune Deficiency Syndrome' (AIDS) (CDC, 1981, 1982). Merson et al. (2008), contends that very few medical conditions have captured the attention and imagination of both public and scientific communities so rapidly and extensively as AIDS.

As pointed out in the penultimate paragraph, the advent of HIV/AIDS converged with a globalising neoliberal world order. The objective basis and material conditions of this world order is a system of global economic production determined by huge transnational corporate investors and companies from the industrialised states of Western Europe and North America who superintend over the majority of the global productive assets (Gill, 1995). The integration of states into the global economy through their adoption of neoliberal developmental strategies had led to the unparalleled expansion of capital, production and exchange relations across transnational borders. This has further catalyzed massive population mobility be it in form of economic migration and migrant labour, tourism, and business, as people seek for better standards of living and economic opportunities (Lee and Zwi, 1996). Humans through expansive and rapid population mobility had become transporters of diseases. Diseases no longer took years to extend to new geographic areas. Put clearly, local infectious diseases could easily become globalised in a very short time. By the end of 1985, every region in the world had reported at least one case of AIDS (Mann et al., 1992; AVERT 2019). In October, 1987, AIDS became the first ever illness debated in the United Nations (UN) General Assembly (AVERT 2017). As Mann et al. (1992) observe, HIV/AIDS demonstrated its ability to cross all borders, be they economic, social, cultural or political.

Although HIV/AIDS spread throughout the world, its consequences were felt unequally. This was partly due to the economic inequality between states which some attribute to the adverse effects of globalization (Lee and Zwi, 1996; Dodgson et al., 2002). Economic inequality and deprivation leaves populations vulnerable to infectious diseases like HIV/AIDS. The 1970s and 1980s saw many developing countries going through a period of debilitating economic decline driven by massive foreign debt, weak economic growth and adverse balance of payment and balance of trade positions (Lee and Zwi, 1996). The imposition of structural adjustment programmes (SAPs) on these countries by the World Bank as an antidote to their economic problems adversely impacted on their health sectors as these policies encouraged states to reduce spending on health, education and water services (Peabody, 1996; Lee and Zwi, 1996; Kawewe and Dibie, 2000; Ikamari, 2004; De Vogli and Birbeck, 2005; Shandra et al., 2011).

For example, in the 1990s in the Republic of Benin and Zimbabwe, the health sector's share of GDP and budget declined significantly (Okunade, 2005; Naiman and Watkins, 1999). Indeed,

Okunade, (2005) asserts that health expenditure as a component of government spending during the SAP era declined in 15 countries in sub-Saharan Africa. Parker (2002) argues that the structural factors which shape the HIV/AIDS epidemic arise from the restructuring of previously existing health and welfare systems through SAPs in developing countries. Parker's (2002) viewpoint is supported by that of Naiman and Watkins (1999) who note that the introduction of user fees into the public health care system of many sub-Saharan African states as a cost-recovery measure worsened accesses to healthcare for the poor and vulnerable in a period marked by the intensification and spread of HIV/AIDS.

HIV/AIDS has probably been the greatest health challenge in contemporary human history. As of 2018, about 74.9 million people were HIV positive and the global mortality rate of HIV/AIDS was estimated at 32 million (AVERT, 2018). Parker (2002) argues that beyond the massive mortality rate, what is perhaps most important about the shape of the HIV pandemic is the fact that the global distribution of the infection has been anything but equal. An estimated 68% of people living with HIV/AIDS live in sub-Saharan Africa (AVERT, 2018). About 20.6 million of this number live in East and Southern Africa which witnessed an infection rate of over 800, 000 people in 2018 (AVERT, 2018). In other words, the developing south, especially sub-Saharan Africa bears the highest mortality rate in relation to the global burden of the disease. Global burden refers to the rates of disease morbidity and mortality worldwide.

The HIV/AIDS pandemic had become part of the contemporary global landscape. As posited by Doyle (2006) and Poku and Whiteside (2004), the HIV/AIDS epidemic undermined social, political and economic activities worldwide. Few predicted its effect on mortality and morbidity on the global population (especially in developing countries in sub-Saharan Africa) or its devastating social and economic consequences (Merson et al., 2008). While intensified cross-border (between two states) flows can overwhelm the capacity of the state to regulate them, transborder flows (across more than two states) are even more difficult to control (Saker et al., 2004). The speed of globalised travels and exchange relations for a wide gamut of activities conditioned by globalisation processes brought to the fore the fact that an epidemic or outbreak anywhere in the world is immediately a potential threat elsewhere (Gubler, 2011; Collin and Lee 2003; Lee, 2000, 2003; Wilson, 1995).

The spread of the HIV/AIDS pandemic as a global public health risk thus reflects the realities of globalisation. As mentioned earlier in preceding paragraphs, humans through expansive and rapid population mobility had become transporters of diseases. Diseases no longer took years to extend to new geographic areas. Local infectious diseases in a specific location could easily become globalised in a very short time. The spatial dimension, traction and velocity with which HIV/AIDS spread challenged the existing system of disease control and management under the international health regime. The state-centric structures which characterised this regime were unable to deal with these challenges, resulting in the advent of new forms of health relations such as global public-private partnerships (GPPPs) in health to take up some of the health challenges arising from the processes of globalisation (Dodgson et al., 2002; Ruebi, 2018; Brown, 2012; Lee, 2006).

3.4. Understanding the Discourses that Shaped the Global Policy Response to the HIV/AIDS Pandemic and the Emergence of the Global Fund

In the previous section, I highlighted how the intersection of the emergence of the HIV/AIDS virus and a globalising neoliberal world exposed the shortcoming of the state-centric structures of the international health regime. The morbidity and mortality generated by HIV/AIDS as it spread globally led to a realisation of the dangers it posed to human existence and ignited new resolve to tackle and bring it under control.

In this section, I analyse how the quest for a solution and response to the AIDS pandemic was influenced by a confluence of neoliberal discourses within a changing global health environment conditioned by neoliberal economic globalisation. I argue that this environment has fundamentally determined the nature and character of the Global Fund's policy and practice orientation. These discourses are presented in detail below:

3.4.1. The discourse on the control of infectious diseases as a global public good

The global public goods worldview was articulated primarily by Kaul and her co-authors through their work in the United Nations system specifically with regards to the United Nations Development Programme (UNDP) (Kaul and Faust, 2001; Kaul et al., 2003; Kaul and Conceicao, 2006). Kaul and her co-authors argued that the porousness of borders has globalised health conditions and that global cooperation in managing these conditions was of concern to all humanity. They opined that the AIDS pandemic in sub-Saharan African states represented

existential threats to global health that transcend the continent and that the spread of the pandemic would have serious consequences for economic globalisation and the prosperity and well-being of industrialised countries. Thus Kaul and Faust (2001), Kaul et al. (2003) and Kaul and Conceicao (2006) advocated for a shift in healthcare financing away from a focus on the state towards the embracing of the private sector. Framing the control of infectious diseases as a global public good implies that it requires public-private cooperation in the public interest beyond state control and management of infectious diseases.

Therefore, the global public good perspective emphasises collective action for health between the public and private sectors at the global level. The discourse on global public goods by Kaul and others resonated with the resolve of the UN under the leadership of Kofi Annan to ameliorate and overcome the dire financial situation of the UN agencies (including the WHO). Furthermore, the WHO as the agency of the UN charged with global health was convinced that the emerging complexities of global health could not be managed by the UN system alone and that new forms of health relations (such as public-private partnerships) were necessary to confront the dangers posed by globalization, particularly in relation to the realisation of the Millenium Development Goals (see Chapter 2.5).

3.4.2. The discourse by the World Bank and WHO related to an economic approach to healthcare financing

In the late 1970s, the World Bank began to play a more prominent role in healthcare financing. The economic and fiscal crises of the 1980s faced by states in the global political economy and the rise of neoliberalism enabled the Bank's move into the health landscape and by the 1990s, the World Bank had emerged as a key actor in global health (Kickbusch, 2000; Ruger, 2005; Brown et al., 2006; Parker, 2002; Lee, 2009; Harman, 2010; Sridhar et al., 2017). Over time, the World Bank has emerged as the biggest source of donor health financing in developing countries. In its 1993 'World Development Report: Investing in Health' (WDR, 1993), the Bank articulated and presented its approach to healthcare development which quantified the effect of HIV/AIDS in economic terms and called for the inclusion of the private business sector in healthcare financing

The Bank called for the deployment of performance-based accountability tools and systems in aid program delivery. The Bank's position was that priority attention should be given to

developing cost-effective interventions for health problems that carry a large disease burden (high rates of morbidity and mortality like HIV/AIDS) (WDR, 1993; Lee and Zwi, 1996; Lopez et al., 2006; Abbasi, 1999). One of the cost-effective interventions designed by the World Bank is the Disability Adjusted Life Year (DALY). The Bank notes that the DALY is a mechanism introduced to quantify the cost-effectiveness of health programs and systems (WDR, 1993:5). The World Bank (cited in Abbasi, 1999:1005) describes the DALY 'as a unit used for measuring both the global burden of disease and the effectiveness of health interventions, as indicated by reductions in the disease burden. It is calculated as the present value of the future years of disability-free life that are lost as the result of the premature deaths or cases of disability occurring in a particular year'.

Brown et al. (2006) assert that this neoliberal economic approach to healthcare development by the World Bank depoliticises health by reducing it to certain technical model and criteria derived from the corporate business sector. Furthermore, the Bank, through a series of policy pronouncements promoting market-based ideas, also canvassed for greater private business sector participation in healthcare financing. The Bank also began to push for a broader role for non-governmental organisations (NGOs) in implementing developmental aid as part of neoliberal structural adjustment policies which favours NGOs to undertake healthcare service provisioning.

With regards to the World Health Organisation (WHO), Gro Harlem Brundtland's appointment as it's Director-General in 1998 engendered a shift in the health policy methodology of the WHO. This shift was from a focus on 'health as a fundamental human right' as enshrined in the WHO Alma Ata declaration (WHO, 1978: 1) to a new pro-market policy emphasis on increased healthcare financing from the private sector. As explained in Chapter 2.5, the challenges posed by globalisation required the WHO and the UN system more broadly to engage with the private business sector in partnerships in order to achieve global health objectives like the millennium development goals (MDGS). Brundtland created a WHO Commission on Macroeconomics to evaluate the role of health in economic development (CMH, 2001; Banerji, 2002; Brown et al., 2006). The WHO new policy thrust as contained in the report mirrored the neoliberal economic rationale and approach of the World Bank in linking economic growth and development to increased investment in healthcare.

The CMH report also followed the World Bank's advocacy that health investments should be administered on the basis of economic and technocratic parameters and had to be planned and measurable in order to be effective (CMH, 2001). Liden (2013) notes that the similarities in the approach adopted by the WHO and the World Bank were not a coincidence because the authors of both the World Bank's 1993 'World Development Report: Investing in Health' and the WHO CMH reports (2001) were drawn largely from the same set of people (Linden, 2013:16). He explains that Brundtland had already been strongly influenced by the thinking of the authors of the World Development Report and as such decided to bring them on board the CMH project. They included Dean Jameson and Chris Murray, Julio Frenk, Anne Mills and then Harvard economist, Jeffrey Sachs (Linden, 2013:16).

3.4.3. The World Bank's promotion of partnership oriented approaches in aid delivery

In the last decades of the 20th century (1980 – 2000), the World Bank through policy position papers and publications such as 'Education and Health in Sub-Saharan Africa: A Review of Sector-Wide Approaches' began promoting health partnership-oriented approaches such as the sector-wide approach (SWAP) (World Bank, 2001). According to the World Bank, developmental project assistance in Africa had become fragmented; donor-driven and lacking impact on targeted issues in recipient countries (World Bank, 2001). The main attributes of the approach include partnership, common management systems and technical assistance in the form of capacity building programmes (World Bank, 2001). The Bank further criticised the proliferation of donor organisations and disease control programs. In making this criticism, it argued that there was a lack of coordination and harmonisation between donor activities and programmes which adversely impacted on the realisation of results (World Bank, 2001: 2).The World Bank's view was that this problem could best be confronted through the coordination and harmonisation of parallel projects by donors. The Bank also advocated that donors should undertake this process in partnership with national health stakeholders in recipient countries. The Bank further averred that donors can directly fund specific aspects of a recipient country's national health priorities in partnership with the recipient country (World Bank, 2001).

3.4.4 Donor government criticisms of existing multilateral mechanisms for funding disease control

While donors were willing to mobilise funds when needed to tackle HIV/AIDS, they were also concerned with the bureaucratic bottlenecks regarding UN agencies' operations and the inability of multilateral programmes to achieve intended results in terms of impact in developing countries. Countries like the United States (under the Bush administration), the Japanese government and the European Commission were highly critical of what they perceived as the inefficiencies, bureaucracy and wastefulness of the UN system and its agencies (Macro International, 2007; Lidén, 2013; Koenig-Archibugi, 2016). For example, donors were disillusioned with the perceived failure of the WHO's malaria control activities through national malaria control programs in aid recipient countries (Macro International, 2007). Donors were also concerned that global tuberculosis control activities (under the WHO) had never really been successful and that the disease was developing progressively resistant strains which were costly and challenging to treat, thereby driving growing levels of global tuberculosis mortality (Macro International, 2007). Furthermore, donors expressed concern with what they observed as the operational weaknesses of the then WHO's Global Programme on AIDS (created in 1986) and the Joint United Nations Agency on AIDS (UNAIDS) established in 1996 (Koenig-Archibugi, 2016).

The US, the European Union and the Japanese were not alone in their criticism. For instance, the Bill and Melinda Gates Foundation (BMGF) emphasised the importance of performance-based accountability for efficient management of developmental resources in aid programmes, noting that the UN was bedeviled by an entrenched and corrupt patronage system (Macro International, 2007). Donors also picked up on the World Bank's advocacy for cost-effective and measurable health indicators (see Section 3.4.2 above) by stating that health interventions must be measured and cost-effective to achieve intended performance results (Macro International, 2007). As posited by Radelet (2004), donors held a strong conviction that health aid and the institutions that provided it, had by and large been ineffective in driving development and, particularly, in tackling HIV/AIDS, Tuberculosis and Malaria mainly through the United Nations system.

3.4.5. Conceptualisation of infectious diseases as a threat to the global economy and security

During the 1990s, a fundamental discourse in the global responses to the HIV/AIDS pandemic was the framing of HIV/AIDS as a threat to global security and economic development (Ingram, 2005, 2007 and 2009; Zacher and Keefe, 2008; McInnes and Lee; 2006; Koenig-Archibugi, 2016). The discourse was underpinned by the belief that the spread of HIV/AIDS across global geographic spaces posed a serious threat to global economic growth and security. Poor health in developing countries was presented as a threat to global economic growth that could undo decades of work with regards to the gains of economic globalisation. After all a sick workforce is an economically unproductive workforce.

In the year 2000, an intelligence assessment and analysis generated by the United States National Intelligence Council (NIC) projected that HIV/AIDS mortality in sub-Saharan Africa would reduce life expectancy on the continent by 30 years and annihilate close to a quarter of its population (King 2002). The report also noted that HIV/AIDS in particular and other emerging infectious diseases would endanger US and global security for decades and worsen socio-political instability in strategic countries in which the US had significant economic interests and investments (King, 2002:763-764). As Kickbusch (2000) observes, recent administrations in the United States have positioned global health beyond being a health issue to being one with major economic and security interests.

Ollila (2005) argues that industrialised countries perceive health-related challenges in developing countries as a threat to their vital interests (2005). While she notes that the United States has always associated national interests to its development aid, she argues that the mid-1990s has witnessed an intensification of this narrative as the United States consistently links its engagement in global health to its national security and economic interests (Ollila, 2005). The then Clinton administration in the United States empowered a National Science Council to investigate the security threat posed by infectious diseases. Clinton later publicly declared that HIV/AIDS posed a threat to U.S. national security in particular and global security in general. He noted that if left unchecked, it could undermine the efforts channeled towards creating free-market democracies globally (Gellman, 2000).

The United Nations Security Council (UNSC) embraced this conceptualisation of HIV/AIDS a a threat to global economic development and in January 2000, called for an extraordinary emergency session of the Council. The Council was to deliberate on the threat to developing nations (especially Sub-Saharan African countries) posed by HIV/AIDS (UN Security Council, 2000). After deliberations, a UN Security Council resolution (UNSC 1308) addressing HIV/AIDS as a threat to global security and economic development was adopted (Ingram, 2007; Koenig-Archibugi, 2016).

3.4.6. CSO advocacy for access to HIV/AIDS medicines and for increased global funding for HIV/AIDS

Prior to the establishment of the Global Fund, CSO's played a crucial role in galvanising the political traction needed to create it (Doyle and Patel 2008; Ingram, 2009; Seckinelgin, 2004, 2008; Wogart et al., 2008; Hoen, 2011; Piot, 2005; Nunn, 2009; Piot et al., 2008; Hien and Kohlmorgen, 2008; O'Manique, 2004; Barnes, 2011, Smith, 2014; Brown, 2012). Barnes (2011) identified three ways in which CSO activism influenced the construction of the Global Fund as a partnership.

According to Barnes (2011), the discovery of anti-retroviral drugs clearly revealed the depth of economic inequality between the industrialised nations of the north and the developing countries of the south. Whilst they were comparatively cheaper in the north, the drugs were expensive in the southern hemisphere where the morbidity and mortality of the disease was far higher relative to the north. In this context, she averred that CSOs' began to advocate for equality in access to treatment and for the support of donors to make essential access to these medicines in developing countries a reality (Barnes 2011). However, pharmaceutical firms defended their proprietary rights to charge premium prices for innovative drugs like antiretroviral AIDS drugs and threatened to sue any company or country that makes generic substitutes. Their position was reinforced by the Agreement on Trade Related Intellectual Property Rights (TRIPS), introduced by the World Trade Organisation (WTO). The position of the pharmaceutical companies provided a focal point of agitation and drew criticisms not just from activist NGOs, but also from an ever-widening activist base that included the media, anti-globalisation campaigners, scientists, global aid advocates, lawyers, musicians, anti-big business activists, social justice movements, lawyers, governments from developing countries, anti-neoliberal and leftist academia (TAC,

2010; Hoen, 2011; Wogart, 2008; Seckinelgin, 2004, 200; Piot, 2005; Nunn, 2009; Piot et al., 2008; Hien and Kohlmorgen, 2008; O'Manique, 2004; Barnes, 2011, Smith, 2014; Brown, 2012).

Secondly, Barnes (2011) noted that CSOs presented their campaign for 'access to medicine' as a human rights issue. The fundamental reasoning given for the adoption of the human rights discourse is that the demand for access to treatment is underpinned by the right to life, equality and health despite the inability of those affected to afford the medicines. CSOs' argued that global health inequities were a function of the prevailing neoliberal modes of globalisation which privileged rich industrialised countries (and their corporate behemoths like global pharmaceutical firms) while disadvantaging poorer developing countries (Barnes 2011). They therefore advocated for global structural reforms that would bridge global health inequalities and bequeath a more equal, just and inclusive world order based on health for all irrespective of citizenship, race or class. The identification of equality and inclusion by these activists suggests that they believed that people should have a say and also participate in the modes of health governance that affects their existence.

Barnes (2011) states that the contestation around access to medicine and for more participatory forms of governance generated widespread public awareness and support. CSOs and their sympathisers organised the 'Global March for Treatment' in Durban, South Africa during the international AIDS conference in 2000 which helped place access to anti-retroviral drugs squarely on the global political agenda (Barnes, 2011). This action drew critical and unflattering attention to the silence of donor governments and the obduracy of pharmaceutical companies (Barnes, 2011). Consequently, the G8 began to pay more attention to the position of these activist CSOs and the need for action to increase global funding for access to medicines in developing states (Barnes, 2011).

3.5. The Influence of the Bill and Melinda Gates Foundation (BMGF) on the Global Health Agenda

The Bill and Melinda Gates Foundation (BMGF) is the biggest private sector investor in global health (including in the Global Fund) (Viergever and Hendriks; 2016; Stuckler et al., 2011). Birn and Richter (2018) observe that the BMFG outspends any other government apart from that of the United States on global health. By 2015, the BMGF annual spending was around $6 billion (Birn and Richter, 2018). Of this amount, about $1.2 billion was spent on diseases such as HIV, malaria, and tuberculosis, while $2.1 billion was spent on biomedical solutions and technologies encompassing health issue areas such as polio eradication, vaccine production and supply, family planning, and child and maternal health (Birn and Richter, 2018).

While the World Health Organisation (WHO) is an inter-governmental agency funded by states, the BMFG (which is a private entity) has extended funding support to the WHO. McCoy et al. (2009: 1648) notes that between 1998 and 2007, the WHO received funding totalling $336 million from the BMGF. This makes the BMGF one of the pre-eminent financiers of the WHO beyond the contribution of donor states such as those in the G8 (McCoy et al., 2009). According to Birn and Richter (2018), by financing the WHO, the BGMF has extended its influence into this organisation. In addition to directly contributing to the funding of the WHO, the BMGF has entered into partnerships with the WHO and funds these partnerships. Through such partnerships with the WHO, the BMGF is able to influence and shape global health agendas in a wide variety of areas. Such public-private partnerships include the Roll Back Malaria and Stop Tuberculosis Partnerships. By 2006, the number of public-private partnerships funded by the BMGF was more than 70 (Brown et al., 2006).

According to Ollila (2005), the BMGF has a seat on all the policy boards of the global health partnerships and organisations in which it has invested money. For instance, it has a seat on the board of a group of leading global health organisations referred to as the H-8 (McCoy et al., 2009:1650). The H-8 is an informal grouping of actors in global health and includes the WHO, World Bank, United Nations Children‘s Fund (UNICEF), the United Nations Population Fund (UNFPA), Joint United Nations Program on HIV/AIDS (UNAIDS), the GAVI Alliance, the Global Fund and the BMGF itself (Birn and Richter, 2018; McCoy et al., 2009; Curtis, 2016). They are all funded in one way or the other by the BMGF and are as such, influenced by it.

Therefore, the BMGF plays a significant role in shaping the global health agenda. The BMGF is also heavily involved with shaping and setting the health agenda of the G8 (McCoy et al., 2009; Curtis, 2016).

Taken together, the financial power at its disposal and the relationships it has created gives the BMGF significant leverage in global health (McCoy et al., 2009; Stuckler et al., 2011). Curtis (2016) decries what he sees as the outsized influence of the BMGF in shaping global health. He noted that while all the H-8, numerous partnerships, consortiums and research institutes depend on BMGF funding, none of them can hold it to account. As a philanthropic organisation, it is only subjected to tax accountability in the United States, but is not held to account for its activities anywhere in global health (Curtis, 2016). Beckett (2015) notes that no foundation in the history of international or global health has had the same profound influence and effect on all facets of global health like the BMGF (Beckett, 2015).

3.6. The Establishment of the Global Fund to Fight HIV/ AIDS, Tuberculosis and Malaria

In line with the overarching neoliberal discourses detailed above, suggestions were made on the type of funding structure to be established for a coordinated global process of policy response to HIV/AIDS. The framing of the HIV/AIDS crises as a threat to global economic growth and security began to gain political traction and commitment among donor governments of the G8. The need to tackle these diseases in order to improve economic growth and productivity and to sustain the gains of economic globalisation positioned health in a socio-economic context and made use of economic language acceptable to donor governments of the G8. At the G-8 meeting in Okinawa, Japan in 2000, the G-8 leaders made significant commitments to scale up funding and decrease the global burden of HIV/AIDS by creating a new funding mechanism. Tuberculosis and malaria were also added to HIV/AIDS by the G8 at this meeting as priority diseases to be battled with a new funding mechanism.

As the idea for more global funding began to gain traction and commitment among donor governments of the G8, activist CSOs asserted that any new funding entity should be socially inclusive and participatory by including people living with HIV/AIDS in its governance framework (Barnes, 2011). By advocating for the inclusion of those living with HIV/AIDS in the governance framework of the new funding entity, these activist groups wanted to curtail the influence of pharmaceutical firms and donor governments whom they hold culpable for the delay

in access to treatment that caused high mortality in developing countries (Barnes, 2011; Smith, 2014; Brown, 2012; Hien et al., 2007; O'Manique, 2004). The position of these CSOs suggests that participation is conceptualised as a mode of accountability; that is as a way of holding the new entity to account (Barnes, 2011). Developing countries also expected to have a voice in the emerging entity (Barnes, 2011).

Following the pattern of the summit in Okinawa in 2000, the Abuja summit of April 2001 saw the then Secretary-General of the UN, Kofi Annan formally request the establishment of a funding mechanism involving public-private partnership targeted at HIV/AIDS, Malaria and Tuberculosis. At the UN General Assembly session on HIV/AIDS two months after the Abuja summit, Kofi Annan reiterated his call for annual financial targets of between $6 - 10 billion annually in new funding to combatting these diseases. At the G8 summit in Genoa in July 2001, the Global Fund to fight HIV/AIDS, Malaria and Tuberculosis was launched with $1.3 billion dollars (Genoa 2001 G8 Comminique: Paragraph 15). The G8 called 'on other countries, the private sector, foundations, and academic institutions to join with their own contributions – financially, in kind and through shared expertise' (Genoa 2001 G8 Comminique: Paragraph 15).

A Global Fund Transitional Working Group (TWG) was subsequently inaugurated to draw up the guiding Framework Document that would operationalise the Global Fund. According to Koenig-Archibugi (2016), the construction of the Global Fund reflects the inclinations of the largest donors. Firstly, he posits that donors wanted to construct a financial instrument that would focus simply on malaria, tuberculosis, and especially HIV/AIDS instead of on a broader mandate, for example, the strengthening of primary health care services. Secondly, he notes that donors did not want this new entity to be situated within the United Nations (UN) system. For example, the United States, the European Commission, and Japan specifically rejected the option of letting either the WHO or UNAIDS manage this new entity and the funds accruing to it. Thirdly, the largest donor governments did not want it constructed on the basis of the intergovernmental model reflective of the agencies under the UN system and advocated for the inclusion of private business interests and civil society organisations (Koenig-Archibugi 2016).

However, it is germane to note that some European countries and developing country representatives wanted it located within the WHO or the broader United Nations system, but that this was firmly rejected by the United States (Barnes, 2011). Finally, the new funding entity was

legally incorporated as a non-profit foundation under the Swiss civil law (Koenig-Archibugi 2016; Lidén, 2013). It was named the Global Fund to Fight HIV/AIDS, Malaria and Tuberculosis. It was officially launched in January, 2002 by the United Nations and donor governments as an independent public-private organisation outside the confines of the WHO and the broader UN system.

3.7. Conclusion

Global health reflects the realities of globalisation; especially the increased movement of persons and goods and the dissemination of public health risks such as infectious diseases. HIV/AIDS is a disease whose rapidity, morbidity and mortality were driven by globalisation. This is evident in its epidemiology, the global response mobilised to curtail its rapidity, morbidity and mortality and the dominance of neoliberal discourses in understanding it. The rapidity with which the HIV/AIDS disease spread as a transborder health risk meant that the state and the World Health Organisation (WHO) were constrained in their capacity to manage it. Thus additional or new forms of health relations such as public-private partnerships were needed to confront the complexities of new and reemerging infectious diseases.

The location of the Global Fund as an independent, stand-alone organisation outside the confines of multilateral institutions of the United Nations system (WHO, World Bank etc.) was like a vote of no confidence in these institutions by donor governments, particularly the United States. This was despite the desire of developing countries and the lobbying by actors within the UN to have the Fund domiciled within the UN system. Futhermore, the inclusion of private sector actors in the construction of the Global Fund as a public-private partnership in health signalled the desire of donor governments to create an organisation with private business attributes, while still maintaining some sort of public personae (government presence). This was in the belief that 'industry' gets things done quickly, efficiently and effectively, unlike the multilateral institutions of the United Nations (UN) system which donors perceived as characterised by bureaucratic inefficiencies and bottlenecks.

In Section 3.4, this study highlighted the discourses that shaped the global policy response to HIV/AIDS in relation to the emergence of the Global Fund. The only anti-neoliberal discourse that influenced the formation of the Global Fund was that put forward by activist CSOs. They were opposed to the powers of corporate business, and in particular, pharmaceutical companies

and their initial refusal to bring down prices of life-saving drugs. They also expressed concern about the inequalities arising from neoliberal modes of globalisation. These CSOs insisted that any new global funding mechanism should be inclusive, open and participatory to all stakeholders, particularly those affected by the diseases.

In sum and as noted in the introductory section, the critical political economy approach adopted in this study enables this researcher to understand that the spread of the HIV/AIDS pandemic and the responses to was driven by neoliberal globalisation which Gill (1995, 1998) conceives as a globalising market civilisation (see Chapter 2.4). This approach helps us recognise the crucial importance of relations of power in shaping the discourses which underpinned the global policy response to HIV/AIDS and the emergence of the Global Fund. As such, I have found it important to draw attention to the dominance of donor governments and other donors such as philanthropic organisations. As well as conceiving the morbidity and mortality of HIV/AIDS in technical and economic terms, neoliberal discourses entrenches the powers of donors and defines the standards by which current health policy responses on infectious diseases in the global health regime are appraised and executed. This draws attention to donor dominance in global health policy processes.

Put clearly, a neoliberal ethos and narrative underpin the emergence of the Global Fund and has fundamentally determined the nature and character of the Global Fund's accountability policy and practice orientation**.** In Chapter Five and in relation to the first research objective of this study (which is to determine how the Global Fund understands accountability in its policy documentation and what structures and procedures it has put in place to address accountability concerns), I will examine how this neoliberal ethos and narrative is reflected in the Global Fund's policy documentation and how it informs its understanding of accountability. Having traced the origin of the Global Fund in this chapter, this study proceeds to Chapter Four to give some background on Ghana (as the social context of this study) before moving on to discuss the institutional accountability policy and practice of the Global Fund in subsequent chapters. To Chapter Four I now proceed.

CHAPTER FOUR

GLOBALISATION, POLITICAL ECONOMY AND THE HIV/AIDS CRISIS IN GHANA

4.1. Introduction

As I noted in the concluding section of Chapter Two (see Section 2.11), globalisation transformed structures and conditioned outcomes across a broad spectrum of social spheres (like the political economy and health sectors of aid recipient countries). In Chapter Three, I located the emergence of the Global Fund in the intersection between a globalising neoliberal world order and the morbidity and mortality that characterised the outbreak and spread of HIV/AIDS worldwide such as in sub-Saharan Africa countries like Ghana.

Ghana is the social context of this study. In this chapter, I intend to explore the nexus between globalisation, political economy and the HIV/ AIDS crisis in Ghana. The rationale for this chapter is to explore, understand and highlight the objective conditions of the Ghanaian political economy context in which the Global Fund accountability practice in relation to the second research objective is examined in Chapters Six and Seven. The second research objective of this thesis is to investigate how the Global Fund's policy understanding of accountability works itself out in practice in Ghana, in particular in relation to its implications for country ownership of the national HIV/AIDS response policy.

Globalisation impacted on Ghana (like other sub-Saharan African countries), especially due to the introduction of structural adjustment programmes (SAPs). SAPs fundamentally altered the structure of the Ghanaian political economy and its health sector. The chapter proceeds as follows. Section 4.2 gives a brief overview of the political economy of Ghana pre-SAPs. In Section 4.3, the chapter discusses the implementation and consequences of SAPs on the political economy, with emphasis on the health sector. Section 4.4 examines Ghana's national HIV/AIDS response. The section argues that the constraints on state financial capacity, arising from the consequences of debilitating structural adjustment programmes (SAPs), impacted on the ability of the state to adequately respond to an emerging HIV/AIDS epidemic through its national HIV/AIDS response framework. The constraints on state financial capacity created a gap for the Global Fund (and other donors) to come into the health sector and support government efforts in financing the national HIV/AIDS response.

However, as Section 4.5 explains, the participation of donors generally in the response and the practice methods they employ gave rise to questions of accountability over the country ownership of the national HIV/AIDS response in Ghana. Section 4.6 concludes the chapter and links the significant questions over donor practice methods and accountability over the ownership of the national HIV/AIDS response to the need to examine the Global Fund's accountability practices, in particular in relation to its implications for country ownership of the national HIV/AIDS response policy in Ghana.

4.2. Overview of the Political Economy of Ghana

4.2.1. Immediate post-independence era (1957-1966)

In his analysis of structural adjustment in Ghana, Konadu-Agyemang (2000) argued that at independence in 1957, the economy of Ghana manifested all the most essential characteristics of underdevelopment. In this context, he asserted that the economy was structurally dislocated because production and consumption were not integrated within the country, but through external trade because the commodities such as cocoa and gold which it produced were sold as raw materials to fund the purchase of manufactured goods (Konadu-Agyemang, 2000:471). He argued that this structural dislocation via the focus on raw material production created the dependency of the Ghanaian economy on the volatile global commodities market. However, it should be acknowledged that the British left Ghana in a better state than its peers in sub-Saharan Africa. In this vein, Konadu-Agyemang (2000) observed that Ghana at this period 'accounted for 10% of the world's gold exports, and was the world's foremost producer and exporter of cocoa.' (2000:472). He further posited that Ghana ' had an advanced education system, low national debt and foreign reserves of £200 million (the equivalent of three years' imports) and, it's per capita income at independence was comparable to that of South Korea and far higher than that of countries like Nigeria, India and Egypt' (Konadu-Agyemang, 2000: 472 - 473).

It was in this environment of economic buoyancy and stable macroeconomic conditions that Nkrumah emerged as president and undertook to modernise and improve the Ghanaian economy. He conceived a centrally controlled economic strategy built around a development plan with emphasis on free social service provisioning for Ghanaians which he achieved (Amo-Asante, 2016; Adom, 2015). However, there was a flaw in the planning of the development strategy. Its implementation and sustenance was predicated on price stability in the global commodities

market (Amo-Asante, 2016). Therefore, the crash in commodity prices in the 1960s, its impact on government revenue and the subsequent decline in the standards of living of the populace led to the ousting of Nkrumah by the military. The military cited the decline in the country's economic fortune as the reason for his removal (Amo-Asante, 2016).

4.2.2. Sustained period of socioeconomic instability (1966-1982)

The overthrow of Nkrumah gave rise to a period of continuing instability with 'seven changes in the political leadership between 1966 and 1982 of which five were military leadership' (Adom, 2015:72). It was a turbulent era in the political history of Ghana characterised by political instability and inconsistent policy choices. This political instability and the resulting inconsistency in policy choices is a reflection of the Cold War politics and its ideological influence on the Ghanaian military. In this regard, Oloyode (1990) postulated that contending factions of the military carried out coups and counter-coups during this period in order to maintain or reproduce their dominance over other factions. This factional battle and infighting in the military were ideological in nature between military officers who wanted to continue with Nkrumah's socialist rhetoric and those who wanted a more pro-western orientation. This ideological battle was exemplified when General Ankrah, who replaced Nkrumah, abandoned his socialist rhetoric and embraced a more liberal pro-western stand. This shift to liberal economic policies put the government at loggerheads with workers who protested against such policies.

Under pressure, General Ankrah handed over to Dr Busia in 1969 to usher in Ghana's second republic (civilian administration). Busia continued with the liberal policies of the Ankrah regime. However, Busia inherited significant debt from the preceding government, and by 1971 this debt had ballooned to double its size (Adom, 2015:75). Busia's government was toppled by the military in 1972 on the basis of failure to improve the economy amid a growing debt burden. Generals Akuffo and Acheampong emerged as military leaders and contrary to Busia's liberal policies adopted a more socialist ideological stand. Despite their shared socialist orientation, they were overthrown by Flight Lieutenant Jerry John Rawlings, a fellow socialist-oriented officer who espoused strong Marxist revolutionary ideals. Jerry John Rawlings emerged as military leader and handed over to Dr Hilla Liman in 1979 to usher in Ghana's third republic (civilian administration). However, two years later, Jerry John Rawlings overthrew Dr Liman to bring an end to the third republic and to dominate Ghanaian politics for the next couple of decades.

4.2.3. Understanding Ghana's vicious debt trap and the global commodities crises of the 1970s as catalysts for the implementation of Structural Adjustment Programmes (SAPs)

A combination of factors worsened Ghana's economic prospects in the 1960s and 1970s. Brunelli (2007) identified these factors to be the oil price shocks whose effects on Ghana were exacerbated by falling global commodity prices for cocoa which was the government primary revenue earner. These factors made it impossible for Ghana to meet its debt obligations and also meant that it had an increasingly greater need for external resources to meet new domestic demands and needs. Debt management took several methods such as debt rescheduling. Ghana's relations with the International Monetary Fund (IMF) and World Bank on debt matters can be traced back to 1966 when negotiations for debt servicing became imperative (Hutchful, 1987). Such negotiations were commonplace between successive Ghanaian governments and these institutions when the need arose (Hutchful, 1987).

The response of donor governments to resolve the debt problem and reclaim the loans they and western commercial banks extended to debtor nations was the implementation of SAPs through the IMF and World Bank. Both institutions took the position that the underlying causes of Ghana's economic problems were low productivity, poor governance, over-bloated public service, unnecessary government interference in the markets, excessive government spending, and state ownership of economic assets (Konadu-Agyemang, 2001; Hutchful, 1987). In order to remove these identified endogenous impediments and for Ghana as a debtor nation to receive new loans and debt relief, economies needed to undergo structural adjustments (Brunelli, 2007) by accepting the implementation of structural adjustment programmes (SAPs) so as to 'lock-in' neoliberal market reforms. These market reforms were supposed to spur economic growth and development. SAPs were first implemented in Ghana in 1983 and lasted until 1999.

4.3. A Globalising Neoliberal Market Civilisation, Structural Adjustment Programmes (SAPs) and the Political Economy of Ghana

Structural Adjustment Programmes (SAPs) are policy initiatives and expressions of what Gill (1998, 2003, and 2008) calls a 'globalising neoliberal market civilisation' (see Chapter 2.4). These initiatives, associated with international financial institutions such as the IMF and World Bank exert disciplining (conditioning) effects on domestic policy-making by states (see Chapter 2.4). The critical political economy approach adopted in this study requires careful attention to be paid to the hegemonic ideological arrangement that underpins a political system such as a

world order (see Chapter 2.2). In line with this approach, Cox (1983), Germann (2006) and Langridge (2013) assert that institutions such as the IMF and World Bank play a fundamental and active role as part of a 'historic bloc' of capitalist social forces linked with international finance in the neoliberal world order. As explained in Chapter 2.4, these institutions symbolise the rules which enable the extension of the neoliberal world order. As well as being products of that order; they ideologically propagate the values (norms) of the neoliberal world order in order to maintain and sustain it.

In 1983, President Rawlings and his then ruling Provisional National Defence Council (PNDC) agreed to implement the IMF/World Bank SAPs as the guiding framework of the government's Economic Recovery Programme (ERP). By accepting to implement SAPs under the overarching supervision of the IMF/World Bank, the Ghanaian government constrained its sovereign rights to national policy-making. SAPs are reform prescriptions states must implement as a condition to access IMF and World Bank loan facilities and to maintain their international creditworthiness (Grinspun and Kreldewicb, 1984). The goals of the SAPs implemented in Ghana were ostensibly to promote economic growth by relieving indebtedness, to alleviate poverty, and to improve the living conditions in Ghana (Odutayo, 2015). The policy prescriptions included the privatisation of public enterprises, export promotion, currency devaluation, deregulation of all economic sectors for foreign investment, stabilisation of government revenue by cutting down on government expenditure on social services, and trade liberalisation by removing tariffs on imports and foreign currency regulation (Konadu-Agyemang, 2000, 2001; Hutchful, 1987, 1997, 2002; Anyinam, 1993; Appiah-Kubi, 2001; Afriyie, 2009; Fosu and Aryeetey, 2007; Ismi, 2004).

Ghana's SAPs policy prescriptions fell into four broad reform categories: mining sector reform, trade and manufacturing sector reform, education sector reform and the health sector reform (Britwum et al., 2001). These will be discussed individually below, with particular attention to health sector reform as it is most relevant to this study.

4.3.1. Mining sector reform policy

Gold mining is the pre-eminent activity in Ghana's mining sector. Before the advent of structural adjustment, the Ghanaian mining sector, which was under state control and management, was in a near-comatose state due to lack of quality oversight and investment. In this regards, Britwum et al. (2001) observed that most of the mines were not producing optimally, while others were

closing down. Under SAPs guidelines, the government enacted several important legislations to open up the mining sector to attract foreign direct investment in new mines, while privatising old ones. The enacted legislations comprised the 'Minerals and Mining Law 1986 (PNDCL 153), Establishment of Minerals Commission, 1986 (PNDCL 154) Minerals and Royalty Regulations L.I 1349 (1987), and Small Scale Mining Law 1989 (PNDCL 218)' (Britwum et al., 2001:36). These laws offered generous incentives to foreign mining sector investors such as tax exemptions and favourable rates of profit repatriation (Britwum et al., 2001; Ismi, 2004; Akabzaa, 2009; Hilson, 2004).

In this vein, production and foreign investments multiplied in the sector and gold production in Ghana grew by more than 500% (Britwum et al., 2001; Ismi, 2004; Hilson, 2004). By the end of 1999, foreign direct investment in the sector approximated to about US$ 3 billion (Britwum et al., 2001; Ismi, 2004). Due to increased production as a result of significant foreign direct investment, Ghana became Africa's second-largest gold producer (after South Africa) and gold constituted more than 90% of the total value of its minerals output (Britwum et al., 2001). With regards to the ownership and nationality structures of the mining industry, approximately 75% to 85% of mines by the mid-1990s were owned by foreigners (Britwum et al., 2001; Ismi, 2004).

While it is undeniable that production and investment increased, critics express scepticism with regards to the gains obtainable by mining communities from increased foreign investment in their domains (Britwum et al., 2001). In this context, Ismi (2004) argued that SAPs had empowered transnational entities to transfer profits out of the country without creating sustainable economic growth for host communities in particular and the state in general. There are also some negative social and environmental consequences associated with mining activities. These include displacement of families as multinationals acquire agrarian land for mining rights (about 30,000 people were displaced between 1990 and 1998), unemployment due to privatisation of public assets and water pollution in major mining hubs such as Tarkwa, Akwatia and Wassa West districts (Ismi, 2004). Water pollution from mining activities destroyed thousands of aquatic lives, and severely damaged rural livelihood as communities in these districts could not fish or drink from the waters. The waters also poisoned and damaged food crops (Hilson, 2004; Ismi, 2004; Britwum et al., 2001).

In adopting a broader perspective with reference to the focus on the production of raw materials by peripheral states like Ghana, Cox and Schechter (2002) argue that governments become effectively more accountable to global bond and commodities markets than to their own public (Cox and Schechter, 2002). For example, the price of gold produced in Ghana and sold globally is not determined by the Ghanaian state, but by commodity and bond markets owned by private sector investors in developed countries who are out to make a profit. The price mechanism works in a way to guarantee their profit. Any global fluctuations or volatility in the price of gold poses consequences for the economy of Ghana as gold is a prime revenue earner for the state. Thus the options of the Ghanaian state in domestic policy-making such as national budgetary planning, exchange rate, monetary and trade policies become constrained by financial interests linked to the global economy. This is because the state lacks the power to determine or regulate the conditions under which it engages with the global commodities market when pricing its commodities (Afriye, 2009).

4.3.2. Trade and manufacturing sector policy reform

Britwum et al. (2001) observed that Ghana's earlier post-independence period witnessed economic growth. For instance, between 1960 and 1970, the gross national product grew at a rate averaging 10% to 13.0 % (Britwum et al., 2001). However, manufacturing sector expansion stagnated after 1970 due to low productivity, a lack of investment and underutilisation of existing capacity and there was no change in sector performance by successive regimes till 1983 (Britwum et al., 2001; Hilson, 2004). With the adoption of SAPs by the government in 1983, the trade and manufacturing sector policy reform was enacted. The policy was targeted at increasing the competitiveness of local manufacturers and restructuring the economy from an import-substitution to an export-orientated model in order to earn the foreign exchange needed to sustain the economy. In this regard, a plethora of initiatives were unleashed. For example, price controls on goods were removed, the national currency was devalued and its value tied to market forces of demand and supply, tariffs and customs duties were abolished to liberalise imports, export duties were removed and incentives introduced to encourage exports (Hilson and Potter, 2005; Britwum et al., 2001; Konadu-Agyemang, 2000). In response to these initiatives, the manufacturing sector capacity utilization grew from a low level of 18% in 1984 to 40% in 1988 and Ghana's industrial exports also expanded significantly (Britwum et al., 2001; Hilson, 2004).

However, the implementation was not all positive. Questions arose as to the benefits of opening up the economy completely to foreign direct investment. In this context, Britwum et al. (2001) observed that the reforms failed in their objective to improve the competitiveness of local firms in the global market as local firms lacked any competitive edge over their foreign counterparts. Other noted failures of this policy include the death of small and medium scale enterprises due to unfair competition from foreign firms, imported cheap foreign-made products that undermined local production and the rise in domestic unemployment levels (Britwum et al., 2001). Privatisation of public assets under this policy led to massive loss of jobs, and unemployment. For example, about 54,000 workers (constituting 39% of its entire staff strength) were retrenched by the Ghana Cocoa Board, and about 45,000 public servants lost their jobs. Approximately 200,000 workers were retrenched under SAPs (Ayinam, 1993; Britwum et al., 2001). Konadu-Agyemang (2000) records the number of job losses at 300,000. Redundancies and job losses (with no social security provision) drove families deeper into poverty and despair.

In relation to export promotion, cocoa production was a key target of the SAPs policies as it was the primary agricultural produce and export of Ghana. Cox (1987) argues that the objective of neoliberal reforms (such as SAPs) is the 'internationalisation of the state'. This is a global procedure by which state policies and practices are adjusted and linked to the dynamics of the global production process as exemplified by SAPs in Ghana. Under SAP, cocoa production was allotted 67 % of the total sum earmarked for agriculture (Drafor et al., 2000). Cocoa was a prime export target because it was crucial for foreign exchange earnings to pay debt. The quota of the national recurrent budget dedicated to agriculture dropped from 10% in 1981–82 to an about 3, 8% in 1988–90 (Drafor et al., 2000). The percentage of the agricultural sector budget relative to the entire national expenditure in this period was dismal as it was pegged at 6% to 12% (Anyinam, 1983; Drafor et al., 2000).

Germann (2006) and Poku, (2005) argue that the growing commodification of agriculture is a function of the global production restructuring process and that the emphasis on cash crops for export at the expense of food crops diminishes food security in developing countries and impacts negatively on rural population livelihoods. According to Germann (2006), this global production restructuring process is fundamentally linked with the interests of the transnational capitalist bloc. In this context, Anyinam (1983) argues that the increase in the cost of agricultural produce

during SAPs in Ghana was in the interest of large farmers and agribusinesses that are positioned to benefit from market forces.

4.3.3. Education sector reform policy

The education sector also underwent drastic reforms during SAPs. A decline in government revenue with regards to the economic crises of the 1970s and 1980s had led to a massive cutback in government funding of the education sector with negative consequences (Abukari et al., 2015; Dei, 2004; Amo-Asante, 2016; Britwum et al., 2001). Education's share of national budgetary expenditure had decreased to 27% in 1984 from 38% in 1976 and the share of GDP allotted to education declined to 1.0% in 1983 from 6.4% in 1976 (Britwum et al., 2001; Amo-Asante, 2016). This deteriorating condition of the sector was a target of SAPs. In this regard, education reforms based on a Ghanaian government 1974 Education Commission report on 'The Structure and Content of Education' were adopted (Britwum et al., 2001). These reforms sought to increase the quality of educational standards, to control government expenditure on the sector and partially recover educational costs, and to improve sector organisation and budgeting processes (Abukari et al., 2015; Dei, 2004; Amo-Asante, 2016; Britwum et al., 2001; Sowa, 2002).

Abukari et al. (2015) assert that the reform fundamentally shifted the state away from playing a key role in social service provisioning to only being an enabler and regulator with an emphasis on improving market linkages. This essentially meant privatisation of education based on a market-determined approach. This approach generated a lot of negative consequence in an environment of economic uncertainty. The introduction of cost recovery mechanism of tuition fees and other sundry charges by government as a response to its reduction of education sector funding positioned education outside the scope of most of the Ghanaians especially the rural poor. In this vein, Abukari et al. (2015) and Sowa (2002) noted that parents had to pay an assortment of levies and charges for their children. For instance, parents were charged levies for the building of classrooms and workshops (Sowa, 2002) and tuition fees were introduced across the board in the sector (Sowa, 2002; Abukari et al., 2015). In response, there was deterioration in the levels of school enrolments among poor households and populations. These outcomes in the sector worsened prevailing structural disparities in access to education between the urban rich and rural poor. In this context, Anyinam, (1993) asserted that illiteracy rates were high in the

rural areas where they were as high as 74.5%. Parents often cited the cost of school fees as reasons for their children being out of school.

4.3.4. Health sector reform policy

Healthcare in the immediate post-independence era was underpinned by the establishment of a National Health System (NHS) (Wireko, 2015; Abukari et al., 2015; Adisah-Atta, 2017; Arhinful, 2003). Under this system, the government directly delivered free health care to the people. The NHS system led to the establishment of expansive healthcare infrastructure around the country. Under the NHS, both the rural and urban populace had relatively equitable access to healthcare, unlike the colonial era healthcare system that favoured the urban populace. However, this model was not sustainable. It was affected by the general economic malaise that bedevilled the Ghanaian economy in the 1970s and 1980s. In response, even before the introduction of SAPs, the government had introduced a token user fee regime as a cost-recovery measure (Britwum et al., 2001:59).

Once SAPs were introduced in Ghana, health sector reform was a key component (Britwum et al., 2001; Amo-Asante, 2016). Aspects of SAPs such as stabilisation, liberalisation, deregulation, and privatisation condition and affect health systems (Kentikelenis, 2017). They have both direct and indirect effects (Kentikelenis, 2017). These are discussed below.

(a) Direct effects of SAP policies on the Ghanaian health system and outcomes

The stabilisation conditionality component of SAPs in Ghana required a downwards adjustment of government expenditure in the social sector relative to gross domestic product (GDP) (Johnson, 1998). This led to a drastic reduction in the number of public sector welfare projects mostly beneficial to the poor in the rural areas such as healthcare facilities (Konadu-Agyemang, 2000; Hutchful, 2002; Anyinam, 1993; Addison and Osei, 2001). Throughout the period of SAP reforms (1983–1999), the structure of public sector budgetary disbursements in Ghana has not been ‘pro-poor’ with regards to the health sector. For example, in the allocation of budget during the first phase of structural adjustment stabilisation programme (1983–1986), the percentage share of the health sector relative to other expenditure items was very small. Konadu-Agyemang (2000:475) and Anyinam (1993) note only around 5% of the government budget was allotted to social services (such as health and education), while 62% of the total funds went to public

infrastructure and 30%–32% was allotted to export-oriented production, a key target of SAPs (Konadu-Agyemang, 2000). According to Konadu-Agyemang, (2000), this pattern of budgetary expenditure (decrease in government budget to health sector) was consistent for the 15 years (1983–1999) during which SAPs were implemented.

The drastic reductions and shortfalls in public health expenditure induce negative outcomes on the volume and quality of healthcare and facilities provision (Konadu-Agyemang, 2000; Anyinam, 1993). In this regard, Adisah-Atta (2017), Wireko (2015), Arhinful (2003), Senah, (2001), Konadu-Agyemang (2000), Anyinam (1993), and Waddington and Enyimayew (1989) argue that spatial (rural-urban) inequalities in the distribution of healthcare facilities are an enduring fixture of the health system in Ghana. Structural adjustment worsened these inequalities, excluded the poor and made healthcare provisioning worse in rural areas. On the issue of rural-urban regional inequality of mortality patterns due to the accessibility of healthcare services, Anyinam, (1993) and Senah (2001) provide ample data. For example, out of the 1,200 doctors licensed in Ghana in 1988, less than 20% of them worked in the rural areas, housing 70% of the population.

There were only 19 doctors servicing a population of 1.2 million people in the rural north. About 40% of the 121 hospitals in the country at that time were located in only two cities, Accra and Kumasi (Anyinam, 1993). Similarly, Senah (2001) noted that the Greater Accra Region which is made up of only 15.8% of the national population had 70% of doctors of total Ghanaian doctors nationwide (Senah, 200). With regards to spatial allocation of medical facilities, Konadu-Agyemang (2001) states that in 1999 in the twilight of SAPs, 8 million Ghanaians in the rural areas were denied access to medical facilities due to the preponderance of such amenities in the urban areas relative to the rural areas (see also Nyonator and Kutzin, 1999 and Manji and Burnett, 2005).

The contraction of public health care expenditure engendered a moratorium on new recruitments and stagnated pay due to caps or ceilings placed on wage increases in the health sector (Odutayo, 2015). The net effect and outcome of this was a ‘brain drain’. The term ‘brain drain’ refers to the sustained migration of professionals from one country to another in search of better labour conditions (Odutayo, 2015). Ghana experienced a massive brain drain, affecting 56% of its medical personnel (Kalipeni et al., 2012). Kalipeni et al. (2012) note that departing medical

professionals ordinarily take with them the value of their training funded by their countries of origin. Therefore, the brain drain has a significant economic cost (Martineau et al., 2004). According to Senah (2001), by 1999, only 360 of the 1,600 or more doctors produced by the University of Ghana, were still in the Ghanaian healthcare system and that there was only one doctor per 40, 000 Ghanaians.

Privatisation as a component of structural adjustment affected the health system in Ghana directly via the introduction of a comprehensive user fees regime in 1985 by the Ghana Ministry of Health (MOH) for the use of public health facilities as a cost-recovery measure pegged at 15% of its recurrent operating costs (Waddington and Enyimayew 1989; Anyinam, 1993; Agyepong, 1999; Demery, et al., 1995; Nyonator and Kutzin, 1999; Arhinful, 2003; Carbone, 2011; Durairaj et al., 2010; Adisah-Atta, 2017; Korankye, 2013; Senah, 2001; Konadu-Agyemang, 2000; Akazili et al., 2014). The user fee regime was christened the 'cash and carry system' by Ghanaians because you had to pay for all facets of medical services such as consultation and medicinal expenses like drugs, needles, injections etc. Pregnant women, the elderly and children were, however, exempted from those paying fees (Waddington & Enyimayew 1989; Anyinam, 1993; Agyepong, 1999; Nyonator and Kutzin, 1999; Arhinful, 2003; Carbone, 2011; Durairaj et al., 2010).

After the implementation of user fees, the number of people using public health services declined dramatically, especially in the rural areas (Akazili et al., 2014). For example, in an empirical study carried out by Waddington and Enyimayew (1989) in the Ashanti-Akim district of Ghana with regards to the impact of user charges upon public health service usage since its implementation in 1985, the authors found that while user fees led to the successful recovery of 15% of Ministry of Health expenditure as revenue for the government, usage of public health facilities had dropped dramatically because some people simply could not afford it. In similar study undertaken in the Volta region of Ghana in 1996 by Nyonator and Kutzin, (1999) and in the Greater Accra region district of Dangme West by Agyepong, (1999), the general trend was a sharp drop in accessibility to healthcare as these are poor regions in Ghana where people live in very poor conditions. Authors such as Mensah et al. (2009), Anyinam (1993), and Konadu-Agyemang (2000) all argue that the drop in access to health care taken together with the effect of

other social indicators of SAPs made life unbearable for the poor. Many resorted to patronising all manners of quacks and spiritualists, often with disastrous results.

Deregulation as a component of structural adjustment is supposed to reform the health sector by increasing the role of the private sector in health services provisioning (Turshen, 1999; Adama, 2010; De Vogli and Birbeck 2005). In Ghana, private spending accounted for 51% of total expenditure on health, government spending accounted for 37%, and the remaining 12% was spent by NGOs (Demery et al., 1995). This contrasts sharply with the early post-independence era in which the state was the leading provider of healthcare (Wireko, 2015). A study undertaken by Adama (2010) on the Ghanaian health sector revealed that those private sector actors do not normally undertake the preventive and community medicine common with public facilities, and were focused on curative services which increase their profit margins. They also lack the reach and spread of public hospitals as they are majorly domiciled in the urban areas and their services affordable only by the relatively well off.

Another direct effect of SAPs on the Ghanaian health system was liberalisation. Liberalisation manifested in the form of health system decentralisation. Decentralisation involves the devolution of fiscal and operational functions to subnational levels (Kentikelenis, 2017) or to the private (profit and non-profit) sectors (Sahn and Bernier, 1995). Agyepong (1999) argue that revenue generation and cost recovery were seen as ends in themselves, rather than as the means of improving quality and access to healthcare services. For instance, she averred that hospital administrators tended to congratulate themselves on having revenue surpluses in their institutional accounts, while minimum levels of drug stock are observed in the breach, thereby resulting in artificial drug shortages for patients even when such drugs are available in the open market (Agyepong, 1999).

(b) Indirect effects of SAP policies on the Ghanaian health system and outcomes

SAPs also had indirect effects on the health of Ghanaians as a result of decisions in other sectors that were not directly related to the health sector, but which impacted upon the health system in some way. For example, a key strategy of the stabilisation component of SAPs is the devaluation of national currency in order to improve the external trade competitiveness of countries by reducing the cost of exported goods (Poku, 2005; Kentikelenis, 2017). However, a consequence

of a devalued national currency is that imported goods become more expensive and this affects the health system by hindering access to imported machinery and essential medicines (Kentikelenis, 2017). In this context, Konadu-Agyemang (2000) notes that the devaluation of the Ghanaian cedi, from 2.75 to the US$1 in 1983 to 2,300 to the US$1 in 1998 (approximately 80,000% devaluation) has raised the cost of imported machinery, drugs, school supplies, and other essential items' (2000:474). This has negatively impacted on the health system and its utilisation by poor households.

Trade liberalisation policies which are an integral part of SAPs can also affect health systems indirectly (Kentikelenis, 2017). He notes that liberalisation can catalyse external dependency, impede the development of infant industries and generally make the domestic economy vulnerable to global economic shocks and fluctuations (Kentikelenis, 2017). In Ghana, the restructuring of domestic production patterns to an export-oriented production strategy ensured that production was geared towards servicing Ghana's external debt to the detriment of local industrial production (see Section 4.3.2). For example, Anyinam (1993) notes that the focus of this export production was targeted at customary exports such as cocoa, timber etc. Konadu-Agyeman (2000) observed that debt servicing consumed a massive 62% of these export earnings. This consumption pattern ultimately endangers food security and diverts resources away from domestic priorities germane to the wellbeing of the populace, thereby impinging on the right of Ghanaians, particularly children, to good health, education and adequate nutrition (Konadu-Agyemang, 2000). Furthermore, food insecurity manifests due to the elimination of food subsidies, leading to malnutrition. According to Anyinam (1993), data from growth-monitoring centres like the Ghana Living Standards Survey (GLSS) and the Ghana Demographic and Health Survey (GDHS) indicate that malnutrition worsened with the percentage of underweight children having increased from about 33% in 1980 (pre-SAPs) to 51 % in 1985 (SAPs era). Lack of good nutrition decreases resistance to diseases and creates vulnerability to infections. Similarly to the Ghanaian context, Loewenson (1993), and Breman and Shelton (2001), argue that available evidence shows that SAPs have been linked with undernutrition due to growing food insecurity in African countries that implemented SAPs.

The privatisation and deregulation elements of SAP also affect health systems indirectly. Anyinam (1993) gave a rundown of retrenchment figures in various sectors of the Ghanaian

economy due to the privatisation of government assets. These include 41,000 - 45,000 dismissed civil servants, and the 29,000 workers who were removed from the payroll of the Ghana Cocoa Board which constituted about 39% of the Boards entire workforce (Anyinam, 1993). In all, he notes that approximately 200,000 workers were retrenched under SAPs. Konadu-Agyemang (2000), writing a few years later, puts the retrenchment figure at 300,000. These kinds of redundancies and job losses (with no social security provision) drive families deeper into poverty and make them unable to afford health services due to a lack of income. When unemployment occurs, families struggle to eat and have less to spend on their health needs. Furthermore, Anyinam (1993) notes that although this era also saw wage increases of about 75% between 1983 and 1986, these were negated by the cost for education, health, and other social services, the rise in inflation and also by higher food prices. For example, during this period, rates for electricity rose by between 47 and 80% and health fees by 800 to 1,000% (Anyinam, 1993).

The privatisation of water supply in Ghana also had indirect effects on health. This privatisation was undertaken on the premise that a debt-laden government should not subsidise water and sanitation (Ismi, 2004). This meant higher water rates for consumers already impoverished by SAPs. Provision of water, and sanitation, are important indicators of health outcomes (Peabody, 1996). According to Ismi (2004), 35% of Ghanaians lack access to safe drinking water. Poor households, which make up to 50% to 70% of Accra's population, are less likely to have water pipes connected to their residences (Ismi, 2004). Consequently, these households buy untreated water from commercial hawkers or get it through wells. A decrease in water affordability can correspond to an increase in diseases stemming from reduced access to clean water. Apart from the access problems and the prohibitive cost of water in Accra, mining activities devastated swathes of mining communities in Ghana such as Tarkwa, Akwatia and Wassa West districts via extensive water pollution and agrarian degradation thereby leading to diseases such as onchocerciasis, malaria, and schistosomiasis, pulmonary tuberculosis, silicosis and skin diseases (Hilson, 2004; Ismi, 2004; Britwum et al., 2001).

4.3.5. Was Structural Adjustment a success or failure in Ghana?

Ghana is considered as the SAPs 'poster child' of the International Monetary Fund and World Bank (Mkandawire and Soludo, 1999) because the implementation of SAP in Ghana for about two decades (1983 to 1999) is generally considered a success by these institutions. The usual

achievements of SAPs in Ghana often cited by proponents of SAPs such as the World Bank, and the IMF revolve around aggregated economic GDP data. For example, Ghana experienced GDP growth rates of 5-6 % between 1984 and 1991 and 2.5–4% from 1992 upwards. Other often cited positive attributes of SAPs include currency stabilisation, control of inflation, attraction of foreign investment, expansion of industrial capacity, and an improved balance of payment position (Konadu-Agyemang, 2000; Anyinam, 1993; Hutchful, 1997; World Bank, 1995).

However, despite these positive economic figures, SAPs exacerbated deteriorating socio-economic conditions. Therefore, macro-economic successes of SAPs must be considered alongside the negative socio-economic effects on Ghana as described above in preceding sections. An influential multi-country participatory assessment of SAPs undertaken by the Structural Adjustment Participatory Review International Network (SAPRIN, 2002) indicated that SAPs in many sub-Saharan African states (including Ghana) reversed development gains in despite their stated aim of promoting economic growth and development (SAPRIN, 2002). Furthermore, the kinds of aggregated macro-economic data used by those who claim that SAPs were successful tend to mask the realities at the micro-economic level where the lives of citizens are directly impacted (Tsikata, undated). Therefore, critics of SAPs like Poku (2005), Mkandawire and Soludo (2003), Bond (2006), Greer (2012), and Cheru (2002), posit that statistical GDP economic growth and other positive macroeconomic indicators do not necessarily translate to better standards of living for the populace at the micro-level as evidenced across sub-Saharan Africa. Poku (2005) further argues that what should matter most in terms of assessing the success of policy prescriptions should be how the policy has impacted upon the lives of the populace in terms of development. This view is supported by Odutayo (2015), Anyinam (1993), Opoku (2010) and Konadu-Agyemang (2001) in the Ghanaian context.

In applying this line of argument to Ghana, Odutayo (2015) concludes that structural adjustment in Ghana has failed in three fundamental ways. As stated by her, SAPs have ‘failed to alleviate poverty, failed to improve living conditions in Ghana, and failed to promote economic growth by relieving indebtedness’ (Odutayo, 2015: 6). The 1998/1999 Ghana Living Standards Survey (which was commissioned at the tail end of SAP) also noted that about 40% of the Ghanaian populations were mired in poverty, with 26.8% of this figure classified as destitute (Sowa, 2002). Furthermore, SAPs policies encouraged massive borrowing over the years and made Ghana

poorer and heavily indebted to the developed countries. Afriyie (2009) unambiguously captures this in his articulation of the effects of SAPs on Ghana when he stated that earnings from export revenues were primarily dedicated to debt servicing and this greatly eroded the ability of the state to provide for the educational, health and other needed social services for the population.

Due to its debilitating economic insolvency, Ghana immediately enrolled in the heavily indebted poor countries (HIPC) initiative in 2001 after the end of SAPs in 1999 (Opoku, 2010). At this point, Ghana's GDP per capita was $270, but it was burdened with a total debt approximating to about a massive 124% of GDP (Sowa, 2002). The HIPC initiative targets the reduction or cancellation of the debts of the poorest nations. This action really calls into question the much-vaunted success of SAPs in Ghana (Opoku, 2010). If SAPs were such a success, why the astronomical increase in the debt burden? Why the immediate enrolment in HIPC? The heavily indebted poor countries (HIPC) initiative was constructed as the first comprehensive debt relief framework. The IMF and World Bank had in response to worldwide protests and riots on the hardship imposed on developing countries by SAPs conceptualised national strategies for reducing poverty in countries admitted under HIPC. The HIPC involved the introduction of Poverty Reduction Strategy Papers (PRSPs) which countries adopted in order to be eligible for debt relief. As these PRSPs were very similar in nature to SAPs (because they embed conditional prescriptions just like SAPs), the HIPC initiative is a continuation of SAP by another name.

Furthermore, the profound socio-economic effects of SAPs on the political economy of Ghana resonate with the observations of Cox (1987) and Grinspun & Kreklewich (1994). They assert that the countries positioned far from the centres of power in the world order suffer the adverse conditioning effects of neoliberal restructuring (such as SAP) the most. Therefore, the global economy is made up of states that are not affected in the same way or form by internationalising forces such as the IMF and World Bank. For example, the United States (US) can be placed in Cox's (2002) first category of the world order due to its material capabilities and access to the centres of power. This enables it to defend its national interest even when global consensus is against it in international relations. In contrast, Ghana is in the third category of countries in the world order by virtue of its social position from the centres of power (see Chapter 2.4). Thus it lacks the material capabilities and influence to resist these powerful internationalising forces (such as the IMF and World Bank) and to avoid been sanctioned by them.

In sum, I posit that overall, the implementation of SAPs in Ghana was not a success. Structural adjustment failed to engender development and to improve the living conditions of Ghanaians. SAPs policies prioritised debt repayment and servicing over the living conditions and welfare of Ghanaians. SAPs damaged the socioeconomic fabric of Ghana by weakening the state economy, deepening poverty, and reversing the gains in universal healthcare delivery. It undermined the public health infrastructure which underpinned the very basis of a potential and effective state response to the outbreak and spread of a then-emerging global HIV/AIDS pandemic.

4.4. The HIV/AIDs Crisis in Ghana, and the Response to the Crisis

The outbreak of the HIV/AIDS epidemic coincided with the implementation of the structural adjustment programme in Ghana. The adverse consequences of structural adjustment on the Ghanaian political economy and specifically on the health system constrained the ability of the Ghanaian state to respond to this emerging and rapidly spreading disease pandemic. This Section 4.4 examines Ghana's national HIV/AIDS response and donor financial support in the national response process.

4.4.1. Organisation of the health sector in Ghana

The operations of health sectors are underpinned by health systems. In Ghana, the health system is made up of public and private health service providers. The public health system encompasses all health facilities under the Ministry of Health (MOH) and other government ministries, departments, and agencies (Abor et al., 2008; Couttolenc, 2012). The private sector consists of traditional, private-for-profit, and private not-for-profit service providers (e.g. mission hospitals) (Abor et al., 2008; Couttolenc, 2012). The MOH is mandated with the overall responsibility of managing and coordinating the health sector's central-level operations such as policy making, implementation and regulation of the health sector (Couttolenc, 2012). Healthcare services are provided via a network of health facilities and infrastructure (Abor et al., 2008).

The Ghanaian Ministry of Health (MOH) is the health sector regulator and sits at the apex of the health system. In undertaking policy formulation, the MOH collaborates with other partners in the health sector. These include other government agencies, bilateral and multi-lateral donors, and civil society organisations. Policy implementation involves the public, private and traditional systems (Abor et al., 2008; Couttolenc, 2012). Under the Ghana Health Service and Teaching Hospitals Act 525 of 1996, the MOH reassigned to the Ghana Health Services (GHS) the

functional and operational management of public health facilities. The GHS is also tasked with regulating state-run health institutions and implementing government policies at subnational levels such as districts and municipalities (Abor et al., 2008; Couttolenc, 2012).

There are also various government boards tasked with specific regulation of aspects of the health system. For example, the Teaching Hospital Board (THB) is responsible for tertiary health regulation (Abor et al., 2008). The Quasi-Government Institution Hospitals (QGIH) is mandated to regulate the activities of health facilities owned by the government or public institutions like the prison system, some universities, and the armed forces (Abor et al., 2008). The Private Hospitals and Maternity Homes Board (PHMHB) oversees the practice of the private sector which is made up of private medical facilities and mission hospitals (Abor et al., 2008; Couttolenc, 2012). Lastly, the operations of traditional healers are regulated by a directorate within the Ministry of Health. Healthcare providers under this system are the Traditional Medical Providers (TMP), Alternative Medicine (AM) and Faith-based Healers (Abor et al., 2008).

4.4.2. Epidemiology of HIV/AIDS in Ghana

Ghana's first HIV/AIDS case was reported in 1986 (Zakaria, 2015; Ghana HIV/AIDS Strategic Framework, 2001-2005). The HIV/AIDS prevalence rates in Ghana increased from 2.5% in the late 1980s to 1990s to 5.3% by 2000 for those between 15 and 49 years of age (MOH, 2001). Current estimates place Ghana in 33rd position in relation to global HIV/AIDS prevalence (Global Fund Ghana Audit, 2019). HIV/AIDS prevalence is reported particularly in major urban centres and in roughly more than half of the ten regions in the country (Global Fund Ghana Audit, 2019). Furthermore, Ghana is one of 30 countries with high levels of TB/HIV co-infection (Global Fund Ghana Audit, 2019). Despite substantial donor support, Mikkelsen et al. (2017) and Dieleman (2018) posit that Ghana still faces significant challenges in providing access to adequate anti-retroviral treatment for those affected by the diseases.

4.4.3. Financing the fight against HIV/AIDS: the national response to the crisis

The establishment of the National AIDS/STD Control Programme (NACP) in 1987, signalled the beginning of the national response to the outbreak of the HIV/AIDS epidemic. NACP is supervised by the Ministry of Health (MOH) through the Ghana Health Service (GHS) (Zakaria, 2015; MOH, 2001). By the year 2000 and through global advocacy by multilateral institutions like the World Bank, HIV/AIDS was no longer classified as simply a biomedical health problem,

but as a developmental issue because of its morbidity and mortality on productive segments of populations in specific settings of global health. This recognition led to the creation of the Ghana AIDS Commission (GAC) in 2001 by an act of parliament. The creation of the GAC emanated from a National HIV/AIDS Strategic Framework developed in 2000 by the Ghana government (Ghana HIV/AIDS Strategic Framework, 2001-2005, 2016-2020). This National HIV/AIDS Strategic Framework was embedded under the government's Growth and Poverty Reduction Strategy (Zakaria, 2015; Ghana HIV/AIDS Strategic Framework, 2001-2005, 2016-2020).

The national strategic framework placed the management of HIV/ AIDS at the centre of the government's broader poverty reduction strategy along with issues of human capacity development, gender and children's rights and education (Zakaria, 2015; Ghana HIV/AIDS Strategic Framework, 2001-2005). The framework established a bi-modal aid delivery mechanism for the management of HIV/ AIDS. Donor partners could interface with the government directly via the Ghana AIDS Commission (GAC) or District AIDS Committees (Zakaria, 2015). The Ghana AIDS Commission (GAC) is the national coordinating agency for all HIV/AIDS in Ghana (Zakaria, 2015; Ghana HIV/AIDS Strategic Framework, 2001-2005). The Commission was domiciled directly under the purview of the Ghanaian presidency, underlining the serious nature and multi-sectorality of the state response to the disease. The domiciliation of the GAC under the presidency was also an acknowledgement of the political element and different actors and interests across a broad spectrum of society, involved in the implementation of the national response.

As discussed earlier, the structural adjustment programmes clearly weakened the Ghanaian economy and impacted negatively on the capacity of the state to solely finance its national response. Due to the challenges of insufficient funds, the government could not single-handedly meet its obligations to affected citizens of the epidemic. Such obligations included access to of anti-retroviral drugs (ARVs), the establishment of testing and counselling centres, and prevention of mother-to-child transmission (PMTCT) (Zakaria, 2015). Other identified priorities needing a significant amount of funding involved workforce training and capacity development, blood safety programs, and institutional development, all of which are critical for a successful response (Zakaria, 2015). These commitments were beyond the financing capacity of the state in a political economy still recovering from the debilitating consequences of structural adjustment.

Zakaria (2015: 8) notes that the payments going to external debt service are greater than the total amount allotted to pensions, social security, gratuities and health. As such, many social sectors remained under-financed and financial sustainability is a key concern (Ladj et al., 2017).

Donors responded by funding some of these challenges posed by an emerging HIV/AIDS epidemic. A national study undertaken by Asante et al. (2007) highlighted that in 2007, 71% of all expenditure on HIV and AIDS came from donors, while public sector funds and private sources accounted for 28% and 1% of the spending respectively (Asante et al., 2007). In another more recent study by Zakaria (2015:28), donor funding was found to account for nearly 80% of the entire HIV/AIDS budget in Ghana, while government contribution accounted for 15% and Ghanaian private sector contribution (national health insurance fund) made up the remaining 5%.

Ghana receives both bilateral and multilateral aid. A multitude of bilateral partners (donor states) provide fundamental support through their developmental aid channels. Some of these donor countries are the United States, Britain, Germany, Denmark, the Netherlands and Japan (Zakaria, 2015). Multilaterals such as the World Bank supported the creation of the Ghana AIDS Commission (under its Multi AIDS Programme) and funded it. Apart from the support of the World Bank, the International Monetary Fund (IMF) supports the national HIV/AIDS response via debt cancellation grants under the HIPC (highly indebted poor countries initiative (Zakaria, 2015; Ladj et al., 2017).

4.5. Donor Practice and Emerging Questions of Country Ownership in Response to the HIV/AIDS Crises

While the involvement of donors led to improved funding for the national response, their practice modalities in the operationalisation of the response gave room for concern with regards to the country ownership of the national HIV/AIDS response. Country ownership is underpinned by the Paris Declaration on aid effectiveness, which will be discussed in detail in Chapters 6 and 7. The aid effectiveness principles promoted by this Declaration include harmonisation, alignment, coordination and managing for results. In seeking to align and harmonise donor funding in line with the logic of its internal development policies in the context of country ownership, Ghana adopted a series of aid delivery operational frameworks. Such frameworks are the Sector-Wide Approach (SWAp), Sector Budget Support (SBS) and the Multi-Donor Budget

Support (MDBS) (Zakaria, 2015; Ladj et al., 2017). These frameworks are meant to improve the effectiveness of the national HIV/AIDS response in order to achieve country ownership.

However, while ostensibly adopting the principles put forward by the Paris Declaration, donors consistently applied practice modalities that made it difficult for country ownership to take place. For example, under the SWAp arrangement in Ghana, there were two types of donors: pool donors who contribute to the SWAp and allow their monies to be spent on any programme within the response, and donors who earmarked funds (Zakaria, 2015; Pallas et al., 2015). Earmarked funds are funds dedicated to a specific purpose and cannot be used for any other purpose. This limits the ability of the government (through its agencies) to own the response process. For example and still on earmarking of funds, government priority areas for the health sector are documented in strategic five-yearly health development plans called Programme of Work (PoW) produced by the Health Ministry (World Bank, Ghana Country Report, 2007). The POW acts as the guiding framework for the operationalisation of the SWAp. An analysis of the POW (1997- 2001) shows that the malaria and HIV/AIDS financing provided to the Ministry of Health were practically all externally funded and earmarked (World Bank, Ghana Country Report, 2007:30). In other words, funds came into the SWAp, but were dedicated to specific projects by the donors (World Bank, Ghana Country Report, 2007:30). The implication of this type of practice modality within the SWAp is that country ownership is undermined as the donors specify how the money must be spent, thereby limiting the government's ability to set the national response agenda.

Under the Common Management Agreement (CMA), which embeds the code of practice of the SWAp, there are certain entities established as part of the organisational and implementation framework of the SWAp to implement the national response and deliver on the programme of work (POW). These entities are intended to expedite greater policy and technical dialogue between health sector leadership, donor and civil society partners etc. These include the Inter-Agency Leadership Committee (IALC), which is made up of the top echelon of the Ministry of Health and its agencies, the Health Sector Working Group (HSWG) which encompasses government, donor, NGO and other private sector actors; and the Inter-Agency Coordinating Committees (IACC) which is mandated to discuss technical issues (Pallas et al., 2015). NGOs may also offer advice via their involvement in the Health Sector Working Group (HSWG) which

liaises with higher level such as the Inter-Agency Leadership Committee (IALC). As observed by Pallas et al. (2015) in their analysis of the Ghana SWAp, donors often held pre-meetings before official meetings that took place within the Health Sector Working Group (HSWG) mentioned above to take joint position. This practice helps them influence and shape proceedings on the national response agenda through the Health Sector Working Group (HSWG) and consequently, the SWAp process, thereby complicating country ownership.

In an earlier section, I alluded to the creation of the Ghana AIDS Commission (GAC) (see Section 4.4.3 above). In June 2002, the World Bank supported the GAC in setting up a $ 25 million US dollars health fund referred to as the Ghana AIDS response fund (GARFUND) (Zakaria, 2015). The funding provision attached to the commission allowed a bi-modal aid delivery mechanism. Donors could engage directly with the national government through the GAC or directly with District AIDS Committees (DACs) and civil society organisations (CSOs). Available documentary evidence suggests that donor developmental agencies processed significant percentages of their health funding to more than 2,500 community-based organisations (CBOs), national NGO's and International NGOs (INGOs) to implement aid programmes outside government structures as part of the national response to the management of HIV/AIDS (Zakaria, 2015; GHANA NASA Report, 2007). These include the Christian Health Association of Ghana (CHAG), the Ghana Red Cross, Save the Children Fund (SCF) UK, Centre for Development of People (CEDEP), CARE International, Action AID and Stop the Killer AIDS (Anarfi and Appiah, 2004).

The DACs hold implementation authority over HIV/AIDS activities in their various district assemblies (local or municipal councils). Districts look for ways to implement their district plans, if not receiving adequate government funding. This is where alternative sources of resources from donors become germane to the districts. Districts can choose to implement those prioritised items since funding is available (if nothing is forthcoming from the government) irrespective of if the districts feel that they have their own priority needs different from those of the donors. As such, direct funding of the District AIDS Committees (DACs) provides leeway for donors to dictate priorities and programmes not necessarily aligned and harmonised with government priorities thereby highlighting issues in relation to what is 'owned' and 'not owned' in the context of the national response.

Another way in which donors contribute is through the sector budget support (SBS) mechanism managed by the Ministry of Finance and Economic Planning. Unlike the funding through the Health Ministry SWAp or the GAC allotted funds, all donor money for the response under the SBS mechanism is captured directly into the government treasury account as part of consolidated government revenue. Once deposited into government treasury account, the donor support is then captured together with Ghana's domestic resources as part of the national budget and disbursed to the intended sector. For example, all monies intended for the response are captured through this national budgetary process and allocated as sectoral allocations to the government sectoral agencies involved in the response such as the Ministries of Health, Education and so on by the government. Hence the name, sector budget support (SBS).

While this mechanism was intended to streamline all donor funds (to allow for stronger government oversight) through greater alignment and harmonisation with national systems, donors continued to provide conditionalities detailing where their money must be spent and trying to dictate to the government on how to run the sector. For instance, Ladj et al. (2017) posited that in 2008, three donors (DANIDA, DFID, and the Netherlands) decided to move to SBS under an agreed Framework Memorandum of Understanding (FMOU) signed by the donors, and by the Health and Finance Ministries on behalf of the government (Ladj et al., 2017). The FMOU detailed the institutional arrangements guiding the provision of SBS in the health sector. Furthermore, the government signed individual bilateral agreements with each of the donors with respect to providing SBS for the Ghana health sector Programme of Work (POW) 2007-2011 which embeds the national HIV/AIDS response programme for five years (Ladj et al., 2017).

However, according to Ladj et al. (2017), the content of the FMOU and individual agreements seem to contradict each other in practice. For example, while the FMOU required all funds to go into the government treasury, DANIDA inserted conditions that must be met before its funds are released. Secondly, while the FMOU enshrined specific dates for which funds are to be made available by donors under the SBS, DFID's bilateral agreement provided for different disbursement timeframes subject to the government meeting other conditions. Additionally,

DFID funds could not be used for certain pre-identified expenditure types and there was a provision that subsequent funds would only be disbursed if earlier tranches had been used for the intended purposes as outlined by DFID. Also, under the SBS, the Finance Ministry transfer all monies budgeted to the health sector to the Health Ministry account since the Ministry has overarching responsibility for the sector. However, the agreement with the donors allows the use of specific codes to send monies directly to intended beneficiaries identified by donors thereby cutting the Health Ministry out from such transactions making it difficult for them to monitor such spending (Ladj et al., 2017). Each donor deploys its own tracking tool, used by the agencies or programmes receiving the funds (Ladj et al., 2017). These patterns of donor practice weaken country ownership.

Another relevant process regarding donor funding in Ghana is the Multi-donor Budget Support (MDBS) mechanism (Woll, 2008). A fundamental difference between the MDBS and other previously discussed funding mechanisms is that while the other mechanisms are simply a way of delivering donor funding, the MDBS links funding directly to government reform measures with regards to Ghana's poverty reduction strategy (Woll, 2008; Whitfield, 2005). Poverty Reduction Strategy Papers (PRSPs) are developmental inputs conceptualised by the World Bank as the basis of good governance reforms and required as part of the HIPC process. Funding under the MDBS is linked to these good governance reforms. The MDBS conditions funding commitments and disbursement to the government on the achievement of the good governance reform targets laid out in the PRSP. Therefore, while the MDBS promotes donor alignment and harmonisation, the linking of funding to PRSP targets shows how donor conditionalities remain in place despite an apparent commitment to country ownership. Critics note that while PRSPs are ostensibly county-owned, this ownership is constrained. For example, Armah et al. (2002: 4) notes that country ownership of the PRSP process in Ghana was undermined by the unequal power relations between Ghana and donors. Picking up on the theme of power relations, Whitfield (2005: 654-655), argue that the PRSP approach in Ghana reflects a situation in which government actors choose policy programmes acceptable to the World Bank and the International Monetary Fund (IMF) for funding in the PRSP.

In summing up this section, this study takes the stand that donor practice often includes conditionalities regarding when the funds can be spent, where they can be spent and how the

health sector is managed. This is exemplified by their earmarking of funds within the SWAp, and the inserting of conditional funding and expenditure clauses in its agreements with the government under the SBS. Donors, also under the SBS, deployed the use of specific codes to send monies directly to intended beneficiaries identified by them, thereby cutting out the Health Ministry from such transactions. Each donor deploys its own tracking tool, used by the agencies or programmes receiving the funds. Funding under the MDBS process is tied to 'good governance reforms'. Other donor practices include the funding of donor programmes outside formal government structures in a decentralised health system through non-state actors. When donors directly fund non-state actors (e.g. INGOs, CSOs etc.) outside of recognised government channels or framework (e.g. the GAC, Health or Finance Ministry,) how does the government hold these non-state actors accountable for their activities to Ghanaian citizens? Taken broadly together, the nature and character of donor practice raises significant questions of country ownership and complicates accountability in the national HIV/AIDS response process in Ghana.

4.6. Situating the Entrance of the Global Fund as a Donor Operating in the National HIV/AIDS Response in Ghana

As explained in Chapter Three, the Global Fund was established in 2002 as a result of global consensus on the need for a new system to finance efforts to tackle the morbidity and mortality of AIDS, tuberculosis and malaria worldwide. These three diseases are among the biggest impediments to good health in much of the world. The Global Fund has funded US$ 19.3 billion in funding for more than 572 programs in 144 countries since its inception in 2002 (Kapilashrami, 2010). The role of the Global Fund in HIV/AIDS is especially noteworthy, for which it has leveraged large sums of funding (Kapilashrami, 2010). It delivers a quarter of all global funding support for AIDS, three-quarters for malaria and two-thirds for tuberculosis (Kapilashrami, 2010).

In 2002, Ghana became the first aid recipient of the Global Fund (Global Fund Ghana Audit, 2019). With Global Fund support, Ghana has overtime made substantial headway in the prevention and management of HIV/AIDS, Tuberculosis and Malaria (Atun et al., 2011). The Fund remains the key financier of the national response in Ghana. In 2002, it allocated US$ 429,599 which increased to US$ 128 million in 2010 (Adjei et al., 2011). By 2017, the Global Fund had allocated US$ 377 million for HIV/AIDS management in Ghana (Global Fund Audit

Report, 2015). At present, the Fund has disbursed approximately US$804 million across various grant awards to Ghana out of a total grant package of US$965 officially signed and documented (Global Fund Ghana Audit, 2019).

In 2019, Ghana ranked 13th in terms of global malaria incidence, in contrast to the 11th position it occupied in 2015 (Global Fund Ghana Audit, 2019). With regards to HIV/AIDS, a measure of the global HIV/AIDS prevalence ranks Ghana in the 33rd position (Global Fund Ghana Audit, 2019). HIV/AIDS prevalence is most present in major urban centres (Global Fund Ghana Audit, 2019). While Ghana is not ranked among the 30 countries with the highest global high burden of tuberculosis (TB) as a disease on its own, it is one of the 30 countries with the highest levels of TB/HIV co-infection (Global Fund Ghana Audit, 2019).

The Global Fund, as a donor operating in the national HIV/AIDS response, describes country ownership as a core principle of its accountability policy that informs its practice in aid recipient countries (Global Fund 2001, 2012). However, there has been a significant lack of scholarship investigating the Global Fund's accountability practice in specific settings of global health, particularly in relation to its implications for country ownership of health policy. The practice relations of the Global Fund will be discussed in Chapters Six and Seven with regards to the second research objective.

4.7. Conclusion

As stated in the introductory section of this chapter, this chapter seeks to explore and understand the objective conditions of the Ghanaian political economy context. In so doing, the chapter helps lay the ground for addressing the second research objective of this thesis which is to investigate how the Global Fund's policy understanding of accountability works itself out in practice in Ghana, in particular in relation to its implications for country ownership of the national HIV/AIDS response policy.

In order to undertake this exploration of the Ghanaian political economy context, I examined the nexus between globalisation, political economy and the HIV/ AIDS crises in Ghana. Globalisation impacted on Ghana (like other sub-Saharan African countries), especially due to the introduction of structural adjustment programmes (SAPs). SAPs fundamentally altered the structure of the Ghanaian political economy and its health sector.

The transformative effects of a globalising neoliberal market civilisation via structural adjustment programmes (SAPs) on the political economy of Ghana poses critical challenges for national development. It constrains autonomous state action (due to the policy prescriptions forming part of such programmes), and at the same time, strengthens the material and structural power of capital (through the influx of foreign direct investment, debt repayment agreements etc.). The experience of Ghana under SAPs is similar to that of other developing countries. It is difficult to pinpoint a specific country worldwide where IMF and World Bank SAPs has been a resounding success without lamentations from those impacted by such policies. SAPs manifestly undermined the Ghanaian economy (68% of all revenue generated during the SAPs era was allocated to debt servicing), failed to diminish poverty, improve the standards of living of the people, and end the vicious cycle of indebtedness by engendering economic development.

As explained and highlighted in section 4.5, due to the government's weak financial position, it was unable to effectively fund its national HIV/AIDS response. Donors, in support of the government, entered the health sector in support of the response to the threat posed by an emerging HIV/AIDS epidemic. While the involvement of donors led to improved funding for the national response, their practice modalities in the operationalisation of the response gave room for concern with regards to the country ownership of the national HIV/AIDS response. Country ownership is underpinned by the Paris Declaration on aid effectiveness (which will be discussed in detail in Chapters 6 and 7.

The Global Fund lays claim to promoting country ownership as a core principle of its accountability practice in aid recipient countries such as Ghana. Therefore, there is a need to understand the Global Fund's policy in relation to accountability and how this policy is translated into practice in the health sector in Ghana. The next three chapters will therefore examine the Global Fund's policy understanding of accountability and how this understanding informs its practice, particularly in relation to its implications for country ownership of the national HIV/AIDS response policy in Ghana. Chapter Five will examine the Global Fund's understanding of accountability in policy, while Chapters Six and Seven focus on the accountability practice of the Fund in Ghana,

CHAPTER FIVE
EXAMINING THE GLOBAL FUND'S UNDERSTANDING OF ACCOUNTABILITY IN ITS POLICY DOCUMENTATION

5.1. Introduction

The goal of this chapter is to engage with the first research objective of this study which is to analyse how the Global Fund understands accountability in the policy documentation and what structures and procedures it has put in place to address accountability concerns. Before proceeding to address the research objective, it is imperative to refresh the reader's mind concerning relevant aspects of the prior discussion. The conceptual and theoretical basis of this study was laid out in Chapter Two. In that chapter, and in line with the critical political economy orientation of this research, I posited that globalisation had altered the traditional state-centric focus of the international health regime and catalysed a paradigm shift to a formally multi-actor global health regime. The multi-actor orientation speaks to the rise of global public-private partnerships (GPPPs) in health and the increased prominence of non-state actors in the global health regime. The increased prominence of these other non-state actors is due to their formal incorporation into health policy processes and decision-making structures in the global health regime. GPPPs in health are examples of organisations incorporating these non-state actors (alongside state actors) into health policy processes and decision-making structures in global health.

This shift also implies changes in how accountability for public health policy processes is currently understood in global health relative to international health. The understanding of accountability in the international health regime centred on state-based policy processes (e.g. elections and parliamentary oversight) at the national level and state-led representation at the international level (e.g. the World Health Organisation). However, in the global health regime, accountability is understood differently. As GPPPs are not states, they derive their understanding of accountability from the nature and character of their individual policy arrangements. Their individual policy arrangements inform their practice when they participate in public health policy processes in specific settings of global health.

In order to address the first research objective of the study, this chapter is divided into five sections. Section One is this introductory section. Section Two undertakes a general overview of

existing literature on accountability in relation to the Global Fund. In so doing, it explores the focus and various ways in which scholars and agencies have discussed and analysed accountability in respect of the Global Fund. The aim of this section is to highlight the gap in the literature which the first research objective of the study aims to address. In Section Three, the study engages in a critical interpretative analysis of the Global Fund policy documentation in order to highlight and discuss how the Fund understands accountability in its policy documentation. Section Four identifies and explains the institutional accountability structures of the Global Fund. These structures play key roles in the Fund's accountability practice in specific settings of Global health. Section Five summarises and concludes the chapter.

5.2. Accountability and the Global Fund as a Global Public-Private Partnership in Health: A General Overview

Before proceeding to address the first research objective of this study, it is necessary to review the existing literature on accountability in relation to the Global Fund. In undertaking this review, the study will explore the focus and various ways in which scholars and agencies have discussed and analysed accountability in respect of the Global Fund.

Public agencies such as the United States Government Accountability Office (GAO), have discussed the performance of the Global Fund. In a series of reports in 2003, 2005 and 2007, the GAO broadly appraised the activities of the Fund. The 2003 report noted that the Global Fund has progressed in key areas of its operations, but that difficult challenges remain. In terms of progress, it noted, for instance, that the Fund had put in place adequate monitoring and evaluation mechanisms for procurement processes, grant performance and financial accountability (GAO, 2003). In relation to challenges at the country level with regards to the Fund's operation, the report posited that governance structures at that level were not performing optimally in a manner envisioned by the Fund (GAO, 2003).

The GAO's 2005 report laid particular emphasis on the Fund's practice of performance-based funding (PBF). The Global Fund PBF measures verifiable performance against agreed-on targets (GAO, 2005). However, the report observed that while the Global Fund was responding to challenges in its activities, the Fund needed to improve its information gathering and management system and also to improve its documentation process for PBF. The GAO (2007) report identified improvements in the information and documentation management of the Fund

with regards to the PBF process that was detailed as a challenge in the 2005 report. Nevertheless, it stated that the Fund needed to standardise oversight expectations and assessment by developing an adequate risk management framework. The need for this framework was due to significant concerns regarding the capabilities of local fund agents (LFAs) to assess and verify recipients' procurement capacity and ability to implement programmes. Thus the overall consensus of these reports was that while the Global Fund had started well, there was still room for various kinds of improvement in its policy and practice.

In addition to these agency reports, several scholars have written about the Global Fund's accountability. Such scholars have focussed on various aspects of the Fund's policy and practice, depending on their research area of interest. A key area of interest has revolved around participation and decision-making within the Fund. Brown (2009, 2010) notes that the multi-sectoral inclusion of non-state actors in the decision-making structures of global health bodies was now a rule, rather than an exception. He reports that the stated goal of multi-sectoralism in the Global Fund was supposed to create a link between decision-makers and those on the ground through representation. Multi-sectoralism is also intended to drive ownership of policy and to improve the legitimacy of global health institutions (Brown, 2009, 2010). Brown (2009) highlights what he conceives as structural weaknesses with regards to the process of incorporating non-state actors into the decision-making processes of the Global Fund. For example, he identifies the lack of structural safeguards to ensure that the decision-making process of the country-coordinating mechanism (country level governance instrument of the Global Fund) is truly multi-sectoral in all cases. Other identified weaknesses include the dominance of decision-making processes by powerful countries, and the marginalisation of various stakeholders and civil society groups; particularly those representing affected communities (those living with any of HIV/AIDS, tuberculosis and malaria) (Brown, 2009). He concludes that these structural weaknesses constituted a barrier to the effective participation of non-state actors (civil society) in these decision-making processes.

Brown's (2009, 2010) discussion resonates with the observations of Oberth (2012) on the theme of multi-sectoral participation in the Global Fund's decision-making processes. She posits that civil society representation was key to the participation of 'affected communities' in decision-making processes. Similarly to Brown (2009, 2010) and Oberth (2012), Harman (2009a) avers

that that contestation still persists with regards to the degree to which these non-state actors actively partake in decision-making in global health initiatives like the Fund. She also notes that the decision-making process is still dominated by key powerful actors (Harman, 2009a). The focus on multi-sectoral participation is also evident in Hatendi-Gutu's (2007) discussion of multi-sectoralism in the Fund's practice in Zimbabwe. According to Hantendi-Gutu (2007), an examination of the Fund's institutional arrangements highlights that the local governance structures put in place by the Fund hindered the ability of local stakeholders to partake or play a meaningful role in the HIV/AIDS response process. Similarly, Spicer et al.'s (2010) multi-country study on Global Fund practice in Africa argues that while multi-sectoral participation has led to improved transparency and did reflect greater political commitment from the Global Fund, the quality of local participation was often limited.

While the preceding scholars focus on the limitations of the Fund's institutional mechanisms for effective multi-sectoral involvement of non-state actors on decision-making bodies, other scholars have examined multi-sectoral inclusion of non-state actors from other angles. For instance, Gomez and Atun (2012) observe that the Global Fund's financing of civil societal institutions has catalysed the growth and emergence of new civic movements and deepened governance at multiple levels (Gomez and Atun, 2012). Long and Duvvury (2011) also take a different stand to multi-sectoral participation in that they are more concerned with how civil society drives accountability in global institutions and the extent of civil society accountability to the constituencies it claims to represent in relation to the Global Fund activities.

There is also some literature on aspects of decision-making in the Fund other than the question of multi-sectoral participation. Chan et al. (2010) note the deficit in the quality of data that underpin decision-making for results-based funding. In response to this data deficiency, they argue that all major global donors (including the Global Fund) should emphasise timely and reliable data to drive performance-based financing and decision-making. Implicit in their analysis is the idea that reliance on data is crucial to the Fund and its accountability principle of performance-based funding (PBF). In relation to PBF, Olarinmoye (2012) argues that the inclusion of a broad gamut of actors is key to participation and accountability in the Global Fund's PBF process. An interesting point to note here is that while Chan et al. (2010) conceive the Global Fund PBF from

evidence (data) driven prism, Olarinmoye (2012) examines the PBF from the perspective of the mix of actors involved in the process.

Furthermore, there are scholars who have also examined the Global Fund's accountability processes from various other perspectives. Collins et al. (2008) focus on social justice in their examination of the accountability of global health actors, including the Global Fund. In making a case for social justice, they posit that prominent global health actors 'have often failed to live up to their own commitments or meet the needs of those they serve' (2008:1). They point out that national governments and donors like the Fund are all guilty of a lack of accountability to those they claim to serve. They also noted that there was an avalanche of accountability-inspired projects globally, yet the issue of accountability to those they serve remains problematic. In order to remedy this accountability deficit and promote social justice, they argue that there will be a need for donors to embrace health systems strengthening which target the health system as a whole, rather than focusing on disease-specific programmes. Such a measure, they note, will make it possible for those in need of health services to assess health services more broadly. They further suggest that improvements in areas such as drug procurement and in the management of supply chain systems will ensure that drugs get to those who need it on time (Collins et al., 2008).

Goosby (2019), on the other hand, implicitly rejects the position of Collins (2008) on the absence of social justice in the accountability relations of the Fund. He does this by identifying various accountability provisions embedded in the Fund's policy and practice which arguably address the question of social justice. Some such provisions are that the Global Fund Board and CCM governance models at global and country levels all give attention to transparency, participation and representational issues. He also notes that these accountability provisions reduce and mitigate conflict of interests in relation to stakeholders. He further suggests that donors can hold the Global Fund accountable through improved oversight of the use of funds, while the Global Fund holds aid recipient countries accountable for the use of grants allotted to them (Goosby, 2019). However, a glaring omission in Goosby (2019) text is that he does not articulate or explain how aid recipient countries can hold the Global Fund accountable for its practice in their domains in his analysis.

In an exploration of the Global Fund's accountability practices, Godwin et al. (2009) examine the accountability modalities put in place by the Fund to assess the National Strategy Applications (NSA) submitted by countries for Global Fund grants. They identify three layers of accountability that can be deduced from the process. One is mutual accountability (accountability is supposed to accrue to all parties involved in the process), institutional accountability (where predetermined responsibility for agreed roles are fulfilled by stakeholders to drive efficiency and effectiveness) and programme accountability (for performance-based results). While the analysis of Godwin et al. (2009) is systematic, they did not pay attention to the global health actors who affect accountability dynamics by providing technical assistance in writing those National Strategic Application Plans for recipient countries. These plans may therefore be more reflective of donor language and interests rather than the interests of the concerned countries.

Bruen et al. (2014) examined accountability in global health cooperation. Using the Global Fund as an example, they illustrated how accountability in global health cannot be understood simply as one set of actors holding another set of actors to account. Rather, it is a complex multipolar relationship across various levels of relations. They argue that the complexity in the understanding of accountability relations in global health is due to the emergence of global public-private partnerships and the formal involvement of non-state actors in policy-making processes. Their analysis is in line with the position of this study in relation to how the emergence of global public-private partnerships and the formal involvement of non-state actors in health policy processes (underpinned and driven by neoliberal globalisation) have catalysed a shift in the understanding of accountability. Furthermore, Bruen et al.'s (2014) examination of the increased prominence of non-state actors in global health and the role of power relations as a key determinant of accountability includes a specific focus on policy areas of accountability crucial to the Global Fund's policy understanding of accountability (see Bruen et al., 2014: 8-11). Therefore, their discussion has been helpful in developing part of the analysis here, but my own study differs from Bruen et al.'s (2014) in certain respects. For example, their analysis of the Fund was not located in any specific context of global health. Also, while Bruen et al. (2014) discuss the Fund's accountability policy more broadly, they do not focus in particular on its implications for country ownership of health policies in specific settings of global health.

This study therefore notes that while the notion of accountability in relation to the Global Fund remains the subject of quite some discussion in scholarly literature on global health, there has been little reflection or consideration on how accountability appears or is understood in policy by the Global Fund. Neither has sufficient attention been given to how such policy understanding of accountability informs the Fund's practice when it participates in public health policy processes in specific settings of global health (such as Ghana). This study aims to address these shortcomings in the existing literature.

5.3 Examining the Global Fund's Understanding of Accountability in its Policy Documentation

As articulated in the introductory section 5.1 above, this chapter addresses the first research objective of this study which is to analyse how the Global Fund understands accountability in the policy documentation and what structures and procedures it has put in place to address accountability concerns.

In order to attain this first objective, this study adopts a critical interpretative method (see Chapter 1.7.3.1). The critical interpretive approach believes that knowledge is a function of social construction and shaped within society by power relations and ideology. With regards to the Global Fund, a critical interpretive case study approach assumes that the Global Fund's policy understanding of accountability is socially constructed. Therefore, this approach is employed to examine how the Global Fund understands accountability in its policy documentation and how such policy understanding of accountability informs the Fund's practice when it participates in health policy processes in specific settings of global health (such as Ghana). The single most important policy document of the Global Fund is its foundational partnership policy framework document (Global Fund, 2012a). The official Global Fund website functioned as the key source of reference (data collection) for the Fund's policy documentation and other publications. The Global Fund makes public most of its documents online, thereby creating access to examine its policy documentation. Other supporting literature to aid analysis was located through publicly available academic databases and search engines.

As discussed in Chapter Three, the underlying ideological position informing the Global Fund's policy documentation is a neoliberal one. Neoliberal discourses favour a technical and

depoliticised understanding of HIV/AIDS which promotes the role of non-state actors and entrenches the powers of donors (government and corporate) in global health policy processes.

The Global Fund lays out a set of policy principles in its foundational policy framework document which embeds its institutional policy and practice arrangement and which it asserts distinguishes it from other donors and multilateral organisations in the global health regime. These policy principles include the following commitments: that it funds but does not implement projects; that it will respect country ownership through country-led formulation and implementation processes; that it will leverage and make available financial resources to combat HIV/AIDS, TB and malaria; that it values transparency; that it adopts a performance-based funding system; and that it endeavours to operate in a balanced manner in terms of distributing its funding across different regions, diseases, interventions and in prevention and treatment (Global Fund , 2012a: 91).

To examine how accountability is understood by the Global Fund, it would be necessary to critically examine this foundational partnership policy framework document (and other documentation) in which these policy principles appear. A critical interpretative reading of this partnership policy framework document identifies three spheres of accountability: governance, programmatic and financial policy spheres of accountability (Global Fund, 2012a). These three spheres each have a different emphasis and are therefore examined separately below.

5.3.1. Governance Accountability Policy

The Global Fund states in their policy documentation that the overarching governance policy direction of the Global Fund is to operate 'in a transparent and accountable manner based on clearly defined responsibilities' (Global Fund, 2012a: 91). Transparency is a key accountability related concept deducible from the governance accountability policy documentation of the Global Fund. For example, the Fund's anti-corruption policy states that it intends to protect the Fund from fraudulent activities by enabling transparency to drive accountability, fraud prevention and detection (Global Fund, 2017a). The risk appetite framework and the risk management policy seeks to guide the Fund in making transparent decisions in its risk-taking activities and to put in place responsible risk management procedures (Global Fund, 2018, 2014a). The word 'transparency' is also clearly reflected in the various codes of conducts governing the Fund's operations (Global Fund, 2012b, Global Fund, undated, Global Fund,

2020) and its conflict of interest policies (Global Fund, 2018, Global Fund, 2017b, Global Fund, 2014b, Global Fund, 2020).

Boven (2010) describes transparency as a virtue of accountability. As Boven (2010) explains, accountability as a virtue 'is used primarily as a normative concept, as a set of standards for the evaluation of the behaviour of public actors' (2010: 946). Following from the above, it is clear that the Fund wants to position itself as a transparent and accountable organisation. Walker (2012) suggests that the adoption of transparency as a theme can be viewed as a quest by the Global Fund to seek legitimacy from donors and provide assurances that it will operate differently relative to the agencies of the UN system (Walker, 2012). This observation by Walker (2012) speaks to donor criticisms of what they perceived as the lack of accountability, inefficiency, bureaucracy and wastefulness of the UN system and its agencies in the build-up to the construction of the Fund. These criticisms were crucial in the decision to locate the Fund outside the UN system (see Chapter 3.4.4). This implies that the Global Fund views its legitimacy in the eyes of its donors to be crucial to its governance accountability model.

Critics note that the Global Fund has been transparent in making information about its activities public on its website, but that it has been beset by transparency issues that revolve around corruption, fraud and conflict of interest. For example, in 2011, the Global Fund faced internal management squabbles and allegations of theft in a few recipient countries (van Schaik and van de Pas, 2014: 60). The problems led to an overhaul of how the organisation allocates money and the appointment of a new director. With regards to conflict of interest, it is accused of conflicts of interests in relation to alcohol producers. In South-Africa, it finances the so-called Tavern Intervention Program (TIP) that is targeted at minimising alcohol-related harm and the spreading of HIV/AIDS. The program, which is implemented by liquor producer SABMiller, has been 'criticized for providing unwarranted justification for their image as socially-responsible producers, while the company actually is said to be at the root of the problem by ensuring that its sales and profits are maintained '(van Schaik and van de Pas, 2014: 60).

The Global Fund's governance policy posits that its governance model is multi-constituency in orientation due to its construction as a global public-private partnership (GPPP) in health (Global Fund, 2012a: 91, Global Fund, 2017). Furthermore, the Fund also describes itself as a funding rather than an implementation agency (Global Fund, 2012a: 91). The Fund also states that it will

respect country-level partnerships through 'country-led formulation and implementation processes' (Global Fund, 2012a: 91). There are three fundamental assumptions underpinning these policy positions articulated by the Global Fund. Firstly, crucial to the governance accountability policy of the Global Fund is the notion of participation. The notion of participation is inherent in the conceptualisation of the Global Fund as a global public-private partnership (GPPP) in health. This is because the Global Fund is emblematic of new actors in global health that has extended participation to non-state actors (alongside state actors) into health policy processes and decision-making structures in global health to undertake and proffer solutions for the resolution of existing global health policy challenges. By extending the participation of non-state actors in global health decision-making structures, the Fund is positioning itself as distinct to the traditional global health multilateral organisations whose formal membership and decision-making structures are limited to states. Secondly, by referring to itself as a funding and not an implementation agency, the Global Fund is also positioning itself as distinct or different from the traditional global health multilateral organisations such as the WHO and the World Bank who maintain country offices and directly fund and implement projects. Thirdly, in promising to respect 'country-led formulation and implementation processes', the Global Fund adopts country ownership as a policy principle in which recipient countries take control of their development strategies in contrast to the donor-led structural adjustment programmes.

The extension of participation to non-state actors can be attributable to two currents. These are the advocacy by the World Bank for the formal inclusion of the private business sector in healthcare financing and a broader role for non-governmental organisations (NGOs) in implementing developmental aid as part of neoliberal structural adjustment policies which favours NGOs to undertake healthcare service provisioning (see Chapter 3.4.2) and the advocacy by civil society organisations for more inclusive governance frameworks for those who were previously excluded and marginalised in traditional multilateral institutions (see Chapter 3.4.6). When considered holistically, the inclusion of these actors in its multi-constituency governance model is championed by the Global Fund as an exercise in expanding democratic participation and accountability in global health agenda-setting and decision-making processes (Barnes, 2011). The Global Fund's multi-constituency governance model is reflected in the composition of its Board at the global level and in the guidelines for the composition of the country-level

governance mechanism referred to as the country coordinating mechanism (CCM) (Global Fund, 2012a). Therefore, it is through the analysis of the governance mechanism adopted by the Fund that we can understand who is included (or excluded) from participating in its decision-making processes (such as agenda-setting and policy formulation) and how those involved can be held to account at the global and country levels.

(a) The Global Fund Board

Christiansen et al. (cited in McGill, 2014) provide a helpful definition of governance, saying that it is the 'production of authoritative decisions which are not produced by a single hierarchical structure, such as a democratically elected legislative assembly and government, but instead arise from the interaction of a plethora of public and private, collective and individual actors' (2014: 36). This definition is useful when thinking about the governance structure created by the Global Fund especially in relation to who partakes in its governance activities.

The Global Fund Board is responsible for organisational strategy and development which requires partner engagement and deliberation encompassing all constituencies (Global Fund, 2011a, Global Fund, 2012a). Thus, the board includes representation from a wide spectrum of constituencies such as civil society organisations, philanthropic foundations, people living with HIV/AIDs, donor state governments, recipient state governments, the private business sector and multilateral agencies (Global Fund, 2011a, Global Fund, 2012a). An examination of the Fund's Board highlights that it encompasses 20 voting and seven non-voting members (Global Fund, 2011a; Global Fund, 2005a).

The 20 voting members are categorised thus: eight seats for donor governments; seven seats for developing country members; one seat for private business interests; one seat for private philanthropic foundations; one seat for developed country NGOs; one seat for developing country NGOs; and one seat for affected communities (organisations representing people living with any of the three diseases). The Board also has seven non-voting ex officio members. These are the Global Fund Board Chair, a member representing the WHO, a member representing the Joint United Nations Programme on HIV/AIDS (UNAIDS), a member representing a partnership constituency that works with the Fund (currently Roll Back Malaria), a member representing the

trustee of the Global Fund (the World Bank), and an additional non-voting public donor (currently South Korea) (Global Fund, 2020c). See Table 5.1 below for a summary.

Table 5-1: Board composition of the Global Fund as of May (2020c)

Voting Members: Seven Member Developing Countries Representatives (drawn into regional groupings). One Representative for Each Region.	Voting Members: Eight Member Donor Country Representatives (drawn into country groupings). Some Countries are Stand Alone and not in any Group.	Five Voting Members Drawn from Civil Society and the Private Sector	Non –Voting Members (Currently Seven).
1.Eastern Mediterranean, 2.Eastern and Southern Africa, 3. Eastern Europe and Central Asia, 4.Latin America and Caribbean, 5.South East Asia, 6.West and Central Africa, 7. Western Pacific.	1. Canada, Switzerland and Australia, 2. European Commission, Belgium, Italy, Portugal, Spain, 3. France, 4. Germany, 5. Japan, 6. United Kingdom, 7. United States of America, 8. Point Seven (Norway, Denmark, Ireland, Luxembourg, Netherlands, Sweden)[1]	Affected Communities: Lean on Me Foundation, Developed Country NGOs: Interagency Coalition on AIDS and Development, Developing Country NGOs: Alliance for Public Health, Private Foundations: Bill & Melinda Gates Foundation, Private Business Sector: Goodbye Malaria	1.Board Chair, 2.Vice Chair, 3.Member from WHO, 4.Member from UNAIDS, 5.Member from a partnership constituency that works with the Fund (currently Roll Back Malaria); 6.Member from the trustee of the Global Fund (the World Bank), 7. Additional Non-Voting Public Donor (currently South Korea)

Source: Global Fund, 2020c

The implication of the Global Fund's categorisation of board membership is that donor states representatives (eight in total) outnumber representatives from developing countries (seven in total). When private foundation and private business representatives are added, the figure for the

[1]While the Global Fund refers to this grouping of states as Point Seven, it is actually made up of only six states.

donor bloc becomes ten. If the three representatives of the civil society organisations (NGOs representing developed and developing countries and the one from affected communities) are added up and counted as a bloc representing those implementing the funds, it brings the number of constituents on both sides to an equal number of ten each. However, there is no guarantee that the NGO representing the developed countries will always align with the implementing bloc because the developed country NGOs get their funding from the wealthy donor bloc and are not likely to oppose them in key policy issues or deliberations. As such McGill (2014) postulated that when the influence of donors on the board is combined with that of rich and powerful NGOs from these developed countries, it raises questions as to whether deliberations and decision-making were intended to be equal between countries from the northern and southern contexts of global political economy. It is important to state that the balance of power in the Board may most likely be further tilted in future in favour of the donor bloc due to the Global Fund's plans to convert the seat of the non-voting public donor to a voting public donor seat (Global Fund, 2017c: 5).

In order to drive participation and promote accountability, the Global Fund bylaws recognised the right of Board members to establish their own rules of practice for choosing their Board representatives (Global Fund, 2019a; Schneider 2009; Clinton, 2014). Each Board representative is complemented by several other persons, which make up what is called a delegation (Global Fund, 2019a; Schneider 2009; Clinton, 2014). However, only the official representative is empowered to vote in board meetings, while delegate members (up to 5 in numbers per delegation) can participate directly in Board meetings (Global Fund, 2019a; Clinton, 2014). All other remaining delegates and Secretariat staff observe Board meetings via live video stream set up in a separate room (Schneider, 2009; Global Fund, 2019a; Clinton, 2014). The Board Operating Procedures of the Global Fund Board outline the guidelines that regulate the functioning of the Board and its decision-making processes (Global Fund, 2019a; Schneider 2009). It encompasses specific measures that promote broad-based participation of all members in the Board decision making processes (Schneider 2009). The Board representatives congregate thrice yearly for board meetings (Global Fund, 2019a; Schneider 2009). While English is the official language for Board meetings, concurrent translations into any UN language are provided for delegates if requested (Schneider 2009). However, when the contents of translated documents

of board meetings and decision points become contested or disputed, the default position of the Board is to rely on the English version of its board documentation (Global Fund, 2019a).

To further drive a more participatory governance process, the Board provides funding to developing country and CSO constituencies to cover ancillary costs related to their official activities (Global Fund, 2019a). In addition, the formal documents setting out the operating procedures of the Board specify that consensus should guide Board decision-making, but a representative with voting power can call for a vote (Schneider 2009). As indicated above, the members of the Board form two blocs: the donor bloc and the implementing bloc (Global Fund, 2019a; Schneider 2009). The donor bloc is made up of the donor states and the private foundation and business sector representatives. On the other hand, the implementing bloc is made up of the NGO representatives, developing states, and the representative for affected communities. In principle, a two-thirds majority from both blocs is needed for a motion to be deemed as successfully passed or carried (Global Fund, 2019a; Schneider, 2009).

While the official policy principles and arrangements that underpin Board activities discussed above strive to promote social inclusivity and broad-based participation in agenda-setting and decision making; in practice, the degree to which the objectives of participatory decision-making have been achieved by the Board is contested. For example, Brown (2010) notes that donor governments possess and have exercised veto power because they could threaten the withdrawal of future funding to the Global Fund (Brown, 2010). As an example, he claims that the United States government under Bush administration pressured the Global Fund to finance abstinence faith-based programs in relation to HIV/AIDS by threatening to withhold funds (Brown, 2010). Bush was keen to pacify and woo the conservative wing of his Republican party who wanted a stop to the provision of condoms which they felt promoted sexual immorality and undermined faith-based abstinence programs (Brown, 2010). Furthermore, according to Brown (2010), donor representatives often meet before official Board meetings to take predetermined positions that will guide their deliberations in Board meetings. He suggests that other non-donor partnership members are of the view that this practice has undermined the very essence of multi-sectorality and deliberative engagement. The consequence of creating and retaining the donor caucus is that Board meetings become a venue to advance and defend predetermined donor positions rather

than an avenue to truly practice multi-sectoral deliberations as envisaged in the official principles and procedures of the Global Fund (Brown, 2010).

Bruen et al. (2014) also argue that the deliberative intent behind having a multi-constituency board has been undermined by donor delegations. For example, he posits that misgivings have been expressed by the developing countries and NGO representatives sitting on the Global Fund Board that a proposal by the Board to develop a new pricing framework for procurement had been done in a closed up fashion without any input from them which is against the spirit of deliberation and that no official information was publicly disclosed about this (Bruen et al., 2014). In a similar vein, Walker (2011) contends that where agenda-setting in the Global Fund is up for consideration, donor interests take preeminence over the notions of social deliberations and participation. Donors wield economic power and influence which positions them to take the lead in Board agenda-setting deliberations. In further highlighting the power imbalance that underpins Global Fund Board operations, Jonsson (2010b) argues that donor representatives control and superintend the two committees strategic to Board operations, namely the Policy and Strategy Committee and the Finance and Audit Committee (Jonsson, 2010b).

Donor power play in the Global Fund Board has also been highlighted in a study by Clinton (2014) who notes that some non-English speaking recipient countries in 2004 complained that the Partnership Forum documents were written only in English language and were difficult for them to comprehend or understand. While Clinton states that the Board showed understanding, it did not initiate any process to respond to this concern neither did the Secretariat exhibit any inclination on their own to accommodate this concern (Clinton, 2014:283). She observed that the English-only language approach made wider participation in the Board and on Board committees difficult for many implementing countries (Clinton, 2014:283). Additionally, Clinton (2014) reports that donor board members meet outside board meetings to discuss the activities of the Global Fund. For example, she claims that in 2006, donor government representatives convened in Durban, South Africa, and that the purpose for this meeting was for the Fund Secretariat to render a progress report to donors on the activities of the Fund. Normally board meetings are mentioned in board reports released periodically by the Global Fund. However, she noted that there has not been any mention of this particular meeting in board reports from 2006 (Clinton 2014: 284).

Still on donor-recipient country power relations in the Global Fund board, Clinton (2014) posits that donor board members attended meetings convened by Fund Secretariat with its technical partners such as the World Bank and the United States President's Emergency Plan for AIDS Relief (PEPFAR). Importantly, she observes that there is no evidence that recipient countries attended nor were they invited to these meetings (Clinton 2014:285). Furthermore, according to Clinton (2014:285) since 2005 the Board has limited its meetings to twice a year rather than the three or four times annually that had been the norm till that point. This reduction in the number of yearly board meetings constrains the space for recipient countries to engage or deliberate with the board or with one another as the occasion demands. She could not locate any evidence that the Board (with recipient country members in attendance) discussed this reduction in meetings or that recipient countries accepted the measure (Clinton 2014: 285).

When the power dynamics and relations that permeate the Global Fund Board operations or activities are taken together, Brown (2010) concludes that the functioning of the Global Fund Board is affected by power relations which undermine shared understanding or consensus formation. As such, Smith (2014) observes that just like in the traditional multilateral organisations, those with the economic might in the Global Fund are more influential than those meant to receive aid. Therefore, Walker (2011) concludes that although the Global Fund embraces and promotes multi-sectoral representation, the kind of power play between donors and developing countries on the Fund Board is similar to the power politics in traditional multi-lateral organisations where donor governments also dominate and influence Board proceedings.

(b) The country-level multi-constituency governance model: the country coordinating mechanism (CCM)

The governance accountability policy lays out and explains the envisaged roles and responsibilities of the CCM in the governance set up of the Global Fund. As stated by the Fund, it 'will base its work on programs that reflect national ownership and respect country partnership-led formulation and implementation processes' (Global Fund, 2012a). As discussed earlier in the sub-section above, the country coordinating mechanism (CCM) is the governance instrument of the Global Fund at country-level in specific settings of global health (Global Fund, 2012a; Global Fund, 2002, Global Fund, 2018c). Rather than maintaining in-country offices, the Global Fund mandates CCMs to take the lead in agenda-setting and programme implementation

in each country. Thus CCMs act as national secretariats to process country grant applications, set agendas and administer programmes. They are envisioned to be multi-sectoral by encompassing a wide range of stakeholders from the public and private sectors (Global Fund, 2012a, Global Fund, 2002, Global Fund, 2018c).

The inclusion of non-state actors as partners in the CCM suggests that the phrase 'national ownership' as expressed in the quote above encompasses not just the government, but other local stakeholders or constituencies in a specific context of global health. The word 'national' is usually used in referring to government or state-related activities or issues. Thus the CCM is the instrument designated for the realisation of country ownership by the Global Fund. The notion is intended to represent a positive change beyond the contentious days of aid conditionality exemplified by policies such as structural adjustment programmes (SAPs). It signals the belief that recipient countries (both in terms of their governments and their citizens) should lead and control the design of externally funded programmes.

In referring to the CCM as a country led partnership, it suggests that the Global Fund is desirous to expand the democratic space by providing a platform and a voice for non-state actors and other marginalised groups to be formally involved in health policy processes such as agenda setting and decision-making. In this context, accountability relations between donors and recipient countries is not expected to be limited to relations between donors and recipient country governments, but would extend to those affected by the activities of the Global Fund. The legitimacy of CCMs is therefore a function of their level of inclusivity in terms of broad-based participation and also their performance (Bruen et al., 2014).

Therefore, while CCMs possess the ability to function as an instrument for the realisation of country ownership, it is only in practice at country level in specific settings of global health that the claim of the Global Fund to promote country ownership of health policy through its adoption of a country coordinating mechanism (CCM) can be evaluated. Therefore, the literature on country ownership more broadly and its practice in relation to the Global Fund will be discussed in Chapters Six and Seven. Chapter Six will examine the Global Fund's governance accountability practice in Ghana in relation to the country ownership of the HIV/AIDS response, while Chapter Seven will analyse the Global Fund's programmatic and financial accountability practice in Ghana with regards to the same objective.

5.3.2. Financial Accountability Policy

The Global Fund policy documentation clearly differentiates between financial and programmatic policy spheres of accountability, but acknowledged that clear links exist between financial and programmatic accountability that must be put into consideration (such as when grants are disbursed for programme implementation) (Global Fund 2012a:100-103). The financial accountability policy of the Global Fund delineates the parameters and regulations that guide the accountability relations between the Fund and its grantees such as in financial and programme reporting during grant implementation (Global Fund, 2012a: 103). Financial accountability also revolves around the functions and responsibilities of the trustees of the Global Fund. The World Bank acts as a trustee for the Global Fund with responsibility for financial accountability (Global Fund 2012a:104). In further articulating the basis and purpose of its financial accountability policy, the Fund posits that policy aims to provide the financial framework and principles for the management of donor resources for the achievement of programmatic results by grantees in implementing countries.

This implies that the management of donor resources is crucial to the Fund's business model. These tallies with the Global Fund's organisational motto: raise it, invest it, and prove it' coined by its first ever executive director, Richard Feachem (Bruen et al., 2014). 'Raising it' implies the mobilisation of significant monetary resources by donors, and underlines donor quantifying of the challenge of HIV/AIDs in monetary or economic terms. This relates to the advocacy by donor governments for the mobilisation of significant resources to battle HIV/AIDs and the creation of a new mechanism to administer these resources due to their mistrust of the UN agencies in aid delivery (see Chapter 3.4.4). 'Investing it' (read: ensuring accountability, efficiency and effectiveness in the allocation and use of resources); and 'proving it' (read: result-oriented performance) can be traced to the World Bank, corporate elites and donors insistence in the 1990s on adopting models of accounting practices such as performance-based funding which were targeted at ensuring that aid monies were spent in an accountable, efficient, effective and responsible manner to achieve measurable results (see Chapter 3.4.2, 3.4.4).

The Global Fund was constructed as a financing instrument. In order to perform this function, it aggregates financial resources to address the morbidity and mortality of HIV/AIDS, Malaria and TB. It depends on donors to contribute these financial resources periodically. This periodic

process of mobilising donor funds (from a wide gamut of donors including foundations, governments and businesses) by the Global Fund is referred to as a replenishment cycle (Global Fund, 2019b). Between 2001 and 2013, 'the Global Fund has received a total of $30.5 billion in pledges and $25.6 billion in contributions' (CGD 2013: 9). The bulk of donations came from the G8, the European Union and the Bill and Melinda Gates Foundation (BMGF) (CGD 2013). During the last Global Fund's sixth replenishment cycle held on the 10th of October 2019 in Lyon, France, Global Fund Donors pledged US$14 billion. This was the largest amount ever raised for a multi-lateral health organisation (Global Fund, 2019b). The biggest donor pledge was from the United States government which pledged US$1.56 billion a year for the next three years, making up 33% portion of all pledges made (Global Fund, 2019b). Other major donors such as the United Kingdom pledged £1.4 billion pounds for a three-year period, Germany €1 billion euros, Canada 930 million Canadian dollars, the European Union €550 million euros, and Japan contributed US$840 million (Global Fund, 2019b). Private donors pledged more than US$1 billion, with the Bill & Melinda Gates Foundation contributing US$760 million of this amount (Global Fund, 2019b).

The financial clout of these donors (particularly the US government) positions them as powerful actors in the accountability relations of the Global Fund. The Fund operates at the mercy and benevolence of these donors. Withdrawal or withholding of financial support from donors renders the Fund powerless and incapacitated. In a practical demonstration of US government power in the Fund, the U.S. Government Accountability Office (GAO) in June of 2005 accused the Global Fund of a number of infractions regarding its operations such as the inability to properly monitor and evaluate grants which undermined the results it reports, and generally a lack of basic and available documentation on grant performance, disbursements and renewals (GAO 2005). The U.S. Congress later passed a resolution demanding the establishment of an 'independent auditing structure' within the Global Fund (GAO 2005). The creation of independent auditing structure' was seen by the U.S. Congress as crucial to oversight of the Fund and they threatened to withhold future funds if their suggested recommendations were not implemented.

The Global Fund took steps to implement the conditions handed to it by the US Congress resulting in the establishment of the office the Inspector General (OIG) of the Global Fund in

July, 2005 (Bruen et al., 2014). The creation of the Office of the Inspector General (OIG) demonstrated the concern the Global Fund attached to financial accountability to the donors for the use of the resources they make available. The threat of sanction from the US showcases how donor power can be brought to bear on a donor-financed institution like the Global Fund which can be pressured to modify its behaviour and re-engineer its internal organisational composition (Bruen et al., 2014).

In addition to the OIG, another important fiduciary instrument is the High Level Independent Review Panel. This panel came about as a result of an article published by the Associated Press (AP), in January 2011 which highlighted cases of fraud and mismanagement in the Global Fund. In clarifying the depth of these corrupt practices, AP's news article labelled the level of fraud astounding, with as much as two-thirds of some grants eaten up by corruption' (CDG, 2013:7). The media scrutiny of the Fund's activities led to threats from donor governments such as Sweden and Germany to sanction the Fund by withholding pledges. The scandal and withholding of funds by donors galvanised traction to reform aspects of the Fund's operations. To assuage donors, the Global Fund therefore inaugurated a High Level Independent Review Panel (Global Fund, 2011b; CDG, 2013).

The Panel was mandated to examine the weaknesses in the Fund's fudiciary arrangements, particularly at country levels and to make recommendations on how to improve these arrangements (Global Fund, 2011b; CDG, 2013). The Panel established that existing fiduciary arrangements were insufficient particularly at country levels and needed significant overhauling (Global Fund, 2011b; CDG, 2013; Bruen et al., 2014). A series of important reforms were introduced following the recommendations made by the Panel. The majority of the reforms were aimed at regaining donor confidence and improvements in financial monitoring of grants to recipient countries (Bruen et al., 2014). A greater percentage of subsequent Global Fund reforms have been targeted at addressing the Funds financial monitoring and implementation challenges in order for the Fund to retain the confidence of its donors (Bruen et al., 2014).

As noted in the opening paragraph of this section, the Global Fund policy documentation clearly differentiates between financial and programmatic policy spheres of accountability but recognized the strong links exist between them that must be considered. The performance-based funding (PBF) scheme is the financial accountability mechanism that underpins programme

implementation of Global Fund grants in recipient countries (Global Fund, 2012a; Bruen et al., 2014). It is used to incentivise grant recipients to attain measurable and better results. It inexorably links the programmatic and financial sphere of accountability. Since it is a financial accountability scheme that underpins programme implementation, the PBF is discussed in broader detail in the next section.

5.3.3. Programmatic Accountability Policy

In defining programmatic accountability, the Global Fund stated that ' Monitoring of Global Fund grants will focus on programmatic accountability [which involves] assessing the programmatic progress and public health impact of activities supported by the Global Fund; and providing incentives for improved performance' (Global Fund, 2012a: 101). In order to properly assess the programmatic progress and public health impact of Global Fund supported activities, the Fund avered that it will develop and deploy 'sound processes for specifying, tracking and measuring program results to ensure a sufficient level of accountability' (Global Fund, 2012a: 100). Some of the 'sound processes' identified by the Fund include reliance on performance-based funding (PBF), monitoring, evaluation and auditing tools and on the application of benchmarks, process and output indicators (Global Fund, 2012a: 101).

In the concluding paragraph of section 5.2.2 above, I had earlier posited that performance-based funding (PBF) is the financing scheme deployed to guide the grant award process and to incentivise grantees to achieve projected results and outcomes in programme implementation. Therefore, germane to the Fund's programmatic accountability policy are the PBF process (and the actors who participate in it), programme monitoring, evaluation and auditing mechanisms or tools and the application of benchmarks, process and output indicators which shape and determine programme implementation.

The programmatic emphasis of the Fund on 'sound processes for specifying, tracking and measuring program results to ensure a sufficient level of accountability' underscores the technical and logical assumption that underpins and drives PBF. This technicality and logic imply that the Global Fund PBF is a rational set of laid down procedures devoid of ambiguity and incoherence that grantees need to follow in order to implement programs and achieve results. These procedures kick off from the grant application stage. The CCM writes and submits the proposal. In the proposal writing process, the CCM nominates the Principal Recipients (PRs)

who will implement the programmes detailed in the proposal if it is approved (Global Fund, 2012c, 2013a; CGD, 2013; Warren et al., 2017). After submission, a proposal vetting process coordinated by the Technical Review Panel (TRP)[2] takes place. The TRP recommends grant awards to the Board, while the Secretariat monitors grant performances. If a proposal is successful, the Fund Board approves sustained funding for a five year period (Global Fund, 2006a). Each successful or approved grant embeds the details of the programmes to be implemented and targets to be achieved in the implementation process (World Bank GPR, 2011; Plowman 2008; Fan et al., 2013a, 2013b; Olarinmoye; 2012). The Global Fund does not maintain country offices. So, in order to monitor the funds it disburses to grantees, it appoints what it refers to as a Local Fund Agent (LFA).[3] These agents are usually global accounting firms. An LFA is appointed by the Fund for each recipient country implementing Global Fund programmes. They assess, on behalf of the Fund, the capacity of grantees (principal recipients) to implement approved grants.

In an effort to improve its grant application process, the Global Fund in 2011, adopted a new funding model (Global Fund, 2012c, 2013b; CGD, 2013; Warren et al., 2017). Unlike under the round-based model when calls for funding rounds through the submission of proposal may not align with individual country budget cycles, the new model allows countries (through their CCMs) to align their grant applications with national budget cycles (Global Fund, 2007b, 2010d, 2010e, 2011c, 2011d, 2012c, 2013b; CGD, 2013; Warren et al., 2017). In other words, grant application is now flexible rather than being run in line with a strict submission deadline under the old round-based system. Furthermore, under this model grant applications are no longer referred to as proposals, but called concept notes (Global Fund, 2012c, 2013b; CGD, 2013; Warren et al., 2017). Concept notes are intended to underpin and drive national strategic dialogue. This means that in order for a country to develop a concept note, the input of all relevant stakeholders in-country should be embedded in it. Since this note is aimed at capturing broad-based perspectives, it represents the adopted national strategy of that specific country. Thus national strategic discussion acts as the basis for developing a concept note that will be

[2]The Technical Review Panel (TRP) is a panel made of experts in diverse fields of global public health This panel recommends to the Board of the Fund which funding proposals submitted by recipient countries should be approved, which should be resubmitted or revised and which should be denied. The TRP is discussed in Section 5.3.2 below.

[3]The Local Fund Agent (LFA) is discussed in broader details in Section 5.3.3 below.

submitted to the Global Fund as the grant application (CGD, 2013; Warren et al., 2017; Global Fund, 2012c, 2013b). This national strategy approach is also aimed at investing in activities to help health systems drive activities aimed at addressing critical health issues such as HIV/AIDS, TB and malaria (Global Fund, 2010c). The national strategy approach also empowers the Fund to contribute to maternal and newborn and child health (Walker, 2012).

Although grants are approved for sustained funding for a five year period, the funding cycle for this five year period is in two phases. For example, if a principal recipient (PR) receives a positive endorsement from the LFA, the Global Fund Secretariat signs a two-year grant agreement with the PR (Global Fund, 2007a, 2016, 2011b). The Global Fund then directs the World Bank, as its fiduciary trustee, to release the first batch of funds to the PR. This cycle is referred to as phase one (Global Fund, 2007a, 2016, 2011b). After phase one, the LFA, on behalf of the Fund undertakes an assessment of programmes implemented and targets achieved. If the LFA evaluation is positive, the Fund Board approves funding for the remaining three years of the five year funding cycle. This phase is known as phase two. On the other hand, if the assessment for the initial two years (phase one) funding is negative, the Board can decide to abridge, defer, suspend or completely annul funding for the remaining three years.

The grant evaluation process undertaken by the LFA to determine whether to approve phase two funding for any grant recipient is dependent on the score (grade) awarded to the recipient in the assessment process. To be assessed, the principal recipient must deliver consistent programmatic updates known as Progress Update and Disbursement Request (PUDR) (Global Fund, 2007a, 2011b). The PUDR details grant implementation and performance levels achieved by the Principal Recipient. Based on the LFA's evaluation of the PUDR, it writes a report, makes recommendations, and submits this report to the Secretariat. The Secretariat considers the report and recommendations of the LFA and uses it to assign the grant a performance rating ranging between A1 (exceeds expectations), A2 (meets expectations), B1 (adequate), B2 (inadequate, but potential demonstrated) and C (unacceptable) (CGD 2013; Wafula et al., 2014). Grants rated C will not usually receive phase two disbursements (Wafula et al., 2014). If the Secretariat is satisfied with the performance, board approval is sought for release of phase two grant.

In laying out the PBF processes, the Fund is signalling to recipient countries and their grantees that they must take responsibility for the outcomes of programme implementation and that the

failure or success of grant implementation cannot be attributable to the Global Fund. In making this claim, the Global Fund can point to the fact that the PBF process is well laid out and coherent and that the Global Fund is just a funding and not an implementation agency as it does not own country offices or directly implement programmes.

However, I argue that the programmatic accountability policy of the Global Fund (underpinned by the PBF) neglects the agency of actors (such as the interests that motivate them) and the social relations of power rooted in the nature and character of the global political economy that drives health policy processes. It is in this context that this study takes the position that the use of PBF reflects the influence of the World Bank, donor governments, and corporate donor elites such as the Bill and Melinda Gates Foundation (BMGF) in the construction of health policy that births partnerships such as the Global Fund (see Chapter 3. 4.2 and 3.4.4). The World Bank (a key driver and linchpin of neoliberal reforms) is the fiduciary trustee of the Global Fund (see Section 5.2.2 above). In the 1990s, to promote accountability in development aid, the World Bank advocated the adoption of performance-based accountability models targeted at developing cost-effective interventions to drive esults for those health problems that carry a large disease burden (high rates of morbidity and mortality) like HIV/AIDS (see Chapter 3.4.2).

Unfortunately, the Fund's adoption of performance-based funding elevates the achievement of short-term results over addressing long-term objectives such as tackling the social determinants of health which accounts for structural health inequities between the developed and developing nations and ill health that affects vulnerable populations worldwide, particularly in developing countries. This emphasis on technical criteria favours efficacy and efficiency in the delivery of health aid, but gives little or no consideration to the complex and multifaceted issues that account for ill health in specific settings of global health (Barnes, 2011). Indeed, as argued by Barnes (2011), the Fund's official policies present performance-based funding as just a rational and depoliticised process which describes how grants are to be implemented to achieve measurable results.

Implicit in Barnes' (2011) argument is the view that while the performance-based funding system appears apolitical and technical in nature, it is in reality political. Similarly, Smith (2014) argues that the aim of the Global Fund was to overcome the politicisation of aid delivery associated with traditional multi-laterals in favour of technical approaches and an emphasis on

results. However, she notes that despite the insistence that the apolitical posture of the Global Fund, the logic behind its formation and the nature and character of its operating procedures embeds political concerns. Picking up from the comments of Smith (2014), Saliba-Couture (2011) asserts that the focus on neoliberal criteria (such as performance-based funding) demonstrates a technocratisation of aid delivery and, implicitly, its depoliticisation. Technocratisation imposes a narrow framework for the analysis of political processes such as performance-based funding (Saliba-Couture, 2011). That is technocratisation obfuscates dynamics of power relations inherent in the political processes of the delivery of aid.

Other scholars also note a range of concerns with regards to the performance-based funding model adopted by the Global Fund. McGill (2014) posits that performance-based funding is open to manipulation because recipient countries may choose unambitious indicators that they can easily meet or focus on getting high scores in order to get continued funding, even while the targets do not accurately capture the country's health priorities. As Oxman and Fretheim (2008) note, PBF schemes can have unintended effects such as distorting country priorities. Eldridge and Palmer (2009) note three key concerns with this system. Firstly, concern over the nature of targets and how to achieve them; secondly, concern over how these targets may distort health system planning and lastly, the feasibility and cost of monitoring and evaluation systems. Renmans et al. (2016) opine that the exact mechanisms triggered by PBF arrangements need to be carefully studied in country settings. Chapter Seven on financial and programmatic accountability practice will discuss these scholarly concerns in the process of examining how the PBF mechanism works in the context of country ownership of the HIV/AIDS response in Ghana.

In sum, the foregoing sub sections 5.3.1, 5.3.2, and 5.3.3 have examined the Global Fund's understanding of accountability in the policy documentation and what structures and procedures it has put in place to address accountability concerns. In line with the critical interpretive approach which believes that knowledge is socially constructed and shaped within society by power relations and ideology, this study assumed that the Global Fund's policy understanding of accountability is socially constructed. In so doing, this study has highlighted (by using Chapter Three as a backdrop) that the underlying ideological position informing the Global Fund's policy documentation is a neoliberal one. As discussed in Chapter Three, neoliberal discourses promote the role of non-state actors and entrench the powers of donors in global health policy processes.

Governance accountability policies such as the anti-corruption, risk appetite and risk management, codes of conducts and conflict of interest policies are configured to safeguard donor funds and assure donors that the Fund is a transparent and accountable entity. However, the emphasis of governance accountability is on the governance architecture of the Fund (e.g. the Board and the CCM) in relation to who is included (or excluded) from participating in its decision-making processes (such as agenda-setting and policy formulation) and how those involved can be held to account at the global and country levels. The focus of financial accountability policy is particularly on the financial procedures, regimes and standards operational in the Global Fund, particularly in relation to the management of donor funds. Germane to programmatic accountability policy are the PBF process (and the actors who participate in it), programme monitoring and evaluation mechanisms, and the structures, systems or tools which shape and determine programme implementation.

5.4. Institutional Accountability Structures of the Global Fund

This section discusses the institutional accountability structures of the Global Fund. It focuses particularly on those institutional structures whose mandate and operations directly impact on the practice of the Global Fund in specific settings of global health.

5.4.1. Office of the Inspector General (OIG)

The Office of the Inspector General (OIG) was established in 2005 (Global Fund, 2018d, Global Fund, 2019c). It is an independent structure of the Global Fund, reporting directly to the Board, and is headed by an Inspector General, who is selected by the Board (Global Fund, 2018d). The OIG is entirely independent of the Global Fund Secretariat and undertakes audits, corruption investigations and investigations into cases involving the violation of human rights in Fund programmes (Global Fund, 2016a). The OIG is the key structure within the Fund for shielding its activities from fraud and the misappropriation of donor funds. As discussed earlier in Section 5..3..2, the creation of the Office of the Inspector General (OIG) demonstrated the concern the Global Fund attached to financial accountability to the donors for the use of the resources they make available. Apart from the Global Fund Board, no other institutional structure of the Fund is empowered to demand reports on the activities of the OIG. On the other hand, the OIG is empowered to investigate and audit the Secretariat or any other structures and actors (Bruen et al., 2014).

5.4.2. The Technical Review Panel (TRP)

The Technical Review Panel (TRP) plays an influential role in the governance, financial and programme accountability areas of the Global Fund. The TRP is a body of experts from diverse disciplinary backgrounds who evaluate grant applications (Global Fund, 2019d). It is charged with reviewing all proposals submitted for funding by recipient countries on technical merits (Global Fund, 2019d). This panel recommends to the Board of the Global Fund which funding proposals submitted by recipient countries should be approved, which should be resubmitted or revised and which should be denied. After a country's proposal is assessed and accepted by the TRP, the Board approves proposals for a five-year funding grant (see Section 5.3.3).

In addition to making recommendations for financing, the TRP also advises the Board on the design and execution of its Global Fund strategy. Membership of the TRP is subject to the powers and authorisation of the Strategy, Investment and Impact Committee of the Global Fund Board (Global Fund, 2016b, Global Fund 2019d; Bruen et al., 2014). This committee is made up of representatives of both donor and recipient countries (Bruen et al., 2014; Global Fund, 2016b). Given its powerful role, Bruen et al. (2014), note that it is not unexpected that members of the TRP have been the subject of widespread accusations and criticisms. For example, these scholars note that there have been allegations that the members of the TRP were more attuned and inclined to address donor demands and concerns and this has led to a perception of 'western bias' in the activities of the TRP. However, they note that there has been insufficient evidence to support such allegations (Bruen et al., 2014).

5.4.3. Local Fund Agent (LFA)

The LFA is a key participant in the performance-based funding (PBF) scheme (see section 5.3.3). Its role is to offer independent supervision and authentication of progress and financial accountability on behalf of the Global Fund (Global Fund, 2005d; Global Fund, 2016a, Global Fund, 2011b; Wafula, 2013). This is because the Fund does not maintain in-country offices for oversight of programme implementation. LFAs are usually global corporate accounting firms such as Price Waterhouse Coopers, KPMG, and Deloitte-Touche (Global Fund, 2020d). The contract agreement that is signed between the Fund and LFAs is in the form of a work plan that details the responsibilities of the LFA (Global Fund, 2014c, 2014d; Global Fund, 2019e).

The LFA verifies all PRs disbursement requests and, progress updates and reviews annual audit reports. These services are deemed crucial in assisting the Global Fund to make a determination about whether to continue or discontinue funding of the PRs (Global Fund, 2005d, Global Fund, 2011b, Global Fund, 2016a). The LFAs reports only to the Global Fund Secretariat and is not accountable to the CCM. The public disclosure or non-disclosure of LFA reports is at the discretion of the Fund (Global Fund, 2014c, 2014d; Global Fund, 2019e).

LFAs have been criticised for a variety of reasons. For example, critics have noted that LFAs are usually global accounting firms who possess financial knowledge but lack the expertise to manage health sector programme performance (Wafula et al., 2014). LFAs have also come under scrutiny for not undertaking on-site verifications and depending on results submitted by PRs which might not be reflective of objective conditions of programme performance (Bruen et al., 2014). A 2008 multi-country case study report on CCMs commissioned by the Global Fund noted that LFAs do not engage sufficiently with CCMs and as such, the LFA role is often misunderstood by CCMs (Global Fund, 2008). Furthermore, Clinton (2014) posits that multiple reports, audits and investigations across different countries and grants undertaken by the office of the Inspector General (OIG) questioned the competence and capabilities of LFAs to manage financial and programmatic risks. In response to some of these concerns and as part of a reform process, in 2013 the Global Fund mandated that prospective LFAs to the Fund must possess not only financial skills, but also programmatic skills in order to undertake their job functions (Bruen et al., 2014).

5.4.4. Secretariat

The Secretariat is in charge of the daily activities of the Fund. Put clearly, it is the administrative hub of the Fund. The Secretariat is headed by an Executive Director, who is selected by the Board. The role of the Global Fund Secretariat is to ensure that grantees abide by all the rules and regulations guiding programme implementation. This role is undertaken within the Secretariat by Fund Portfolio Managers (FPMs) who lead country teams. Global Fund country teams are teams set up by the Fund Secretariat to manage grants allocated to each country. They are based in the Secretariat in Geneva, but also visit the country for which they have oversight from time to time.

The LFAs' reports are an important source of oversight for the Secretariat in monitoring grant implementation (Global Fund, 2016a). For instance, the Fund Secretariat suspended its five grants to Uganda in 2005 after an audit undertaken by the then Ugandan LFA, PricewaterhouseCoopers (Kapiriri and Martin, 2006). The audit revealed mismanagement in the implementation of Global Fund programmes (Kapiriri and Martin, 2006). Clinton (2014) suggests that there are some problems in terms of the relationship between the Board and the Secretariat of the Global Fund, arguing that successive Board policies over time have constrained the delegation of authority to the Secretariat and that this inadequate delegation opened opportunities for direct donor influence in recipient countries (Clinton, 2014).

5.5. Discussion and Conclusion

This chapter has addressed the first research objective of the study by undertaking a critical interpretive analysis of how the Global Fund understands accountability in the policy documentation and what structures and procedures it has put in place to address accountability concerns. In this context, a critical reading of the Global Fund policy framework document (which details its institutional policy and practice arrangements) shows that the Fund recognises three spheres of accountability. These are governance, financial and programmatic accountability. With regards to governance accountability policy, I asserted that while there is a general policy focus on sub-accountability policies structured to safeguard donor funds and assure donors that the Fund is a transparent and accountable entity, the emphasis of governance accountability policy is on the governance architecture (e.g. the Board and the CCM) in relation to who is included (or excluded) from participating in the decision-making processes (such as agenda-setting and policy formulation). The Global Fund board model was structured to reflect social inclusivity by opening up decision-making in global health to those who were previously excluded and marginalised in existing multi-lateral institutions such as the W0rld Health Organisation (WHO) whose membership is limited to states. This notion of socially inclusive participation was in response to the concern of activist NGOs in the run-up to the Fund's establishment (See Chapter 3.4.6). The inclusion of previously marginalised groups is championed by the Global Fund as an innovative type of 'democratic participatory space' in global public health decision making (Walker, 2012).

However, I show above that the reality of board operational practice implies that social inclusivity in terms of representation does not imply participation in the decision making processes. To buttress this assertion, I presented numerous examples highlighting how the Global Fund board is essentially a donor-dominated space. The financial sphere of accountability policy is focused on the financial procedures, regimes and standards operational in the Global Fund. I argue that the financial sphere of accountability policy reflects the material capabilities of donors with regards to their role in financing the Global Fund under what the Fund refers to as a 'replenishment cycle' during which donors make pledges and donate to the Global Fund financial coffers. By discussing material capabilities, I refer to donor dominance of the centres of power in the global political economy ((Cox 1987; Grinspun and Kreklewich, 1994; Gill and Benatar, 2017). These material capabilities imbue donors with clout in the global political economy and in determining how global health governance frameworks like the Global Fund is organised and financed in the global health regime. It was in this context that Fuchs and Lederer, (2007) noted that when material power is applied in a business or institutional settings (such as the Fund), it becomes relational (Fuchs and Lederer, 2007). Thus accountability in the Global Fund comprises relations between partners with unequal levels of power (material power). Inequality in power points to the dominance of some partners over the others in the Fund (Bruen et al., 2014).

This supports and confirms this researcher's argument that partnerships function as a specific modality of power relations. This approach is attentive to the dynamics of power relations in partnerships rather than simply accepting at face value claims about 'collaborative decision making' or 'equally shared and mutual power' implied by the use of the term partnership in the international relations and global health literature (see Chapter 2.7.1). As shown above, the material capabilities of donors (and particularly the US government) positions and imbues them as powerful actors in the accountability relations of the Global Fund. Their capacity to mobilise money to replenish the Fund's financial coffers as the need arises is a manifestation of their financial power. The Global Fund's survival is dependent on donor perception of its successes or failures making accountability to donors of paramount importance. As Bruen et al. (2014) note, donors are in a position to apply powerful sanctioning and redress mechanisms against the Fund if it fails to meet their demands and expectations as donors can withhold or withdraw funding. The creation of the Office of the Inspector General of the Global Fund (at donor insistence) also

speaks to their clout. Bruen et al. (2014) see in this partnership relationship an overt imbalance of political influence. The Fund appears to operate at the mercy and benevolence of these donors. Withdrawal or withholding of financial support from donors will render the Fund powerless and incapacitated.

In relation to programmatic accountability policy, this study posited that fundamental to this policy are the actors who participate in the PBF process, the frameworks and specific targets for evaluating programmes, and the structures, systems or tools which shape and determine programme implementation. I argue that donor influence under this policy is expressed in the language of economics, such as quantification, efficiency, effectiveness. The highly technical process of performance-based funding which underpins programmatic activities is reflective of this language. This neoliberal economic approach to healthcare depoliticises healthcare, thereby obscuring questions of power relations. As Barnes (2011) shows, performance-based accounting practices mirror the worldview of donors whose reliance on technocratic and economic approaches demonstrate the elitist nature and character of the policy processes that shape global health aid policy.

In summing up the analysis in this chapter, it is imperative to understand that current frameworks of global health policy processes (such as the Global Fund) are essentially constituted and configured by the material capabilities of donors. Therefore, this study takes the position that the Global Fund's policy understanding of accountability, expressed in three spheres of accountability (governance, programmatic and financial) and the practice mechanisms that underpin them (e.g. the Board, CCM and PBF) are not politically indifferent or neutral, but can best be understood as context-specific and as a function of relations of power. As stated in Chapter 2.10, these mechanisms either reinforce existing power relations between donors and recipient countries or may act as agents of change (e.g. by promoting country ownership in practice) (Bruen et al., 2014). It then becomes imperative to carefully examine these spheres of accountability to better understand their impacts when worked out on the ground in practice, in particular in relation to its implications for country ownership of the HIV/AIDS response policy in Ghana

CHAPTER SIX

THE GLOBAL FUND, GOVERNANCE ACCOUNTABILITY PRACTICE AND COUNTRY OWNERSHIP OF THE HIV/AIDS RESPONSE IN GHANA

6.1. Introduction

In Chapter Four, I examined the nexus between globalisation, political economy and the HIV/ AIDS crises in Ghana. I argued that globalisation (which manifested in sub-Saharan Africa through the implementation of the neoliberal policies of structural adjustment programmes in the 1980s and 1990s) conditioned the political economy of Ghana by 'locking-in' neoliberal reforms. I further argued that the conditioning of the political economy of the state through SAPs constrained and placed limitations on the responsive ability and capacity of the Ghanaian state at a time when an effective and determined state response to rapidly spreading disease epidemic such as HIV/AIDS and its debilitating consequences was crucial. As a consequence, donors entered the Ghanaian health sector to aid government efforts to tackle the epidemic. Donor practices in the national HIV/AIDS response process gave rise to questions over country ownership and accountability.

The Global Fund is a donor involved in the response process and describes country ownership as a core principle of its accountability policy that informs its practice in aid recipient countries. However, in order to examine the practice of the Global Fund in Ghana as a donor in Ghana, it was necessary to understand how the Global Fund understands accountability in its policy documentation and what structures and procedures it has put in place to address accountability concerns.

Therefore, in Chapter Five, I engaged with the first research objective of the study which is to determine how the Global Fund understands accountability in its policy documentation and what structures and procedures it has put in place to address accountability concerns. I argued that the Global Fund understands accountability in terms of governance, programmatic and financial policy spheres of accountability. The governance policy sphere of accountability is supposed to be realised in practice by the Fund's Board at the global level and by the country coordinating mechanisms (CCMs) at the country level. The policy spheres relating to programme and financial accountability are also undertaken in practice through the CCM. The method of implementation mandated by the Global Fund for CCM practice in relation to programme and

financial accountability is referred to as a performance-based funding (PBF) system. I concluded Chapter Five by positing that the governance, programme and financial policy spheres of accountability (and the practice mechanisms that underpin them) in a partnership like the Global Fund are not politically neutral, but should be regarded as context-specific and a function of relations of power. These mechanisms either reinforce existing power relations between donors and recipient countries or act as agents of change (Bruen et al., 2014). It then becomes imperative to carefully examine these policy spheres of accountability to understand their impact when worked out on the ground in practice, in particular with regard to its implications for country ownership of the national HIV/AIDS response policy in Ghana.

This chapter is the first of two chapters that will provide this careful examination. Both Chapter 6 and Chapter 7 endeavour to answer the second research objective of this study: namely to investigate how the Global Fund's policy understanding of accountability works itself out in practice in Ghana, in particular in relation to its implications for country ownership of the national HIV/AIDS response policy. This chapter will analyse the Global Fund's governance accountability practice in relation to this research objective, while Chapter Seven will examine financial and programmatic accountability practice with regard to the same research objective.

This chapter is broken into seven sections. Section One is the introductory section. Section Two engages in a general overview of the concept of country ownership in development discourse. In Section Three, I examine the application of the country ownership concept in the Global Fund. The essence of this section is to highlight the contextual nature of country ownership in practice. Section Four introduces the Ghana Country Coordinating Mechanism (CCM) by highlighting its structure, membership composition and responsibilities. In Sections Five and Six, I provide a critical examination of the practice of the Global Fund based on a field study I undertook in Ghana between February and May 2018. In conducting this fieldwork, my interest was in exploring how the Fund's accountability policy measures are worked out on the ground in practice, particularly in relation to their implications for country ownership of the HIV/AIDS response policy in Ghana. I draw on the observation of meetings, interviews with stakeholders in the national response and also on documentary evidence (see Chapter 1.7.3.2). With specific regards to Section Five, I present divergent respondent perceptions of the CCM regarding the governance of health and its implications for country ownership in Ghana. In order to further

explore possible disjunctures (arising from respondents' comments) between the Global Fund's stated policy goals and practices on the ground, Section Six will critically examine in detail the governance practice of the Ghana CCM as an instrument for the realisation of country ownership and its attendant accountability implications. Section Seven summarises and concludes the chapter.

6.2. Examining the Concept of Country Ownership in Development Discourse

The Global Fund has committed itself to the notion of country ownership (see Chapter 5.3.1). However, its accountability practices potentially undermine country ownership. Before going on to discuss these practices and their impact on country ownership, it is necessary to briefly explain the concept 'country ownership'. Country ownership is currently a greatly valued concept in the discourse on global political economy and developmental aid. Country ownership is a phrase which is intended to represent a paradigm shift into a post-conditionality era away from what had been an era during which International Financial Institutions such as the World Bank and International Monetary Fund, seemed to control governments through structural adjustment programmes (SAPs) which are now widely considered to have been unsuccessful (Walker, 2012). Talk of country ownership represents efforts to increase the involvement of recipient countries (both in terms of their governments and their citizens) in the design of externally funded programmes (Walker, 2012).

As a linchpin and diffuser of neoliberal advocacy, the World Bank began picking up on the idea of country ownership in the 1990s after the failures of SAPs. Gradually, it became an influential voice promoting country ownership by developing various participatory frameworks ostensibly intended to drive recipient country ownership of development strategies such as the sector-wide approach (SWAp), the Poverty Reduction Strategy Papers (PRSPs) and the Comprehensive Development Framework (CDF) (World Bank, 2003). For example, in an evaluation of the CDF, the World Bank argued that development goals and strategies should be 'owned' by the country and that there should be broad citizen participation in shaping them. The Bank further noted that when countries have more voice in shaping reforms, governments and their citizens will endeavour to actualise such reforms (World Bank, 2003).

In order to formalise the shift to a post-conditionality era after the failure of structural adjustment programmes, a global forum on aid effectiveness was convened in Paris, France in 2005. At this

forum, the Paris Declaration on Aid Effectiveness (2005) was issued. A follow up forum resulted in the issuing of the Accra Agenda for Action (2008). Both the Declaration and the Agenda are indicative of how country ownership is supposed to drive aid effectiveness. The Declaration is the first developmental framework validated by both donors and recipients as signatories (OECD, 2005/2008). Country ownership is the central principle at the core of the declaration. The other principles of aid alignment, managing for results, harmonisation, coordination and mutual accountability are presented as being ways to enhance and drive the process of country ownership (OECD 2005/2008:3-7).

Under the rubric of country ownership in the Paris Declaration, recipient governments are expected to take control (leadership) in formulating policies and strategies, while donors as 'partners in progress' provide support when needed. The discussion on ownership indicators in the Declaration bestows governments with control over their development strategies because governments manage national budgets (OECD, 2005/ 2008: 9). Thus, donors are required to allow recipient governments take control, while they provide support to bring these policies and strategies to fruition (OECD, 2005/2008: 3). According to the declaration, donors are required to allow recipient governments to take control, while they provide support to bring these policies and strategies to fruition (OECD, 2005/2008: 3).

However, while the Paris Declaration interprets country ownership as being equivalent to government ownership, this stance does not capture the broader narrative of the role of citizens and civil society actors recognised by the Accra Agenda. Like the Paris Declaration, the Accra Agenda for Action is intended to promote country ownership. However, the Accra Agenda for Action adopted a broader notion of country ownership beyond the government focus of the Paris Declaration by clearly including the need for parliaments, civil society and citizens to be involved in determining national policies. As discussed in the Agenda, the objectives of country ownership include creating more effective and inclusive partnerships that will help overcome management and coordination challenges that bedevil the delivery of aid in recipient countries. The Agenda also emphasises the importance of a focus on achievement of results underpinned by transparent accountability systems and that recipient country governments should engage civil society organisations (CSOs) in policy dialogue (OECD, 2005/2008:15-17).

Scholarly critics have criticised the Paris declaration and its sister Accra Agenda for what they see as ambiguity and the abstractedness of technical language associated with the concept of country ownership. Brown (2017) notes that the meaning of the concept is dependent on the context in which it is used because people use terms such as national ownership, government ownership, democratic ownership and so on (2017:340). Consequently, Esser (2014) describes country ownership as a 'functional tautology' which is devoid of meaning and substance (2014:52). Scholars like Buffardi (2011) and Carothers (2015) argue that the concept is controversial and that the language of the declaration was full of technicalities, while Goldberg and Bryant (2012) cite challenges in achieving country ownership because country stakeholder interests differ and makes it difficult to build broad based consensus on how to achieve ownership. Given the ambiguities in relation to conceptualising country ownership, Buiter (2007) argued that the concept has lost its relevance and that the Declaration has become a particularly bad example of the imprecise language, wordings and phrases associated with international financial institutions. Giving examples of the multi-dimensional usage of the term such as 'the country has designed and drafted the programme', and 'the country agrees with the objectives of the programme' he argued that the imprecise nature and its ambiguity as a definitional framework made it a term whose time has gone and should be dumped (Buiter, 2007: 651).

Rather than 'dumping' the concept altogether, Booth (2012) and Brown (2017) argue that country ownership should be seen as an aspirational objective which recipient countries and donors are aspiring to and should not be seen as an end in itself. Although the concept is ambiguous, Brown (2017) argues that it is useful in problematising aid effectiveness as embedded in the Paris Declaration. Furthermore, as suggested by Cairney (2016), rather than abandoning the term 'country ownership' altogether, it may be better to examine and tease out its meaning as embedded in the Paris Declaration and Accra Agenda for Action in order to understand the aspirations of donors and recipient countries.

Picking up on the theme of broader citizen participation embedded in the Accra Agenda for Action, Johnson (2005) posited that country ownership exists when citizens and government partake in the policy formulation and implementation processes (Johnson, 2005: 3). Booth (2008) in keeping with this broad definition also notes that in many African countries, country ownership had failed because these countries were led by political elites who based policy on

patronage systems that revolved around elite interests. In his view, country ownership should entail more involvement of parliaments and civil societies in national planning processes. However, he warns that it should be noted that parliament (as citizen representatives) and civil society may also become motivated by elite and patronage interests just like other political elites (Booth, 2008:2). In other words, broader citizen participation may be normatively good, but may not necessarily lead to progressive policy-making that promotes the interests of the people, such as marginalised communities.

As can be gleaned from the above discussion, while the Paris Declaration focused more on government ownership of developmental strategies, the Accra Agenda expanded this focus by advocating for the inclusion of citizens and their representatives in shaping those developmental strategies and policies. This aligns with the views of Johnson (2005) and Booth (2008) who say that while government should be in control of national developmental strategies, greater efforts to involve citizens directly or through their representatives in the developmental processes should be undertaken. According to this view, donors are only to play a supporting role by providing support to the aspirations of government and their citizens. In other words, country ownership should accrue to governments and their citizens.

6. 3. The Application of the Country Ownership Concept in the Global Fund

The Global Fund is a signatory to both the 2005 Paris Declaration on aid effectiveness and the follow-up Accra Agenda for Action convened in 2008 (OECD, 2005/2008:12). The Global Fund has embraced and advocated the principle of country ownership from its inception (see Chapter 5.3.1). As further discussed in Chapter Five, the Country Coordinating Mechanism (CCM) is the governance instrument that the Global Fund uses to implement its country ownership principle in recipient countries. They function as national secretariats in each country for grant writing and submission to the Global Fund. CCMs are to be made up of all stakeholder constituencies involved in a national response to HIV/AIDS.

The application of the concept of country ownership in the Global Fund has been investigated by a variety of scholars. While the principle of country ownership is often spoken of and deployed in Fund policy and practice, there is no explicit or collective understanding of the term in practice. Radelet (2004) observes that most CCM members saw the CCM as a platform which could assist them to develop their skills and abilities and to empower them for programme

implementation. He also posits that CCM practice creates problems for stakeholders who often lack the resources to undertake all CCM activities assigned to them (Radelet, (2004).

However, other scholars are more critical of the functioning of the CCM. Doyle and Patel (2008) posit that the CCM usually operates outside state control which undermines the authority of government. Garmaise (2013) argues that the requirement that countries need a CCM to access Global Fund grants negates country ownership. He also observed that from the very beginning, the grant agreement (the contract to be signed with the principal recipient) negotiations process was used by the Global Fund to influence the content of approved programmes. This view is sustained by Rivers (2013) who observes that some programmes approved by the Global Fund Board are removed or replaced at the grant disbursement signing stage between the Fund and principal recipients by the Fund secretariat. Similarly, Van Kerkhoff and Szlezák (2006), highlight how the agency of the Global Fund's technical review panel (TRP) engineered changes in China's national AIDS policy.

In a multi-country study undertaken by Brugha et al. (2005), they found out that CCM applications to the Global Fund for grants were regarded by countries as a competitive process. They also noted that this could account for the lack of communication between recipient countries in sharing lessons and learning from one another's experiences. Furthermore, they assert that rather than focusing on the health priorities of their countries, grant applicants were more interested in ascertaining what to include in the proposal to attract funding from the Global Fund and shaping their proposals accordingly. In this context, it is clear that countries may not advance their own preferences (as one might imagine would be the case under country ownership), but rather work to put together applications they believe are reflective the Global Fund's priorities and are therefore more likely to get funded. These kinds of claims lead Walker (2011) to assert that the Global Fund's rhetoric about country ownership helps to give the Fund legitimacy, but that the Fund does not actually encourage country ownership in practice.

In a report produced by an independent review panel commissioned by the Global Fund, it was noted that while the concept 'country ownership' is generally spoken of and deployed across Fund activities, there is no agreement or mutual understanding of what it means in practice, both inside and outside the Fund (Global Fund, 2011). The panel concluded that country ownership is a contextual concept and that its interpretation is a function of the ability of Fund grantees (aid

recipient countries) to take up accountability and responsibility for Global Fund programmes (Global Fund, 2011).

From the foregoing discussion, it is clear that there is no uniform or collective interpretation of what the term 'country ownership' means in practice. Its meaning is subject to the interpretation of those who are expected to take up accountability and responsibility for Global Fund practice in specific contexts of global health. This implies that the application of country ownership is contextual due to significant variations in different country contexts. Each context generates its own accountability outcomes and implications. This means it is important to examine how the concept works itself out on the ground in particular contexts. The study therefore proceeds to examine the Ghanaian context with regards to the nature and character of the Ghana CCM. The outcomes the CCM practice generates and their accountability implications, particularly with regards to country ownership of health policy (the national HIV/AIDS response), will be analysed in subsequent sections.

6.4. The Ghana Country Coordinating Mechanism

As referenced in Chapter 5.3.1, the CCM is responsible for developing and submitting grant proposals and managing Global Fund grants in-country in specific settings of global health. The CCM nominates principal recipients (PRs) from among the CCM member institutions and organisations as the chief implementers of approved grants. The focus of this section is to introduce the Ghana CCM as the governance instrument for the realisation of country ownership. The section will give insights into its membership composition and the responsibilities that it undertakes.

The Ghana Country Coordinating Mechanism (CCM) of the Global Fund was established in 2002. As defined by its Constitution, the Ghana CCM consists of 25 members. These members are representative of three major sector constituencies which are Public Sector, Civil Society, and Multilateral & Bilateral agencies (Ghana CCM Governance Manual, 2015:2).

As can be seen from Table 6.1 below, civil society representatives dominate the composition of the membership of the Ghana CCM. The civil society sector has 14 representatives, the public sector has seven representatives, while the multilateral and bilateral agencies sector has four members (Ghana CCM Governance Manual, 2015). The dominance of civil society is in line

with the advocacy of the Global Fund that civil society should constitute not less than 40% of CCM membership as a requirement for grant eligibility (Tucker, 2012:4). However, this requirement is not necessarily enforced in all countries where the Fund practices.

Table 6-1: Membership composition of the Ghana CCM

Public Sector – 7 members	**Civil Society – 14 members**	**Multilateral & Bilateral agencies – 4 members**
Health sector (Ministry of Health /Ghana Health Service) - 2 members	Private sector (from service and business industry) - 2 members	Multilateral organizations - 2 members
Education sector - 1 member	NGOs/CBOs (recognized groupings in Health) - 4 members	Bilateral organizations - 2 members
Ghana AIDS Commission - 1 member	Professional Associations - 1 member	
Local Government - 1 member	FBOs (stakeholders such as Christian Council, Muslim Council and African Religion) - 1 member	
Gender, Children & Social Protection - 1 member	Persons living with or affected by the disease - 3 members	
Finance and Economic Planning - 1 member	Key Affected Populations - 1 member	
	Women and Children Interest Groups - 1 member	
	Academic and Research institutions - 1 member	

Sources: Ghana CCM Governance manual, 2015; Ghana CCM website

With regards to how sector representatives are chosen, the Global Fund CCM Governance Manual (2015) explains that sector constituencies determine who their representatives are with regards to the quota allotted to each constituency. Each constituency selects substantive and alternate members who are from different organisations. For example, if the civil society substantive member is from CSO A, then the alternate member must be from a different CSO.

The alternate member represents the constituency in the absence of the substantive member. Both the substantive and alternate members undergo the same selection processes (Ghana CCM Governance Manual, 2015).

Speaking from a broader perspective, McGill (2014) posits that in countries where government principal recipient(s) or government representatives dominate, the Global Fund has adopted a strategy to outbalance them by asking CCMs to choose more non-state actor representatives as principal recipients. Initially Ghana had only state principal recipients. Now they have up to four non-state principal recipients. As can be seen from Figure 6.2 below, a wide gamut of actors, both state and non-state, are nominated by the CCM as principal recipients in various rounds of award in Ghana.

Table 6-2: Grants awarded to Ghana principal recipients as of May 2019

Grant Award Date	Grant Number	Grant Rounds Awarded to Ghana	Disease Specific Area	Totals Amount Signed (USD)	Principal Recipient	Total Grant Amount Committed (USD)
12/12/2002	GHA-102-G01-H-00	1	HIV/AIDS	US$14,170,222	MOH, Ghana	US$14,170,222
12/12/2002	GHA-102-G02-T-00	1	TB	US$5,685,493	MOH, Ghana	US$5,685,493
1/7/2003	GHA-202-G03-M-00	2	Malaria	US$8,849,491	MOH, Ghana	US$8,849,491
08/02/2005	GHA-405-G04-M	4	Malaria	US$87,799,326	MOH, Ghana	US$87,799,326
01/05/2006	GHN-506-G05-T	5	TB	US$28,853,831	MOH, Ghana	US$28,853,831
01/05/2006	GHN-	5	HIV/AIDS	US$113,131,095	MOH,	US$113,131,095

	506-G06-H				Ghana	
01/01/2010	GHN-809-G11-H	8	HIV/AIDS	US$86,634,006	MOH, Ghana	US$86,634,006
01/01/2010	GHN-809-G10-H	8	HIV/AIDS	US$3,137,859	PPAG	US$3,137,859
01/01/2010	GHA-809-G07-M	8	Malaria	US$2,288,504	MOH, Ghana	US$2,288,504
01/01/2010	GHA-809-G08-M	8	Malaria	US$54,768,358	AGMAL	US$54,768,358
01/01/2010	GHN-809-G12-H	8	HIV/AIDS	US$20,706,365	GAC	US$ 20,706,365
01/01/2010	GHN-809-G09-H	8	HIV/AIDS	US$5,458,664	ADRA	US$ 5,458,664
01/07/2011	GHA-M-MOH	9	Malaria	US$180,817,857	MOH	US$145,255,822
01/07/2011	GHA-M-MOH	9	Malaria	US$ 97,429,746	MOH	US$ 84,355,245
01/10/2011	GHA-T-MOH	10	TB	US$ 32,616,275	MOH	US$ 32,610,053
01/07/2015	GHA-T-MOH	10	TB	US$ 54,627,656	MOH	US$ 44,771,568
01/07/2015	GHA-H-ADRA	13	HIV/AIDS	US$3,177,812	ADRA	US$3,177,812
01/07/2015	GHA-H-	13	HIV/AIDS	US$11,688,465	GAC	US$11,688,465

	GAC					
01/07/2015	GHA-H-MOH	13	HIV/AIDS	US$72,950,276	MOH	US$69,243,493
01/07/2015	GHA-H-PPAG	13	HIV/AIDS	US$1,569,910	PPAG	US$1,569,910
01/03/2015	GHA-M-AGAMal	13	Malaria	US$33,031,134	AGMAL	US$32,150,315
13/11/2017	GHA-H-WAPCAS 1658	?	HIV/AIDS	US$13,344,568	WAPCAS	US$5,944,148
01/01/2018	GHA-C-MOH 1625	?	TB/HIV/AIDS	US$76,502,454	MOH	US$29,435,941

Structure of table adapted from Barnes (2011). Source of grants: Global Fund Country Profile Page on Ghana.

The figure above highlights the volume of the Fund's allocation to Ghana, and the number of state and the non-state actor principal recipients. The state principal recipients include the Ministry of Health (MOH) and the Ghana Aids Commission (GAC). The grants allocated to the MOH are implemented on its behalf by the Ghana Health Services (GHS) which is an agency under the purview of the MOH (see Chapter 4.4.2 on the organisation of the health sector in Ghana). The non-state actor principal recipients encompass the West African Programme to Combat AIDS and STIs (WAPCAS), AngloGold Ashanti (Ghana) Malaria Control Limited (AGMAL), Adventist Development and Relief Agency of Ghana (ADRA) and the Planned Parenthood Association of Ghana (PPAG) (Global Fund Ghana Audit Report 2012c, 2014c, 2015).

The Global Fund is the biggest funder of the national HIV/AIDS response in Ghana and at present it has disbursed approximately US$804 million out of a total grant package of US$965 million officially signed between Ghana and the Fund (see Chapter 4.6). Some of the grants in the figure above are still active. This accounts for why in some instances, the amounts budgeted are not commensurate with the amounts committed because the grants are still work in progress.

As of December 2018, Ghana had been successful in about eight funding rounds and the Global Fund had invested a total of 771,266,402 million US$ dollars in Ghana (Ghana CCM, 2020).

6.5. Respondent Perceptions of the CCM in the Governance of Health with Regards to Country Ownership in Ghana

In Section 6.4 above, this study discussed the composition of the CCM and the responsibilities members undertake. In this section, this study will focus on respondent perceptions of the governance role of the CCM with regards to the country ownership of the HIV/AIDS response in Ghana. There are divergent perceptions of the CCM with regards to the issue of country ownership of the HIV/AIDS response in Ghana. Some respondents held a more formalistic perception of the CCM which relate to its functional attributes. For example, they viewed the CCM as a structure for program implementation in terms of expediting the delivery of treatment for HIV/AIDS, malaria and tuberculosis,[4] and as a forum which reads and vets programme reports.[5]

Other respondents seem to think that the CCM does successfully facilitate country ownership in a way which corresponds with the Global Fund's stated policy goals of promoting country ownership as a core principle of its accountability practice in aid recipient countries (see Chapter 5.3.1). In this vein, some government respondents expressed the view that country ownership is achieved as long as there is government leadership of the HIV/AIDS response.[6] Other government respondents noted that the CCM constitution states that the CCM Chair and Vice-Chair must be Ghanaian citizens.[7] Such respondents implied that as the CCM is typically chaired by Ghanaians (usually a representative from a government agency), it can be said that it promotes country ownership. Such respondents interpret the CCM as being a Ministry of Health-led institution or even a quasi-government organisation.

There were other respondents who also felt that the CCM does embody country ownership, but who thought about country ownership in a different way. These respondents seem to think that

[4] Interview 13 Feb. 2018 civil society respondent 7.
[5] Interview 16 Feb. 2018 civil society respondent 9.
[6] Interview 22 Feb. 2018 government respondent 1a; Interview 26 Feb. 2018 government respondent 2a.
[7] Interview 27 Feb. 2018 government respondent 3; Interview 28 Feb. 2018 government respondent 4; Interview 11 May.2018 government respondent 9.

the CCM does successfully facilitate country ownership due to its inclusive multisectoral outlook. In this context, some respondents' describe the CCM as a multisectoral platform that provides an avenue for civil society actors to be formally involved in health policy processes.[8] Other respondents noted that the CCM was a unique platform embedding state and non-state actors together and credit the Global Fund for creating a plural platform that opens up the decision-making space to marginalised groups such as civil society groups and Ghanaians living with HIV/AIDS, TB, and Malaria.[9] These are groups that have been historically side-lined in state health policy making and implementation agencies in Ghana. Respondents further noted that previously existing policy coordination mechanisms such as the health sector-wide approach (SWAp) and the Multi-Donor Budget Support System (MDBSS) as part of the national HIV/AIDS response only involved government agencies.[10]

There were also respondents from the private business sector who also acknowledge the Global Fund for giving private business sector players a formal role (through the CCM platform) to participate in health policy processes in Ghana such as the national response.[11] Embedded in the views of the CSOs and private business sector respondents is the belief that the CCM composition (encompassing state and non-state actors) has encouraged a downward shift in power relations and that entities outside government circles can now participate formally in health policy processes hitherto closed to them. Furthermore, two other respondents credit the Global Fund for encouraging gender affirmative action in CCM, acknowledging the substantial representation of women in the Ghana CCM.[12]

Overall, the perspectives of the respondents above resonate with the policy claim of the Global Fund that its adoption of a CCM governance strategy reflects its commitment to recipient

[8] Interview 6 Mar. 2018 civil society respondent 1; Interview 12 Mar. 2018 civil society respondent 3; Interview 15 Mar. 2018 civil society respondent 8.
[9] Interview 19 Mar. 2018 civil society respondent 2; Interview 22 Mar. 2018 civil society respondent 4.
[10] Interview 15 Mar. 2018 civil society respondent 8; Interview 19 Mar. 2018 civil society respondent 2; Interview 12 Mar. 2018 civil society respondent 3.
[11] Interview 17 May 2018 private business sector respondent 1; Interview 21 May 2018 private business sector respondent 2; Interview 23 May 2018 private business sector respondent 3.
[12] Interview 30 Apr. 2018 civil society respondent 17; Interview 1 May 2018 civil society respondent 18.

country ownership of its development strategies. Put clearly, these respondents suggest that the CCM is successful in achieving what the Global Fund indicates it intends to do; that is in using the instrument of the CCM in driving country ownership through broad-based participation.

In contrast to the perspectives of the respondents above, a number of other respondents were more critical in their views. These respondents see the CCM as an externally-conceived and designed instrument to preserve existing donor influence in aid delivery which does not promote country ownership. Such respondents argue that underneath the policy claim of country ownership, paternalistic perceptions about development still prevail among donors. For instance, some respondents posited that the CCM was externally conceived by the donor as a governance mechanism and that recipient countries (Ghana in this context) had not requested it.[13] Clearly implied in the view of these respondents is that the CCM is a donor-mandated requirement. In narrating their experience in relating to the CCM, two other respondents observed that the preparation of proposals was a key function of the CCM as without it, no funding can come from the Global Fund.[14] This view was due largely to the fact the Global Fund's call for grant proposals required that proposals be submitted through the CCM. Taken together, the views of these respondents suggest that the CCM is reminiscent of traditional donor-recipient country relations in which donors design and designate implementation structures in recipient countries.

In sustaining the criticism of the CCM as a donor imposition, there were other respondents that saw the CCM as a duplication of already existing national coordination structures for the HIV/AIDS response in Ghana. One respondent stated that the CCM duplicates to varying degrees these pre-existing coordination mechanisms already involved in Ghana's HIV/AIDS response.[15] This view is shared by several other respondents.[16] Such coordination structures for

[13] Interview 8 Mar. 2018 government respondent 1b; Interview 14 Mar. 2018 government respondent 2b; Interview 27 Mar. 2018 aid agency respondent 1.
[14] Interview 18 May 2018 government respondent 11; Interview 9 Apr. 2018 aid agency respondent 3.
[15] Interview 16 Feb. 2018 government respondent 5a.
[16] Interview 9 May 2018 government respondent 5b; Interview 26 Apr. 2018 government respondent 6a; Interview 8 Mar. 2018 government respondent 1b; Interview 14 Mar. 2018 government respondent 2b; Interview 30 Apr. 2018 government respondent 6b; Interview 12 Apr. 2018 aid agency respondent 4; Interview 16 Apr. 2018 academic respondent 1.

the HIV/AIDS response include the Ghana AIDS Commission, the health sector-wide approach (SWAp) and the Multi-Donor Budget Support System (MDBSS) (See Chapter 4.5).

Apparently reflecting their doubts and misgivings with regards to the role of the CCM as an instrument for the realisation of country ownership, some other respondents asserted that the inclusion and funding of civil society actors in the CCM have not necessarily guaranteed democratic participation as intended by the Global Fund. They argued that the development process of the concept note is a technical consultant driven process and that this process shuts out those who lack technical knowledge, thus calling into question the participatory and democratic accountability of the CCM.[17] Still on the issue of effective representation and participation in CCM deliberations, some respondents averred that it was problematic to identify who these CSOs report to within their professed constituencies, the nature of consultation and dialogue between CSOs and their constituents and the nature or forms of feedback received.[18] Some respondents also raised questions regarding gender balancing and a lack of emphasis on gender-related issues in the CCM.[19]

Another concern raised by some respondents was that they felt that the embedding of non-state actors into the health policy processes undertaken by the CCM such as the national HIV/AIDS response is part of the neoliberal push, driven by donors, towards the hollowing out of the state in healthcare provisioning.[20] There were also respondents further who expressed misgivings with the CCM practice of using technical assistance provided by donors in the writing of grant proposals. These respondents are of the view that the nature and character of technical assistance provided by donors undermine country ownership.[21]

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[17] Interview 23 Apr. 2018 academic respondent 2; Interview 24 Apr. 2018 academic respondent 3.

[18] Interview 16 Apr. 2018 academic respondent 1; Interview 23 Apr. 2018 academic respondent 2; Interview 24 Apr. 2018 academic respondent 3.

[19] Interview 30 Apr. 2018 civil society respondent 17; Interview 01 May 2018 civil society respondent 18.

[20] Interview 8 Mar. 2018 government respondent 1b; Interview 14 Mar. 2018 government respondent 2b; Interview 04 May 2018 government respondent 7.

[21] Interview 26 Apr. 2018 civil society respondent 15; Interview 26 Apr. 2018 civil society respondent 16.

There was also a respondent who argued that the CCM has become a locus of agenda-setting and decision-making in key facets of the national response beyond the prevention and treatment of the diseases under the Fund's mandate.[22] The respondent's comment refers to the Fund's adoption of a national strategy approach that encouraged country dialogue (stakeholder discussion) in the grant proposal (now referred to as concept note under this national strategy) development process (see Chapter 5.3.3). Furthermore, another respondent indicated that the process of developing concept notes was characterised by excessive English language technicalities. According to this respondent, the wordings of technical information and policy ideas in the concept note undermined ownership and accountability because it makes it difficult for those at the grassroots to be informed and involved.[23]

In summing up this section, it is clear that the role of the CCM as an instrument for the realisation of country ownership in Ghana is contentious. It is subject to the different interpretations, worldviews, expectations and understandings of the country-level participants involved in the HIV/AIDS response in Ghana. While some respondents seem to think that the CCM does successfully facilitate country ownership in a way which is aligned with the Global Fund's stated policy goals, others who are more critical suggest that it does not. This raises questions about the disjuncture between the Global Fund policy objectives and the practice outcomes in relation to the country ownership of the HIV/AIDS response in Ghana. It is in this context that Smith (2014) observed that the contradictions between stated aims (policy goals) and outcomes (practice) need to be critically analysed and in so doing we should pay attention to the interests that congregate within institutional (organisational) arrangements.

6.6. Global Fund Institutional Arrangements, the Ghana CCM and Country Ownership

In section 6.5 above, this study discussed the divergent respondent perceptions of the CCM with regards to the issue of country ownership of the HIV/AIDS response in Ghana. It concluded by alluding to the possible disjuncture between the Global Fund's stated policy goals and practice outcomes. In order to further explore this possible disjuncture, this section will critically examine in detail the governance practice of the Ghana CCM and the outcomes it generates as an instrument for the realisation of country ownership. As a signatory to the Paris Declaration and

[22] Interview 18 Apr. 2018 academic respondent 4.
[23] Interview 26 Apr. 2018 civil society respondent 18.

the Accra Agenda for Action, the Global Fund has committed to giving not just governments, but also the citizens of aid recipient countries (directly or through their representatives) a voice in health policy processes that affects their existence. This section explores whether governments and their citizens do indeed own their health policy processes.

In Chapter 5.3.1, this study asserted that the emphasis of governance accountability policy is on the governance architecture (e.g. the Board and the CCM) in relation to who is included (or excluded) from participating in the decision-making processes (such as agenda-setting and policy formulation). Therefore, in appraising the activities of the CCM in relation to the ownership of the HIV/AIDS response in Ghana, it becomes germane to analyse and pay close attention to how the HIV/AIDS response agenda is shaped and set. For example, who has the CCM assigned a say (voice) and a role (participation) in how the HIV/AIDS response agenda is shaped and set? What roles do they play in this process and how? Also, in order to understand how the response agenda is shaped and set, it will be imperative to keep an eye on how the CCM interacts and interfaces with other institutional accountability structures of the Global Fund involved in the HIV/AIDS response.

6.6.1. The Ghanaian CCM practice, agenda-setting and government ownership of the HIV/AIDS response

As discussed above in the preceding section, some respondents equate country ownership with the Ghanaian government leadership of the HIV/AIDS response. This is because the CCM constitution, in the spirit of country ownership, mandates the CCM Chair and Vice-Chair to be Ghanaian citizens[24]. The CCM Chair is normally retained by a government agency, usually the Ministry of Health (MOH). However, this study notes that while the Ministry of Health is in charge of the oversight of health sector programs, the CCM (which is not a government agency) rather than the Ministry of Health itself, is the secretariat for proposal development, agenda-setting and implementation of Global Fund grants for the HIV/AIDS response. In this vein, some respondents interviewed regarded the CCM as undermining ownership by duplicating to varying degrees pre-existing national coordination mechanisms, some of which are already coordinating

[24] Interview 22 Feb. 2018 government respondent 1a; Interview 26 Feb. 2018 government respondent 2a; Interview 27 Feb. 2018 government respondent 3; Interview 28 Feb. 2018 government respondent 4; Interview 11 May.2018 government respondent 9.

Ghana's HIV/AIDS response.[25] Some of these structures include the health sector-wide approach (SWAp) under the Health Ministry, the Ghana AIDS Commission, the sector budget support (SBS) and the Multi-Donor Budget Support System (MDBSS) (See Chapter 4.5).

Therefore, this study takes the position that a fundamental contradiction exists between the claim that the CCM promotes country ownership and the way in which the CCM bypasses formal institutions of government with which it is supposed to be aligned. As corroborated by Atun (2011), the CCM is solely responsible for overseeing Global Fund grants and is viewed as duplicating prevailing government coordination structures of the national HIV/AIDS response in Ghana (Atun (2011:73). The Global Fund itself in its policy documentation stated that it would 'build on existing coordination mechanisms, in [recipient countries] where none exist' (Global Fund, 2005a:1). The key question to ask then is: are there no existing coordination mechanisms in Ghana that necessitated the use of the CCM structure by the Global Fund? The preceding analysis above shows that there were pre-existing national coordination mechanisms already coordinating Ghana's HIV/AIDS response.

Objective 2 of the Paris Declaration states that donors should help to improve partner country capabilities by aligning aid with their priorities, systems and performance rather than creating parallel structures which defeat the objectives of country ownership. The Fund board also commits to aligning Global Fund practice with existing national coordination mechanisms where they exist in recipient countries (Global Fund, 2007b, 2007d). But, this has not happened in Ghana where a CCM has been set up despite the existence of other coordination mechanisms. Furthermore, there are no indicators or proposed sanctions embedded in the Paris Declaration showing how recipient country governments can hold 'erring' donors to account who create parallel structures and do to not align and harmonise with national systems. It was in this vein that Buiter (2007) posits that it is very simple for global health organisations (such as the Global Fund) to say that they aim to promote and conform with country ownership frameworks and

[25] Interview 16 Feb. 2018 government respondent 5a; Interview 9 May 2018 government respondent 5b; Interview 26 Apr. 2018 government respondent 6a; Interview 8 Mar. 2018 government respondent 1b; Interview 14 Mar. 2018 government respondent 2b; Interview 30 Apr. 2018 government respondent 6b; Interview 12 Apr. 2018 aid agency respondent 4; Interview 16 Apr. 2018 academic respondent 1.

goals if there are no clear indicators to hold them accountable if they fail to comply with country ownership principles.

Another concern regarding country ownership of the HIV/AIDS response through government leadership of the CCM chairmanship, relates to claims by some respondents that the CCM discussion on agenda setting of Ghana's health priorities is not only initiated from within the country, but also initiated from outside. One of the respondents asserted that concept notes (formerly known as grant proposals) detailing Ghana's agenda and strategies for the HIV/AIDS response are influenced by outside forces such as the Global Fund country teams and he gave an example to buttress his view. In his words:

> For example, in the application for health system strengthening, the Ghana CCM wanted the Global Fund to fund different/ additional RSSH [Resilient and Sustainable Systems for Health] investment areas based on its assessment of local priority. However, the Global Fund country team thought differently and steered it to focus on other areas.[26]

Country ownership is thus potentially undermined by the existence of Global Fund country teams. These are teams set up by the Fund Secretariat to manage grants allocated to each country. For example, the Secretariat will set up a Ghana country team, a South Africa country team and so on. These teams are based in the Secretariat in Geneva, but also visit the relevant country on behalf of the Secretariat from time to time. Such 'outside' influences are not accountable to the Ghanaian government nor to its citizens, but certainly exert influence in the agenda-setting of the national HIV/AIDS response. From an accountability prism, Global Fund country teams report solely to the Fund Secretariat.

Another respondent, in supporting claims of external influence in shaping the ownership of the HIV/AIDS response, passionately spoke about what he described as the overbearing role and influence of the Technical Review Panel (TRP) of the Global Fund in agenda-setting.[27] As articulated by him:

> Through its role in the application process made by CCM to the Global Fund, the Technical Review Panel of the Global Fund helps to set and shape the agenda of the Ghana CCM, thereby influencing Ghanaian national health priorities irrespective of the role and headship of the Ministry of Health in the CCM... Ghana has had proposals

[26] Interview 16 Apr. 2018 academic respondent 1.
[27] Interview 23 Apr. 2018 academic respondent 2.

> rejected before by the TRP in three Global Fund funding rounds between 2002 and 2004 because they were deemed ineligible for funding by the TRP… The TRP decides what to approve, accept or reject based on technical criteria and not necessarily based on knowledge of local contexts such as in Ghana.

From the above statement, the TRP is empowered to decide which proposal is to be approved, adjusted, resubmitted or revised and which should be denied. Its power to revise, adjust, or even reject proposals and ask for resubmissions places it in the position to set and influence the health priorities of countries seeking the Global Fund grants. This can be gleaned from the fate of the CCM proposals submitted by Ghana between 2002 and 2004 cited in the quote above. This study avers that this kind of power vested in the TRP in its relations with the CCM undermines the Global Fund's practice ethos of country ownership. While the TRP exerts influence in shaping Ghana's health agenda from outside, it is not accountable to the CCM, while holding the CCM to account via its role in the Global Fund application process. There are no lines of accountability through which the TRP can be held accountable by either the government of Ghana or Ghanaian citizens. The TRP is solely accountable to the Global Fund Board (see Chapter 5.4.2). A decision point contained in the seventeenth board meeting report of the Global Fund shows how the TRP can negate country ownership in recipient countries. The decision point states that the TRP can accept or reject proposals based on their technical judgement with regards to the strength or weakness of the proposal (Global Fund, 2008b). The catch here is that it is the TRP that defines what should be considered major or weak and makes a decision on what should be eliminated in country proposals, despite not understanding a country's context and its peculiarities.

According to some respondents, the CCM has become a locus of decision making in key facets of public health agenda-setting and decision-making.[28] This is due to a new funding model adopted by the Global Fund which embeds a national strategy approach to drive health systems strengthening (HSS) (see Chapter 5.3.3). The HSS national strategy empowers the Global Fund to finance aspects of the response beyond a focus on the prevention and treatment of the three diseases (HIV/AIDS, TB and Malaria). Such areas covered by the HSS include supply chain management, workforce capacity development, financing the building of hospital facilities and the purchase of hospital equipment. The national strategy approach also empowers the Fund to contribute to maternal and newborn and child health (see Chapter 5.3.3). From an accountability

[28] Interview 18 Apr. 2018 academic respondent 4; Interview 8 Mar.2018 government respondent 1b; Interview 14 Mar. 2018 government respondent 2b.

prism, the move to a national strategy approach has two accountability implications for Ghana. These two accountability implications were also noted by Walker (2012) in a different context, but apply equally well in the Ghanaian context. Firstly, it illustrates that the state (in this case, Ghana) recognises the Global Fund's legitimacy and ability to influence the broader health agenda through health system strengthening into areas such as maternal and child beyond a focus on HIV/AIDS, Tuberculosis and Malaria (Walker, 2012:239-240). Secondly, the CCM has become a locus of decision making whose influence extends into sectors which was formerly the sole purview of the Ministry of Health (Walker, 2012:239-240).

6.6.2. The Ghanaian CCM practice, agenda-setting and ownership of the HIV/AIDS response by those affected by the diseases

In Section 6.2, this study took the position that while, country ownership can be understood to narrowly refer to government ownership, but it can also be more broadly understood to encompass ownership by citizens affected by the diseases. In 6.6.1, I discussed country ownership as it relates to the government. Now, in 6.6.2, I will shift the focus to ownership of the HIV/AIDS response by citizens (those affected by the diseases).

The Global Fund claims that CSO participation in its governance institutional policy and practice arrangements strengthens the accountability link between it and citizens of recipient countries affected by the diseases (Smith, 2014; Global Fund, 2018a). As discussed in Section 6.5, some respondents credit the CCM's multisectoral outlook for providing an avenue for civil society actors to be formally involved in health policy processes.[29]They credit the Global Fund for creating a plural platform that gives a voice and opens up the decision making space to marginalised groups such as civil societies and Ghanaians living with HIV/AIDS, TB, Malaria. These are groups that have been historically side-lined in government health policy decision-making and implementation agencies in Ghana. These respondents believe that the CCM composition (encompassing state and non-state actors) has encouraged a downward shift in power relations and that entities outside government circles can now play a participatory role in public health policy-making activities hitherto closed to them. This was in line with the calls

[29] Interview 6 Mar. 2018 civil society respondent 1; Interview 12 Mar. 2018 civil society respondent 3; Interview 15 Mar. 2018 civil society respondent 8; Interview 19 Mar. 2018 civil society respondent 2; Interview 22 Mar. 2018 civil society respondent 4.

made by activist NGO's to the donors who constructed the Global Fund to adopt a more inclusive framework (see Section 3.4.6).

Some respondents observed that previously existing coordination mechanisms such as the health sector-wide approach (SWAp) and the Multi-Donor Budget Support System (MDBSS) as part of the HIV/AIDS response only involved government agencies such as the Ministry of Health and the Ministry of Finance.[30] There was no space on these coordination mechanisms for civil society representation or participation in health policy-making activities. This led to feelings of exclusion, especially among Ghanaians living with the diseases and feelings of frustration among civil society groups who advocate on their behalf. But the CCM has provided an inclusive platform they lacked under the other government-led arrangements as both those living with the diseases and civil society organisations are represented.

While this study concedes that the CCM practice may go some way to make some civil society officials feel more included and empowered, it is important to recognise that expanding the discursive space for wider participation through civil society does not necessarily mean that the voices of the marginalised will actually be attended to in agenda-setting in the Ghana CCM. It was in this context that other respondents, picking up on the theme of participation, highlight some challenges that CSOs have experienced within the CCM. They pointed out that the CCM appears to function simply as a platform to apply for Global Fund grants and that the involvement and voices of those living with the diseases were often subdued and unheeded.[31] They stated that this negated the original conceptualisation of the CCM as a deliberative and inclusive platform where critical decisions regarding agenda setting (and its implementation) are made. In further articulating their position, they postulated that the CCM lacks participation and direct representation from key affected populations (KAP). The key affected populations (KAPs) like the Women having Sex with Women (WSW), Men having Sex with Men (MSM) and Sex Workers (SW) mentioned are represented by proxy through advocacy groups such as the West African Program to Combat AIDS and STI (WAPCAS), and other proxy groups. This viewpoint

[30] Interview 15 Mar. 2018 civil society respondent 8; interview 19 Mar. 2018 civil society respondent 2; Interview 12 Mar. 2018 civil society respondent 3.
[31] Interview 16 Apr. 2018 academic respondent 1; Interview 23 Apr. 2018 academic respondent 2; Interview 18 Apr. 2018 academic respondent 4.

is sustained by Arthur et al. (2017: 10) who aver that the Ghana CCM does not directly interface with these KAP groups. Groups like this are simply assumed to be represented by NGOs and do not have the opportunity of participating directly. This is because state laws in Ghana do not grant legal status or recognition to the existence of these groups in the Ghanaian health system.

Still on the issue of effective grassroots representation and participation in CCM deliberations, some respondents averred that it was difficult to identify who these CSOs report to within their professed constituencies and the nature or forms of feedback received. In this vein, one of these respondents posited that there was insufficient indication of actual communication between some CCM civil society representatives (CSOs) and the grassroots constituents they claim to represent.[32] This led to a gap in information sharing required for holding CCM decision-makers to account. He blamed this information gap on inadequate structural mechanisms that enable the general public to interact with the CCM and influence its agenda. Another of these respondents noted that it was difficult to identify the nature of consultation and dialogue between CSOs and their constituents.[33] In buttressing his position, he explained that when developing proposals (concept notes), CCM representatives are supposed to get feedback from their constituents and to reflect their constituents' views and needs in the concept note developmental process which is the basis of agenda-setting, but that they hardly ever do that. He also postulated that most of these CSOs and their representatives are not known by the professed constituencies they claim to represent.

When asked about this issue of effective grassroots representation and participation in CCM deliberations (discussed above), another respondent claimed that CSOs ability to consult with their constituencies was limited by their weak financial positions and poor or inadequate communication facilities.[34] For instance, it is difficult for them to reach remote rural communities, locations and households. He thus asserted that because of these limitations, consultation was usually restricted to accessible communities, especially those based in urban locations. The assertion by this respondent raises questions about whether these CSOs actually

[32] Interview 15 Mar 2018 civil society respondent 8.
[33] Interview 16 Apr. 2018 academic respondent 1.
[34] Interview 26 Apr. 2018 civil society respondent 15.

represent broader citizen constituencies or if they are solely guided by their own organisational interests and financial limitations in choosing which communities to consult with or not.

This question becomes pertinent because another respondent noted that access to the CCM membership is limited to a select or closed group of CSOs.[35] He further opined that this lack of participation and representation of constituencies beyond a chosen group of CSOs as members of the CCM gives some of these CSOs the belief that they are in a position to choose their degrees of participation and representation relative to the needs and interests of the constituencies that they claim to represent. He described these CSOs included in the CCM membership as a kind of 'old boys club' interested in maintaining their individual organisational interests by drawing on networks of influence and established relationships as CCM members. It is also pertinent to add here that there are respondents who aver that the inclusion and funding of civil society actors in the CCM as principal recipients (PR) is not necessarily about guaranteeing democratic participation as claimed by the Global Fund.[36] Rather, it is viewed as a mechanism adopted by the Fund as part of the neoliberal push (driven by donors) towards the hollowing out of the state in healthcare provisioning.

It is important to consider that the inclusion and funding of civil society actors in the CCM as principal recipients (PR) could account for the closed nature of CCM CSO membership because the implementers of global fund grants as non-state Principal Recipients (PR's) are drawn from the CCM CSO membership list. This means that participating CSOs gain access to Global Fund grants. According to Arthur et al. (2017), non-CCM CSO organisations were of the belief that CCM members influenced grants to go specifically to the organisations they represent and that their actions do not reflect public interest, but rather their individual interest (Arthur et al, 2017: 11 - 13). This view was supported by one of my respondents who argued that CSOs are all too busy seeking funding contracts, monies (grants) and implementing Global Fund programmes rather than undertaking the activist and advocacy roles that underpin their legitainacy. He futher posited that these CSOs are neither accountable to the communities they claim to represent nor to the government who do not fund them, but to the Global Fund Fund through whom they get

[35] Interview 26 Apr. 2018. civil society respondent 16.
[36] Interview 8 Mar. 2018 government respondent 1b; Interview 14 Mar. 2018 government respondent 2b; Interview 4 May 2018 government respondent 7.

grants to sustain their livelihood and legitimacy.[37] This repondent's observations raise the question of whether CSOs can still play the activist and advocacy role that underpins part of their legitimacy in developmental work now that they are implementers of Global Fund grants.

Respondents also credit the Global Fund for encouraging gender affirmative action in CCM, acknowledging the substantial representation and participation of women in the Ghana CCM. The Global Fund's updated rules and procedures on CCMs encourage CCMs to pursue gender affirmative action (Global Fund, 2005b). In addition, the Global Fund's Revised Guidelines on CCMs states that the Fund specifically encourages CCMs to aspire and to pay attention to gender balancing in the composition of CCMs (Global Fund, 2015). Securing gender balance is thus conceived by the Global Fund as an essential element in improving representation and participation in the CCM (Global Fund, 2015). In this context, a respondent asserted that female CCM members work in their organisational rather than individual capacity; therefore gender balance at any given time depends on who attends a specific CCM meeting.[38] Implied in the respondent's comment is that gender balance shifts depending on who a CCM member organisation delegates to represent them at particular meetings. For example, if these member organisations delegate more female representatives, gender balance improves. On the other hand, if more men are appointed, gender balance decreases. Meanwhile, a different respondent particularly stated that gender balancing or parity was not the central issue in the CCM, but what was more important to her was whether gender-related issues are prioritised or discussed by members within the CCM.[39] According to her, while gender-related issues are discussed in agenda setting, there is no attempt to capture gender-segregated data (that speaks to specific gender-related issues) that that is needed to guide agenda (programme) implementation.

Within countries such as Ghana, technical agency experts are often officially engaged by CCM's to assist in writing concept notes (formerly referred to as grant proposals). Consultants can be from bilateral agencies or multilateral agencies. Therefore, some respondents noted that the CCM agenda-setting process is fundamentally a consultant-driven process. Significantly, a

[37] Interview 8 Mar. 2018 government respondent 1b.
[38] Interview 30 Apr. 2018 civil society respondent 17.
[39] Interview 1 May 2018 civil society respondent 18.

respondent observed that numerous consultants are involved in the process.[40] In this context, another respondent also observed that these consultants can also use their position in the concept note development process to frame the agenda in a way that reflects their preferences as supported by the international agencies or foreign governments they represent.[41] He queried whether the CSOs and representatives of those affected can advance their own concerns and agendas for input into the agenda setting process with regards to these external advisors.

The provision of technical assistance in development aid delivery in recipient countries as a basis of donor-recipient country relations post-Paris Declaration is common. However, as shown above, the provision of longer-term technical assistance through those relationships act as a donor conduit of influence on agenda-setting. Technical assistance opens the door for 'outside' influence to shape agenda-setting and limit the influence of the Ghanaian voice, raising questions with regards to notions of accountability. As argued more broadly by Clinton (2014), in 2008 the Global Fund's Board technical assistance working group recommended that CCM representatives from donor countries were encouraged to be involved in technical assistance, whereas representatives from recipient countries were not drawn on in this way. Thus, the technical assistance programmes of the Fund relied heavily on bilateral donors who provided support. Warren et al. (2017), argue that the reliance of the Global Fund on bilateral donors for technical support was a win-win for both parties (the Fund and bilateral donors) because as donors who sit on the Fund board, they have a vested interest in the Funds operations and their investment in it. In articulating the scope of bilateral technical support for the Fund, Clinton (2014) further states that in 2005, the Fund Secretariat undertook an analysis of multilateral and bilateral aid agency representation on CCM's worldwide. In discussing the outcome of this analysis undertaken by the Fund Secretariat, She posited that:

> In Round 1, USAID [United States Agency for International Development] served on 35% of CCMs, GTZ [German Technical Cooperation Agency] 11%, JICA [Japan International Cooperation Agency] 5%. For Round 2 grants, as the number of CCMs rose from 38 to 91, USAID served on 26%, DFID [British Department for International Cooperation] 12%, the French Cooperation Agency on 10%, JICA on 9% and GTZ also on 9%. On the 78 successful CCMs in Round 4, USAID served on 42%, the French Cooperation Agency 21%, GTZ 15%, DFID 13%, JICA 14% and Peace Corps 3%; through USAID and the Peace Corps, the U.S. sat on close to half of CCMs. WHO and

[40] Interview 26 Apr. 2018 civil society respondent 16.
[41] Interview 16 Apr. 2018 academic respondent 1.

> UNAIDS routinely served on more than three-quarters and one-half of CCMs respectively. **Neither in this report or elsewhere does the Secretariat wonder whether the inclusion of bilateral and multilateral agencies on CCMs weakened the central mission of CCMs: to enable recipient countries to 'own' their grant writing and implementation (**2014: 301, emphasis mine).

Therefore, it could be said that technical assistance is one way in which donors exhibit their expertise and impose their authority (Clinton (2014). Such assistance can shape the interests of states and their identities; a development that occurs partly through the supply-driven nature of most technical assistance (Clinton, 2014: 305). Recipient countries accept what donors or multilateral agencies offer, not necessarily what they themselves want (Clinton (2014: 305). In the Ghanaian context, the multilateral and bilateral institutions sitting in the Ghana CCM (as part of the representatives of stakeholder groups in the health sector, see Table 6.1) are not accountable to the government of Ghana or to Ghanaians. While multilateral partners are accountable to their governing boards in western capital cities, bilateral partners are accountable to their home governments; the majority of which are on the board of multilateral institutions generally and the Global Fund in particular.

A related issue raised by some respondents relates to what they felt to be excessive technical and bureaucratic language in Global Fund policy documentation that guides the concept note development process.[42] They argued that the wording of technical information and policy ideas are targeted to meet the demands of donors (who place emphasis on technical and bureaucratic language). Technical reports adopted to guide and explain policy ideas in the agenda-setting process were defined by them as extensive and employing difficult expressions that negated a simple understanding of the information underpinning policy options. As one respondent explained, the technicalities of these reports make it difficult for those at the grassroots to be informed and involved.[43]

This study argues from an accountability dimension that an inability to engage with content due to excessively technical language is an obstacle to meaningful participation and ownership by those affected by the activities funded by the Global Fund. The technicalities of these reports make it difficult for those at the grassroots to be informed and contribute to the policy (agenda)

[42] Interview 26 Apr. 2018 civil society respondent 18; Interview 16 Apr. 2018 academic respondent 1.
[43]Interview 26 Apr. 2018 civil society respondent 18.

development process. Writing more broadly about the power of language as an instrument of accountability with regards to ownership, Esser (2014: 46) asserts that 'it is in the politics of language that policy is made'. Writing about their experience in Cambodia and Pakistan, Khan et al. (2018:219) posit that the language through which technical information is presented disadvantages local policy actors and reinforces the influence of donors. Smith (2014: 202) observes that Global Fund documents are notorious for their density, technicality and complexity and that this creates accountability barriers (2014: 202). By disseminating material in less technical and more readable formats, the Global Fund could improve accountability relations between the Fund and the direct beneficiaries of its programmes in aid recipient countries (Smith, 2014).

In summing up this section, when all the factors that shape the CCM's practice of country ownership (and its attendant accountability implications) are considered together, we are reminded of Gill's (1995, 1998, 2003) concerns about 'new constitutionalism'. Gill (1995, 1998, 2003) uses this term to refer to the growing institutionalisation of neoliberal frameworks in the system of global governance associated with a neoliberal restructuring of the global political economy (see Chapter 2.4). As Brown (2012) posits, these neoliberal frameworks that underpin 'new constitutionalism' could be quasi-constitutional, constitutional or governing agreements and frameworks (such as the CCM). As Brown (2012) further postulates, domestic autonomy over national policy choices and planning is constrained when states sign up to these kinds of regulatory agreements and frameworks (like the CCM in Ghana). This takes us back to Cox's (1981) argument that institutions are constructed to maintain and deepen the ideological norms of any given world order (see Chapter 2.4). This study takes the position that what this implies is that institutions like the Global Fund promote policies such as country ownership in order to deepen the ideological norms of the neoliberal world order and discourage resistance to it through the promise of local empowerment of country-level actors even while such empowerment does not necessarily follow. As Harman (2015) reminds us, shifts in the nature and character of government structures in Africa (such as the inclusion of non-state actors) should not be viewed in isolation as just another phase in policy processes in sub-Saharan Africa. Rather such actions should be understood as being targeted at changing state behaviour and practices in developing countries with regards to how policies are made and implemented as part of the so-called 'good governance' reforms championed by the World Bank since the 1990s.

6.7. Discussion and Conclusion

This chapter set out to examine and address the second research objective of this study which is to investigate how the Global Fund's policy understanding of accountability works itself out in practice in Ghana, in particular in relation to its implications for country ownership of the national HIV/AIDS response policy. The country coordinating mechanism (CCM) is the governance instrument for the realisation of country ownership in practice in aid recipient countries such as Ghana. As noted in Section 6.2, the discourse of country ownership is symbolised by the Paris Declaration on aid effectiveness (and its follow up Accra Agenda for Action). Both the Declaration and the Agenda are indicative of how country ownership is supposed to drive aid effectiveness. The notion is intended to represent a positive change beyond the contentious days of aid conditionality exemplified by policies such as structural adjustment programmes (SAPs). It signals the belief that recipient countries (both in terms of their governments and their citizens) should lead and control the design of externally funded programmes.

However, whether or not this change is realised or how it is realised in practice is another matter. It is only in practice at country level that the claim of the Global Fund to promote country ownership of health policy through its adoption of a country coordinating mechanism (CCM) can be assessed. In this context, this study discussed the Ghana CCM in Section 6.4 in order to understand its composition and appraise its responsibilities in the governance of the national HIV/AIDS response. In Section 6.5, I presented divergent respondent perceptions of the CCM in the governance of health with regards to country ownership of the HIV/AIDS response. Some respondents felt that the structure and practice of the CCM does promote country ownership, while others were more sceptical and critical. Based on these divergent respondent perceptions, I argued that there is a possible disjuncture between the Global Fund's stated policy goals of promoting country ownership and practice outcomes in Ghana. In order to further explore this possible disjuncture arising from respondent perceptions of the governance practice of the CCM, this study in Section 6.6, engaged in a detailed examination of the governance practice of the Ghana CCM as an instrument for the realisation of country ownership. In so doing, I paid attention to how the HIV/AIDS response agenda is set and shaped. For example, who has the CCM assigned a say (voice) and a role (participation) in how the HIV/AIDS response agenda is shaped and set? What roles do they play in this process and how? I also kept an eye on how the

CCM interacts and interfaces with other institutional structures of the Global Fund involved in the national response.

In articulating the findings of these study (detailed in Section 6.6) in relation to the research objectives of this chapter, this study found that a fundamental contradiction exists between the Global Fund's claims to promoting country ownership and their practice of bypassing the existing government coordination mechanisms which were already coordinating Ghana's HIV/AIDS response. The CCM, taken holistically as a decision-making structure on its own does not report to the state, yet it duplicates work already being done by the Ghanaian state.

This study also finds that contradictions remain between the rhetoric of country ownership and the powerful role of principal head office accountability structures of the Global Fund, such as the technical review panel (TRP). The power of the TRP to approve, reject, amend, revise or fund country proposal gives the TRP an overarching influence on recipient country agenda-setting activities. As demonstrated above, the TRP exerts influence in shaping Ghana's health agenda from outside, yet it is not accountable to the CCM but is itself able to hold the CCM to account via its role in the application process. The TRP is also not accountable to the Global Fund secretariat or even the government of Ghana or her citizens affected by the diseases, but is solely accountable to the Global Fund Board.

Further findings indicate that the Ghana CCM assigns a role to a wide gamut of state, non-state, national and international actors. However, while the government agencies that are (or have been) CCM members are accountable to the government in the spirit of democratic accountability between a government and its agencies, the key question to ask is: who holds the Global Fund country team accountable? In addition, who holds the multilateral and bilateral actors operating in the CCM accountable? Are they accountable to the government or Ghanaians? The answer seems to be no. The Global Fund country team is solely accountable to the Fund Secretariat. The Secretariat, in turn, is accountable to the Fund Board. The various multilateral partners are accountable to their governing boards, while the bilateral agencies report to their home governments. There is little accountability to the Ghanaian government or citizens.

While these bilateral and multilateral institutions are on the CCM mainly as technical assistance providers, this study finds that technical assistance provides a channel to influence agenda-

setting. Technical assistance opens the door for 'outside' influence to shape agenda-setting and limit the influence of the Ghanaian voice, raising questions with regards to notions of ownership and accountability. As noted by Chelsea (2014), technical assistance can be a way in which donors exhibit their expertise and then impose their authority. Such assistance can shape the interests of states and their identities; a development that occurs partly through the supply-driven nature of most technical assistance. Recipient countries accept what donors or multilateral agencies offer, not necessarily what they themselves want. Furthermore, the study finds that the Global Fund's move into health systems strengthening (as a consequence of its adoption of a new funding model which embeds a national strategy approach), imbues the CCM with influence which extends into the broader governance of the response thereby raising questions with regards to who governs the HIV/AIDS response.

In relation to the CCM practice, agenda-setting and ownership of the HIV/AIDS response by those affected by the diseases, this study finds that claims that civil society organisations (CSO) are responsive, representative of and accountable to broader communities of affected citizens in Ghana are overstated. Evidence adduced shows that rhetorical commitment to wider participation of such communities through civil society has not necessarily meant that the voices of the marginalised have indeed been heard in decision-making and agenda-setting in the Ghana CCM. Constituents require consistent communications channels with their CCM representatives and also information on their performance on the CCM to hold them to account and influence agenda setting. CSOs do not always disseminate such information and even when they do, the technical nature of Global Fund policy documents limits meaningful participation of broader communities. The absence of such accountability conduits constrains the bottom-up and inclusive approach that is supposed to reflect the voice of grassroots communities of affected citizens and stifles the possibility of their input in agenda-setting. Furthermore, the 'closed old boys network' nature of CCM membership meant that accountability was more horizontal (between them) than to the constituents they claim to represent. As discussed, CSO representatives are principal recipients of the Fund who undertake grant implementation. As will be discussed in Chapter Seven, the Global Fund signs grant implementation agreements directly with the principal recipients; not with the CCM or the government. This ensures that the CSOs are directly accountable to the Global Fund.

When all the findings of this study are taken together, this study takes the position that crucial to understanding how the institutional policy and practice arrangement of the Global Fund impact and shape country ownership is the agency and power of the Global Fund Board. The agency and power of the Global Fund Board are crucial for understanding the power relations and context within the Fund (discussed in broader detail in Chapter Five) and its consequences for country ownership and accountability outside the Fund. As demonstrated in Section 6.6, the Board of the Fund retains substantial scope for flexibility with regard to policy preferences, focus areas or choices. It does this by exercising significant power, for example, in determining which country's grant proposals to accept, revise or reject (through the TRP that reports solely to it), issuing guidelines for the composition of CCMs, the types of treatment regimes to be supported or the issues to prioritise for funding at any given time.

These policy choices, preferences, or focus areas enunciated from time to time by the Board to guide the CCM practice are akin to conditionalities. In this context, De Renzio et al. (2008) therefore posit that in developing countries, donors still determine policy-making and set the conditions that guide such policies. Faust (2010) in pointing out the paradox of country ownership in a so-called post-conditionality context also stated that despite the mantra of country ownership espoused by donors, they continue to condition their assistance to donor policy requirements. This led Saliba-Couture (2011), to posit that a key issue mediating country ownership and accountability is conditionality, especially when such conditions emanate from donors. He thus posited that it is questionable whether conditionality and ownership can be reconciled. However, there are scholars who point out that donors have enunciated reasons for imposing conditionalities. For example, Shah (2017) posits that donors argue that conditionalities are to safeguard the repayment of donor loans and strengthen recipient ownership of the assisted programmes. This point is sustained by Lopes and Theisohn (2003) and Frank (2004) who also articulate donor positions on the use of conditionalities.

This study aligns with Saliba-Couture's (2011) position that donors are aware of the criticisms associated with conditionalities, and consequently, they try to portray conditionality policies as complementary to ownership. He thus concludes that the underlying donor logic is to reconcile ownership with conditionalities. From the perspective of recipient countries, the task becomes one of maximising ownership in the context of conditionality. This creates tensions between a

paternalistic and a partnership logic in a supposedly post-conditional era implicit in the notion of country ownership. In line with Saliba-Couture (2011), this study takes the position that underlying the irreconcilability between country ownership and conditionality is the depoliticisation of the concept of country ownership through a lack of attention to power relations. Describing the relationship between donors and recipient countries as a partnership (as detailed in the Paris Declaration) obfuscates the question of power relations and obscures the context of strong economic and fiscal dependence of aid recipient countries (particularly those in sub-Saharan Africa such as Ghana) on donors.

Therefore, this study concludes that the CCM practice of country ownership in Ghana is reflective of conditional ownership where recipient countries can only maximise ownership in the context of conditionality. While Ghanaian government agencies may take formal leadership of the CCM (e.g. the Ministry of Health holds the chairmanship) and responsibility for the HIV/AIDS response, country ownership is conditional ownership. This is because the CCM practice outcomes which underpin country ownership (and determine accountability) in the HIV/AIDS response are all mediated by the Global Fund's funding stipulations and conditionalities (as espoused by the Fund Board from time to time) which must be adhered to and heeded by the Ghana CCM to maintain its financial relationship with the Global Fund. These policy conditionalities enable the Global Fund Board to govern the HIV/AIDS response 'from a distance' (Collins, 2015:7) in Geneva, while not been present in Ghana.

The mediating role of conditional finance in the relations between the Global Fund and Ghana (through the CCM) is therefore reflective of other finance-driven participatory approaches developed by donors (at one time or the other) in the global political economy for the realisation of supposed recipient country ownership of its developmental strategies. Such participatory approaches include the sector-wide approaches (SWAp), and Poverty Reduction Strategy Papers (PRSP). In the context of Ghana, I have earlier highlighted how the practice of other donors under participatory frameworks such as SWAp, Sector Budget Support (SBS) and the Multi-donor Budget Support (MDBS) mechanism in the HIV\AIDS response raised critical questions of ownership (see Chapter 4.5) While they all promised to represent instruments for the promotion of recipient country ownership of its developmental policies, strategies and agenda, none of them, just like the CCM was able to ultimately grant country ownership to Ghana.

In sum, this study concludes that the Global Fund practice through the CCM in the Ghanaian context reinforces traditional power relations between donors and recipient countries rather than radically promoting change (e.g. by promoting country ownership in practice). However positive the concept of country ownership may seem, the evidence adduced in this chapter suggests that the Global Fund practice through the CCM instrument is insufficiently participatory and representative, with weak (conditional) country ownership, and accountability. This impacts on the ability of the Ghanaian government and citizens to truly own (lead, design and control) their developmental policies and strategies. In this context, country ownership appears to be a rhetorical tool applied by the Global Fund that does not fundamentally catalyse a power shift towards recipient counties such as Ghana. Thus, despite the rhetoric of country ownership, donors continue to call the shots in the design, control and implementation of aid delivery.

CHAPTER SEVEN
THE GLOBAL FUND, FINANCIAL AND PROGRAMMATIC ACCOUNTABILITY AND COUNTRY OWNERSHIP OF THE HIV/AIDS RESPONSE IN GHANA

7.1. Introduction

This chapter, like the preceding Chapter Six, attends to the second research objective of this study which is to investigate how the Global Fund understanding of accountability works itself out in practice in Ghana, in particular with regard to its implications for country ownership of the HIV/AIDS response policy. The previous chapter analysed the Global Fund's governance accountability practice in relation to this research objective, while this chapter will examine financial and programmatic accountability practice with regards to the same research objective. As explained in Chapter Five, the Global Fund's policy documentation understands accountability in terms of governance, programmatic and financial policy spheres of accountability. The governance policy sphere of accountability is supposed to be realised in practice by the Fund's Board at the global level and at the country level through the country coordinating mechanisms (CCMs). The policy spheres relating to programme and financial accountability are also undertaken in practice through the CCM. The method of implementation mandated by the Global Fund for CCM practice in relation to programme and financial accountability is referred to as a performance-based funding (PBF) system (see Chapter 5.3.3). Put clearly, the PBF is the financial regime that underpins programme implementation. So the financial and programmatic accountability policy spheres are inextricably linked in practice when undertaken by the CCM.

The analysis in this Chapter is provided in five sections. Section One is this introductory section. Section Two undertakes a general overview of the concept of performance-based funding (PBF) in relation to country ownership. In this section, I place emphasis on the diverse conceptualisation of the PBF in global health. In Section Three, I examine how the Global Fund conceptualises the PBF, its application and the outcomes it generates with regards to country ownership. Section Four provide an analysis of Global Fund practice in the context of the national HIV/AIDS response in Ghana, based on a field study undertaken in Ghana. I explore how various country level actors appropriate and interpret the Global Fund's accountability

policy measures in practice, in particular in relationship to its implications for country ownership of the HIV/AIDS response policy in Ghana. Section Five summarises and concludes the chapter.

7.2. Performance-based funding (PBF) and Country Ownership: A General Overview

In Chapter 6.2, I provided a broad overview of the concept of country ownership in development discourse. As posited in that chapter, the concept was established as the cornerstone or the basis of international developmental aid by the 2005 Paris Declaration on Aid Effectiveness, and was reconfirmed by the 2008 Accra Agenda for Action. The concept signals a shift whereby recipient countries (in terms of both their governments and their citizens) ostensibly assume leadership and control in the design of externally-funded development aid programmes. All the other principles contained in the Declaration are intended to drive and uphold the principle of country ownership. These other principles are aid alignment, managing for results, harmonisation, coordination and mutual accountability (See Chapter 6.2.).

The principles of aid alignment, harmonisation, and coordination are targeted at encouraging the use of common arrangements or procedures already existing in the aid recipient country. This is in order to reduce transaction costs on the recipient country (in managing multiple donor programmes and the burden of multiple reporting requirements involved). In the absence of such arrangements, each donor usually has its own reporting template. Therefore, the Paris Declaration focused on 'harmonising and aligning' all systems and aspects of aid delivery with those already existing within recipient countries and encouraged better focus and 'managing for results' (achieving higher performance impact) at the country level. Managing for results ties aid funding to progress in benchmarks and targets (OECD 2005, 2008, 2011; Chandy 2011; KPMG 2011; Harmer and Ray, 2009; Warren et al., 2017). The essence of managing for results is to promote aid implementation in a way that drives recipient country ownership by linking funding to country-owned priorities, performance indicators and targets and to encourage data (evidence) based decision-making (OECD 2005, 2008, 2011; Chandy 2011; KPMG 2011; Harmer and Ray, 2009; Barnes et al, 2015).

Performance-Based Funding (PBF) is a key strategy through which 'managing for results' can be achieved. PBF refers to a funding strategy that seeks to link the delivery of development aid to good performance via the achievement of targeted results or outcomes (Eichler, 2006, 2009; Fan et al., 2013; Olarinmoye, 2012; Fan et al., 2013). Therefore, intrinsic to PBF in global health is

the belief that positively impactful health outcomes are best achieved by tying healthcare funding to predetermined and specific performance indicators and targets for the achievement of results (Barnes et al., 2014; Brown et al., 2013). A number of leading development agencies and organisations have used different variants of PBF that obliged recipients of funds to demonstrate that funded programs generated results. These include the World Bank, the GAVI Alliance, the Global Fund, Bill and Melinda Gates Foundation (BMGF) and the Millennium Challenge Corporation (MCC) (Barnes et al., 2014).

Barnes et al. (2014), Brown et al. (2013), and Park and Kwak (2017) note that donors assign various terminologies to refer to 'managing for results' in global health. Therefore instead of talking about PBF, donors may refer to similar terms such as payment by results, performance-based aid, output-based aid, performance contracting, value for money, results-based funding, results-based financing, and pay for performance. All of these terminologies refer to the levels of incentives and performance rewards awarded for achieving results (Toonen et al., 2009). For the sake of simplicity, I will use PBF to refer to all these various terms.

Scholars have examined the application of PBF in global public health in relation to country ownership. In this vein, some scholars' discussion of PBF focuses on the agency and participation of the actors involved. For example, in their multi-country study in Africa, Barnes et al. (2014: 2-3) assert that the PBF has evolved in global health on the 'back of a participation and ownership agenda'. They note that while PBF is framed as an initiative between donors and recipient countries to drive recipient countries' agency in global health, it is subject to capture by donors, and thus may constrain rather than increase African agency. They further aver that in the development of country-specific forms of PBF in global health, there is a propensity by donors to focus on the implementation of a vision of PBF acceptable to them rather than those acceptable to the specific recipient country.

Picking up on the theme of developing countries' agency relative to donor influence, Esser (2014) argues that the application of the PBF in global health in the context of country ownership is a politically-driven semantic exercise that strengthens unequal power relations between donors and recipient countries, while also constraining donor accountability to these countries. For example, he notes that by strictly prioritising what areas or aspects of HIV/AIDS programming to focus on, donors constrain the agency of recipient countries to develop their own solutions,

thereby narrowing their agency which should underpin country ownership. Therefore, he concludes that while country ownership connotes a shift in the balance of power in the implementation of development aid towards recipient countries, the reality is that donors still call the shots in the design and implementation of externally funded aid.

Paul et al. (2014) in their study in Benin noted that while field actors (government and local stakeholders) welcomed PBF, they were not convinced that the PBF was country-owned and driven. This was because PBF as implemented was not aligned with the reform process undertaken by the government and the priorities of local stakeholders. In other words, it was not embedded within the overarching strategic health priorities of Benin. Rather, it operated as an 'isolated' project outside these strategic health priorities and without the buy-in of the stakeholders. Likewise, the authors of a multi-country African study argue that it is vital to secure the buy-in of all local and national actors in health management and provision right from the inception of PBF (Toonen et al., 2009). Failure to adopt such an inclusive approach, they note, will engender limited regulatory oversight and ownership by the government and local stakeholders at the district, provincial and central levels. This view is also shared by Fryatt et al. (2010), who highlight that the buy-in of national stakeholders in PBF implementation improves ownership and accountability.

However, as Brown et al. (2013) highlight, even where PBF adopts an inclusive approach encompassing the government and local stakeholders, this does not necessarily translate into ownership, unless there is national commitment on the part of the government and stakeholders, a view echoed by Brenzel et al. (2009) and Eldridge and Palmer (2009). As Barnes et al. (2014) point out, the central issue should not be whether participation occurs in the PBF process, but whether the PBF process is owned and driven by the agency of the national stakeholders involved rather than the donors.

While the scholars discussed above examine PBF from a participation dimension, some other scholars pay attention to the financial incentive aspect of PBF, arguing that PBF can create perverse incentives. Fryatt et al. (2010) assert that PBF creates perverse incentives especially when data quality is poor or unreliable. Programmatic targets to be achieved under PBF are subject to the quality of gathered data. Actors are incentivised to achieve performance targets and obtain the rewards attached to it by engaging in perverse incentive activities such as

'gaming'. (Kalk, 2011; Eldridge and Palmer, 2009; Magrath and Nichter, 2012; Petersen et al., 2006; Fryatt et al., 2010; Ireland et al., 2011; Eijkenaar et al., 2013). Gaming refers to a situation in which data to drive target setting is manipulated by the actors concerned who focus on meeting the set targets rather than paying attention to the outcome of programme implementation (Kalk, 2011; Eldridge and Palmer, 2009; Magrath and Nichter, 2012; Petersen et al., 2006; Fryatt et al., 2010; Ireland et al., 2011; Eijkenaar et al., 2013).

For example, in a study on Rwanda, Rusa et al. (2009) observe that health workers over-reported their activities in the absence of adequate disincentives such as the application of clear sanctions. Rusa et al. (2009) attribute this over-reporting to human error rather than gaming, but another Rwandan study by Paul (2009) argues that available evidence does suggest that perverse incentives are at play (Paul, 2009:18). In two separate multi-country studies, Oxman and Freitham (2008, 2009) found evidence of gaming. For example, they note that nursing homes were incentivised to claim to have admitted extremely disabled patients whose miraculous recovery could then be reported, thereby assuring the nursing homes of further funding. Similarly, Petersen et al. (2006), Eijkenaar et al. (2013), and Kalk (2011) found evidence of gaming in their studies. Petersen et al. (2006) report that certain patient groups receive preferential treatment relative to others based on the incentives attached to their treatment regimes, while Eijkenaar et al. (2013) show that performance calculations may motivate actors to focus on incentivised healthcare and ignore other important aspects. Kalk's (2011) study also provides evidence of the prioritisation of incentivised healthcare to the relative neglect of non-incentivised healthcare.

In helpful summaries, Ireland et al. (2011), Magrath and Nichter (2012) and Grittner (2013) list a number of possible adverse effects of the financial incentives tied to PBF. These include distortions by focusing on targeted services at the expense of other services, a focus on measurable services rather than on quality, the crowding out or dilution of intrinsic motivation, false reporting, and adverse social relations driven by envy or ill feelings (Ireland et al., 2011: 695; Magrath and Nichter, 2012: 1778; Grittner, 2013: 31). Taken together and in the context of country ownership, such perverse financial incentives (and the resultant 'gaming' of the system) distorts country health priorities and thereby undermines country ownership. When local stakeholders focus on perverse incentives, they distort country priorities and undermine country

ownership by manipulating data underpinning targeted interventions for financial gains rather than taking ownership of the programme implementation processes and implementing interventions as required.

Another way to explore the relationship between PBF and country ownership is to look at the way that PBF relates to broader system-wide objectives such as health system strengthening. As noted by Magrath and Nichter (2012), assessments of PBF schemes seldom investigate their broader long-term effects on the health system, a view echoed by Ireland et al. (2011). In this vein, Brown et al. (2013) posit that for PBF to be effective, it must be reflected as part of overriding national strategic objectives and not as an isolated donor project. The reference to an 'isolated vertical approach' speaks to a fundamental tension between vertical and horizontal health financing in global public health. As Sridhar (2009) explains, while vertical financing seeks short term, measurable results, horizontal funding pays attention to the long term sustainability of the health system. Although there is broad consensus in global public health in favour of horizontal funding, donor practice continues to favour vertical financing which discourages investments in health systems (Sridhar, 2009; Hecht et al., 2004; Eichler and Levine, 2009). As a result of these shortcomings, Paul et al. (2018) characterise the PBF as a donor fad which undermines country ownership by focusing attention on vertical programming for short-term results rather than promoting health systems strengthening.

Still on health system strengthening, scholars point to a lack of donor coordination with recipient countries in programme implementation, thus undermining health system strengthening and country ownership (Travis et al., 2004; Sridhar, 2009; Sridhar and Batniji, 2008; Brugha, 2007; Lele et al., 2005; Mwisongo and Nabyonga-Orem, 2016; Collins and Beyrer, 2016). Sridhar (2009) observes that donors maintain parallel systems to drive programme implementation in recipient countries. In a multi-country study, Biesma et al. (2009), argue that, by funding programmes outside national coordination frameworks, donors distort recipient countries health priorities and implicitly, the ownership process. Similarly, Brugha (2007) avers that donor practice imposes a transaction cost on recipient countries due to multiple isolated projects requiring divers reporting requirements, thereby undermining ownership. Sridhar and Batniji (2008) note that donors focus their practice on their interest and not that of the recipient country, while Vähämäki et al. (2011), conclude that current PBF practice by donors places recipient

countries in a position where they have to continuously measure and report results, while also being responsive to the various priorities of the different donors.

Another way in which PBF impacts on country ownership is through the way in which it exacerbates dependency because recipient countries begin to rely on a wide gamut of donor audit and accountability technologies which adversely affect country ownership. According to Esser (2014), recipient countries are usually mandated to undertake data collection using financial, monitoring and evaluation technologies developed by donors. As described by Biesma et al. (2009) and Mwisongo and Nabyonga-Orem (2016), donors may introduce their own financial management and monitoring and evaluation (M&E) systems rather than using the government systems of the recipient country, thereby creating dependency and undermining country ownership. Using the World Bank and PEPFAR as examples, Mwisongo and Nabyonga-Orem (2016) show that the World Bank relied on its own coordination mechanisms in implementing its Multi AIDS Projects (MAP) instead of using government-owned reporting and evaluation facilities. They also note that aspects of PEPFAR operations are reported only to their own government, while M&E activities are also undertaken by PEPFAR based on their own template through NGOs funded directly by them outside the purview of governments.

In concluding this section, the literature discussed above demonstrates that scholars conceptualise PBF from different dimensions and raise various problems with the way in which PBF is implemented and its implication for country ownership. I now proceed to the next section to examine the Global Fund PBF and the outcomes it generates in relation to country ownership when applied in various contexts of global health.

7.3. Performance-based funding (PBF) and the Application of Country Ownership: The Global Fund Experience

While the previous section looked at the functioning of the PBF in general, this section focuses specifically on the Global Fund and the application of the PBF across Fund practice in specific contexts of global health. As broadly detailed in Chapter 5.3.3, the PBF process starts from the application process to the end of programmes implementation. The CCM develops a proposal/ concept note which it submits to the Fund. The application then goes through a vetting process led by the technical review committee (TRP). If approved by Fund Board (on TRP recommendation), the grantee (principal recipient) will also be vetted by the local fund agent

(LFA) to assess its capacity to undertake programme implementation. If successful, the grantee signs an agreement for a funding cycle of five years with the Global Fund. The agreement states the terms of the contract and the performance targets (results) to be achieved by the grantee.

The funding cycle of five years is divided into two phases. During the first phase of two years, the grantee is expected to submit regular progress reports. The performance of the grantee is evaluated by the LFA which uses a performance scoreboard metric framework to evaluate the grantee, A1 (exceeds expectations), A2 (meets expectations), B1 (adequate), B2 (inadequate, but potential demonstrated) and C (unacceptable). If the Secretariat is satisfied with the performance report of the LFA, board approval is sought for release of grants for phase two. Grants rated C will not usually receive phase two disbursements. In this context, the grant can be suspended, modified or completely cancelled.

From the Global Fund's perspective, the PBF process is compatible with country ownership. However, scholarly observers are less sanguine about the positive relationship between the two. The Global Fund is criticised for paying too much attention to measurement and achievement of results (which underpin its PBF system) in contrast to country ownership and broader improvement in recipient countries health systems (Cairney, 2016; Stillman and Bennett, 2005). For instance, Banteyerga et al.'s (2005) analysis of the PBF in Ethiopia shows that there was immense pressure upon the key organisations involved in the HIV/AIDS national response to deliver rapid and measurable results on Global Fund-supported programs. The danger associated with this pressure for timely implementation is that it focused attention on short term results, rather than the long term sustainability of the health system. Banteyerga et al. (2005) further posit that the centralised approach to the PBF implementation of the HIV/AIDS response alienated regional stakeholders and gave rise to indifference and a sense of lack of ownership on their part to the response process (Banteyerga et al., 2005).

In a multi-country study, Stillman and Bennett (2005) perceive varying degrees of a lack of ownership of Global Fund funded programs. For example, they asserted that in Malawi, evidence abounds of the Global Fund Secretariat demanding processes that were at variance with the processes of the Malawian health system or providing advice which conflicted with national policies. They further posit that in both Benin and Malawi, the Global Fund circumvented existing government procurement and supply systems for the programmatic implementation of

Global Fund grants. The establishment in both countries of parallel, external procurement and supply systems led to duplication of efforts within the country and gave rise to questions regarding ownership However, the study does note that the Ethiopian experience was more positive in that procurement was domiciled with the Ministry of Health procurement division which aligned with country ownership. The study also notes that while stakeholders in Ethiopia and Malawi complained of the rigidity of the PBF implementation process, those in Benin felt the Fund was more adaptable to changes, but also exhibited a tendency to manage the process, thereby negating country ownership (Stillman and Bennett, 2005).

Scholars have also critiqued the proclivity of the Fund to establish new programmatic implementation structures irrespective of existing national programmatic structures already involved in the implementation of national HIV/AIDS responses in recipient countries. For instance, Biesma et al.'s (2012) country study on Lesotho, noted that the PR which was the Ministry of Finance, had to establish a new organisational coordinating unit (the Project Monitoring Unit) as a conditionality to be met before implementing Global Fund programmes for Lesotho. According to Biesma et al., the creation of this coordination unit specifically for Global Fund grants required staff in the Ministry of Finance (and the Ministry of Health, which was a sub-recipient of the grant) to learn how to operate under this unit, while there were existing government coordination systems which they were already accustomed.

Similarly, Cruz and McPake (2011) in their study report on Uganda also note that the performance implementation system of the Fund (PBF) put pressure on the government to respond to the separate implementation requirements of the Fund. For example, the Global Fund grant implementation was undertaken via a distinct project coordination unit domiciled in the Ministry of Health (MoH), but created specifically for the Fund grants (Cruz and McPake, 2011). In their multi-country report on Cambodia, Uganda and Cameroon, Mwisongo and Nabyonga-Orem (2016) argue that rather than working within existing frameworks, Global Fund programme implementation led to the creation of parallel financial disbursement, programmatic, monitoring and evaluation systems, which were similar to those that recipient countries already had in place.

Monitoring and evaluation (M&E) plays a crucial role in the Global Fund PBF. It is through M&E that performance is measured against set targets to determine the achievement of results.

Targets are set, based on available data, such as the number of people on anti-retroviral treatment. Thus, data quality, validity and reliability are key to monitoring and evaluation (M&E) (Global Fund, 2009; Nahlen and Low-Beer, 2007). In their study of the Global Fund PBF practice in Botswana, Molosiwa et al. (2019) note concerns around data collection and quality. They posit that CCM members lacked the technical skills to understand the measurement and evaluation systems underpinning programme implementation which inhibited their sense of ownership of the programmes. Amendah and Ithibu (2018) in their multi-country report on Cameroon, Kenya, Malawi, Rwanda and Zambia observe divergent results regarding data collection and quality control. In Zambia, for example, two systems of data collection existed, one electronic and the other paper-based and the two generated contradictory results. With regards to Cameroon, Amendah and Ithibu, (2018) noted that the multiplicity of forms or registers that needed to be filled by Principal Recipients (PRs) led to problems with data collection and quality. They also stated that data systems in the countries under study were fragmented. The Global Fund manages its own data collection process independent of the national systems. Other donor implementers of HIV/AIDS (such as PEPFAR and the World Bank) also run their own parallel systems of capturing data not aligned with the national systems. These donor systems do not synergise with each other and produce results at variance with each other in the countries under study. Harmonising these various sets of data capturing systems becomes a challenge and undermines country ownership.

Peersman and Plowman (2012) in their multi-country study on recipient country monitoring and evaluation (M&E) systems observe that monies tied to approved grants are reduced or cut by the Global Fund secretariat during the signing of the grant implementation agreement. Furthermore, they report that even when funds were reduced, respondents from study countries stated that PRs receive instructions that targets must remain the same. This negates the underlying logic underpinning a performance framework because a reduction in resources should catalyse a change in the targets as approved resources may prove inadequate for programme implementation.

In concluding this section, this study takes the position that while the PBF system is applied broadly across the Global Fund, its practice outcomes with regards to country ownership are context-specific. For example, in some country context, local stakeholders felt they owned parts

of the PBF practice, while in some other contexts, they do not. Thus, Lu et al. (2006), Katz et al. (2011), Katz et al. (2010), and Nahlen (2007) in their assessment of the performance of Global Fund grants postulate that the implementation of PBF depends on the characteristics of individual grants and the country context in which these grants are activated.

7.4. Respondent Perceptions of PBF, Global Fund Institutional Arrangements and Ownership of the HIV/AIDS Response in Ghana

While the preceding section looked at the application of the Global Fund PBF process broadly across the Fund's practice, this section focuses on the application of PBF in Ghana with regards to the ownership of the HIV/AIDS response. In order to do this, this study will use respondent perceptions of the PBF process in Ghana as a lens to analyse how various country-level stakeholders appropriate and interpret the Global Fund's accountability policy in practice, in particular in relation to its implications for country ownership of the HIV/AIDS response policy in Ghana.

Respondent perceptions will be contrasted with the stated institutional arrangements of the Global Fund. Examining respondent perceptions alongside these institutional arrangements will enable this study to appraise the ownership of the HIV/AIDS response in Ghana.

7.4.1. The role of the OIG and country ownership

Respondents expressed various views with regards to the ownership of the HIV/AIDS response in Ghana. Some respondents were concerned with what they saw as the unbalanced relationship between grant recipients and principal head office structures of the Global Fund, such as the office of the inspector-general (OIG) of the Global Fund. These respondents reported that the OIG undermines country ownership because it is not accountable to the Ghanaian government or the people.[44] The OIG mentioned above by the respondents is tasked with investigating fraud-related matters pertaining to PBF grant implementation and is a principal organ of the Fund domiciled at the headquarters (see Chapter 5.4.1).

For example, this study observed that, as part of its 2010 work plan, the OIG of the Global Fund conducted an audit of Global Fund grants to Ghana from 1 November to 9 December 2010. The

[44] Interview 8 Mar.2018 government respondent 1b; Iinterview 14 Mar. 2018 government respondent 2b.

OIG audit involved an appraisal of US$ 254 million in disbursements across eight grants awarded to the Ministry of Health as a principal recipient (Global Fund Ghana Audit Report, 2014e, 2015). As a principal recipient, all grants awarded to the Ministry of Health (MOH), are implemented on its behalf by the Ghana Health Service as its sub-recipient. The Ghana Health Service is an agency under the Ministry of Health, mandated with the responsibility of implementing national health policies (see Chapter 4.4.2). The OIG audit identified about US$ 9.8 million of non-compliant expenditure, inclusive of US$ 9.35 million linked to construction contracts for the period 2005 to 2011 (Global Fund Ghana Audit Report, 2014e).

After the completion of the audit, it was recommended to the board of the Global Fund that the Ghanaian Ministry of Health should return the sum of US$ 1,509,017 to the Global Fund as a matter of urgency (Global Fund Ghana Audit Report, 2014e). The Ghanaian government agreed to this recommendation. The outcome of the investigation highlights how a non-state agent acting on behalf of a non-state entity (Global Fund) can investigate the fiduciary and financial responsibilities of a state agency like the health ministry involved in the response and hold it to account, while the agent (OIG) and its principal (Global Fund) are not accountable to the government. Refusal to abide by the remedies recommended by the Fund can attract the threat of sanctions in terms of grants suspension. The OIG is accountable and reports solely to the Board of the Fund and not even to the Fund secretariat, or the CCM (see Chapter 5.4.1).

7.4.2. The role of the LFA and country ownership

Responsibility for programme performance management is placed in the hands of the CCM (Global Fund, 2019f). My observations during the period of fieldwork suggest that the Ghana CCM seems constrained by its financial and functional capabilities to take on the role expected from it by the Global Fund in terms of oversight for programme performance management and implementation. For example, I was made to understand that certain administrative bills were still pending, such as rental bills. Due to under-staffing, the CCM Secretariat finds it difficult to undertake its delegated functions such as moving around the country to monitor Principal Recipients (PRs) and Sub Recipients (SRs). These logistical issues constrain the CCM's oversight responsibilities. In-country capacity by the CCM to oversee the programme implementation process is a strong antecedent to country ownership.

Some respondents assert that the functioning of the CCM is complicated by the role of the LFA.[45] The Fund does not maintain in-country offices for oversight and guidance for programme implementation and so LFAs play a big role in ensuring oversight (see Chapter 5.4.3). A fundamental point to note with regards to the accountability relations involved in the programme implementation process is that the Global Fund signs grant agreements (contracts for the release of awarded grants) under the PBF process directly with PRs. The agreement is not signed with the CCM (to which these PRs belong to) or with the government. This applies to all PRs, both state and non-state. The CCM has oversight over grants, but in reality the CCM does not have the power to cancel any grant and it is the LFAs who play a bigger role in assessing performance.

The performance of all these PRs in programme implementation is assessed and graded by the LFA who sends the report to the secretariat in Geneva and provides a copy to the CCM. The LFA reports solely to the Global Fund Secretariat and is not accountable to the CCM (see Chapter 5.4.3). The Fund Secretariat acts on the report of the LFA as the basis of continuing funding or suspending funding to a PR for the next phase of the project implementation. Thus while accountability accrues to the Fund Secretariat and ultimately to the Board through the LFA, there is no clear line of programme accountability to the government or to Ghanaian citizens affected by the diseases by the LFA. The position of the LFA in the PBF process as the basis of programme implementation was a condition imposed by the Global Fund, rather than something requested by recipient countries like Ghana.

Respondents' concerns about the role of LFAs resonate with Harman's (2015) comments on the use of specialist finance organisations (such as LFAs) in HIV/AIDS health programming in aid recipient African countries. She states that such use has entrenched a market culture in the governance of global health, underpinned by the technical and business model of management they promote. She further avers that due to the management responsibilities they now undertake in global health policy processes, they now act as intermediaries between government agencies and donors (2015: 472). The implication of Harman's (2015) comments is that the role of specialist finance organisations (such as LFAs) in HIV/AIDS health programming signposts a

[45] Interview 27 Mar 2018 aid agency respondent 1; Interview 3 Apr. 2018 aid agency respondent 2; Interview 6 Apr. 2018 aid agency respondent 3; Interview 12 Apr. 2018 aid agency respondent 4.

reconfiguration of power relations by weakening the leadership capacity of national authorities and elevating the role of the private sector in national health policy processes.

7.4.3. Technical assistance and country ownership

Respondents also expressed concerns with the Global Fund's health systems strengthening strategy.[46] A consideration of the Global Fund grants awarded to Ghanain recipients suggests that the Global Fund's health system strategy in Ghana is focused on short-term gap-filling. Global Fund grants intended for recruitment and capacity building were used mostly for programme management staff. For example, in grant GHA-102-001-H (2002:5) (awarded to the Ministry of Health as a principal recipient of the Global Fund), the Ministry was advised to recruit a specialist to coordinate HIV/AIDS programme activities between the private sector, the CCM and the principal recipient (i.e. the Ministry of Health). The Ministry was also advised to train two procurement officers on forecasting techniques and procurement of anti-retroviral drugs. Similarly in grant number: GHN-809-G07-M (2009: 2) awarded to the Ministry of Health, a key objective of the grant was to strengthen the health system and specifically human resources capacity for the implementation of malaria interventions. This was to be done by building capacity of national, zonal and district malaria health workforce.

These kinds of specific programme funding made available through Global Fund grants creates a difficult context through which to address health system strengthening (in terms of health workforce development) and drive country ownership in Ghana. The emphasis on specific disease programmes has engendered the strengthening of sub-systems rather than the health system as a whole (Adjei et al., 2011). Furthermore, while Adjei et al. (2011) and Dräger et al. (2006) note that Ghana has made significant efforts to scale up and grow the number of its health workforce, Schieber et al. (2012) argue that current health care provider densities in Ghana are far below World Health Organisation (WHO) recommended levels. For instance, they posited that Ghana when compared with other countries with similar levels of income suffers from a shortage of health specialists, particularly doctors (Schieber et al., 2012: 103).

[46] Interview 8 Mar.2018 government respondent 1b; Interview 14 Mar. 2018 government respondent 2b; Interview 16 Feb. 2018 government respondent 5a; Interview 16 Apr. 2018 academic respondent 1.

7.4.4. The M&E toolkit, KPIs and country ownership

In accounts of events surrounding interactions with the Global Fund regarding programme implementation, certain respondents felt that the Global Fund steers recipients toward predetermined target areas or target outcomes. Narrating his experience in engaging with the Global Fund, a respondent noted that negotiations with the Global Fund were difficult as it appeared the Global Fund representatives had made up their minds on what they wanted prior to meetings.[47] Another respondent postulated that the Fund is bureaucratic in approach and not attuned to local realities.[48] He described his experience thus:

> Accepting what [the Fund] says kick starts grant implementation faster rather than delaying it. All they know is what is written down on paper. For example, it should be this indicator or that indicator; it should be this target or that target. They make suggestions or changes on the type of target indicators that may be acceptable to them in order to continue funding the PR. Such changes must be adhered with. All these go against the notion of country ownership.

This finding aligns with the broader views of Barnes et al. (2014) who argue that the Global Fund imposes 'conditional compliances' on target selection and favours certain types of key performance indicators (target areas) and heavily steers CCMs to adopt targets aligned to these kinds of indicators. My observations in Ghana suggests that the majority of target areas adopted by the CCM for programme implementation were aligned to pre-prescribed key performance indicators (KPIs) derived from the Global Fund's standard monitoring and evaluation (M&E) toolkit. This toolkit is the Fund's standard and procedural guide for selecting and measuring key performance indicators in recipient countries. Recipient countries are thus expected to choose targets that are aligned to the KPIs embedded in the M&E toolkit standardised 'basket of indicators'.

Table 7.1 below provides a snapshot of the key performance indicators laid out by the Global Fund in their M&E toolkit from which recipient countries (such as Ghana) pick their key performance indicators (KPIs) as the basis of target setting.

[47]Interview 8 Mar.2018 government respondent 1b.
[48]Interview 14 Mar. 2018 government respondent 2b.

Table 7-1: Global Fund standardised 'Top Ten' key performance indicators from M&E toolkit for routine Global Fund reporting

Numbers	Top Key Performance Indicators For Routine Global Fund Reporting	Disease Type
1	Number of those presently on antiretroviral treatment (ARVS)	HIV
2	Number of TB cases currently on treatments under DOTS: a. details of new cases b. total number treated successfully c. total receiving MDR-TB treatment	TB
3	Amount of insecticide –treated bed nets (ITNs) shared out or families getting indoor residual spraying, depending on regional location	Malaria
4	Number of those tested and counselled for HIV	HIV
5	Total figure of HIV-positive pregnant women receiving treatment to reduce mother to child transmission (PMTCT)	HIV
6	Total figure of those receiving anti-malarial treatment (specify ACT/non-ACT)	Malaria
7	Total amount of condoms distributed	HIV
8	Total figure of those profiting from outreach community programs. Specify: a. prevention b. support for orphans c. home-based care and external support with regards to behavior change communications outreach activities	HIV/ TB/Malaria
9	Total figure of those receiving treatment for infections associated with HIV. Specify: a. HIV/TB b. opportunistic infections c. STI's with counseling	HIV/TB
10	Health system strengthening for HIV/AIDS,TB and Malaria Specify: a. number of people trained. b. health and related services c. peer and community prevention	HIV/AIDS,TB and Malaria

Sources: Global Fund (2005e); Global Fund (2019g); CGD (2013).

In order to determine whether or not Ghanaian PRs align their targets to these KPIs, I analysed the grants awarded to Ghana PRs and observed that the target objective of each grant corresponds neatly to one of the targets listed above. For example, grant no. GHN~809-G08-M awarded to the Ministry of Health had the overarching target of improving treatment and home-based care for those afflicted by malaria. This objective speaks to KPIs 3 and 6 in the figure

above. Also grant GHA-H-WAPCAS (awarded to West African Program to Combat AIDS and STI) had the target of improving the care available to key affected populations (KPIs) by reducing human rights barriers militating against their access to treatment and a better quality of life relates to KPI 8. Behaviour-change communications and community outreach activities (engagement) in KPI 8 is to address human rights barriers affecting HIV/AIDS treatment of key affected populations such as men having sex with men, women having sex with women and other lesbian, gay, bisexual and transgender communities (LGB) (Global Fund, 2019h). Another grant to the Ministry of Health, targeted at providing treatment to all those afflicted by any of the diseases (HIV/AIDS, TB, Malaria) can be linked to all the KPI's, though its core focus is on TB. Examples abound (see Table 6.3 for a list of grants awarded to Ghana principal recipients as of May 2019). Each one is linked to a KPI in the Global Fund's standardised M&E toolkit.

This study argues that the use of the M&E toolkit enables the Fund to influence and manage programme implementation from a distance and is in contradiction to the Global Funds avowed policy commitment to country ownership through the instrumentality of the CCM. The Global Fund posits that these top indicators are based on commonly agreed measures between multilateral global public health actors (the World Bank, World Health Organisation, United Nations Agency for AIDS) so as to decrease the reporting burden on recipient countries by promoting a shared understanding of monitoring and assessment indicators they can use (Global Fund, 2019i). However, operating within these pre-established indicators raises questions of country ownership as the official policy of the Fund is not to impose indicators and targets on countries, but allow them to use or choose those defined by them through their CCM.

In their study of the Ghanaian health sector, Vecchione and Parkhurst (2018) argue that while the use of donor data (such as the KPIs in the M&E toolkit) appear to be simple technical measures to promote health sector efficiency and effectiveness, their usage has political implications. When such data becomes the basis for national policy implementation, Vecchione and Parkhurst (2018) posit that accountability systems linked to donors and outside the control of the state come into play. This raises questions over accountability, as well as the country ownership of the response.

7.4.5. Audit culture and country ownership

Some of those interviewed for this study believe that the PBF process and the audit culture that it engenders is potentially beneficial for HIV programming in Ghana as it promotes transparency and accountability in the PBF programme implementation process.[49] In contrast to these respondents, there seemed to be a strong perception in the minds of other respondents in Ghana that the PBF and the audit culture that it produces deepens the Global Fund's ability to control and manage programmatic implementation in recipient countries like Ghana. Such respondents posit that in--country efforts by the Global Fund to build up databases and data production exacerbated Ghana's dependence on foreign technology which it does not produce and control.[50] They posit that enormous quantities of data collected and reported digitally by the CCM and PR's to the Fund headquarters in Geneva depend on modernised technological infrastructure which reinforces Ghana's dependence on outside sources.

The Global Fund believes that investment in the quality of data is the key to successful and strategic decision-making in programme implementation (Global Fund 2017d, 2017e). As illustrated in Table 7.2 below, data reporting routines underpin the Global Fund audit practice in Ghana. As observed in Ghana, recipients spend a lot of time on meeting these requirements to the Fund in order to remain eligible for funding and to meet the Funds programmatic and financial accountability standards. The routine use of databases and the need for numbers and indicators is at the core of the PBF and underpins the belief of the Global Fund that producing quantifiable data legitimises national programming efforts in recipient countries, in this case Ghana.

[49] Interview 17 May 2018 private business sector respondent 1; Interview 21 May 2018 private business sector respondent 2; Interview 23 May 2018 private business sector respondent 3.
[50] Interview 16 Apr. 2018 academic respondent 1; Interview 23 Apr. 2018 academic respondent 2; Interview 8 Mar.2018 government respondent 1b; Interview 14 Mar. 2018 government respondent 2b.

Table 7-2: The Global Fund Data Collection and reporting system in Ghana

Data base and data collection and reporting systems	Location	Purpose
Qualitative Risk Assessment, Action Planning and Tracking (QUART)	CCM Secretariat	For managing programmatic and financial risks at country level e.g. monitoring how money is spent
HIV e-tracker	Service delivery sites	For monitoring of HIV/AIDS treatment sites tracking and reporting implementation of the HIV 90 90 90 acceleration plan
The grant oversight dashboard	CCM Secretariat	A data management dashboard deployed to CCMs to help manage the programme implementation and oversight process
e-LMIS software	Installed in national, regional and district health facilities and any other HIV/AIDS treatment sites	Intended to capture and report the number of people using Antiretroviral drugs (ARV)
Viral load software	Service delivery sites	Documents the registers of samples collected from patients (including number of patients and their details) for viral load testing
GeneXpert machines	Service delivery sites such as Tuberculosis (TB) treatment sites	Used for TB detection and to capture and report the number of people enrolled as TB patients and accelerate their treatment
Electronic Register and Tracker (e-Tracker)	Service delivery sites	Used to capture and record the data of people undergoing treatment
SPECTRUM software	Service delivery sites	Used to generate and report regional HIV estimates.

Estimation and Projection Package (EPP) Modeling	Population based survey	For estimation and report of HIV prevalence within the population
The Malaria Matchbox	At the service delivery sites	Assesses whether programs effectively reach all populations affected by malaria, or if some are being left behind.
The Data Quality Audit Tool	Applied to health facilities	Used by Fund external auditors to measure data quality emanating from treatment facilities
The Performance Framework	Details the grant implementation agreement between principal recipients and the Global Fund	Promotes the collection of local data reported in the Progress Updates and Disbursement Requests
Civil Registration and Vital Statistics (CRVS).	Service delivery sites	Used for reporting on births and rate of mortality in hospitals and communities
Electronic Medical Records (EMRs)	Service delivery sites	Used for monitoring the response of patients to treatment for the diseases
On-site data verification (OSDV)	Service delivery sites	Used by the Local Fund Agent to monitor programme implementation
Integrated biological and behavioural surveillance surveys (IBBS)	Population-based survey for service delivery to key affected populations	used to determine and measure access to treatment available to KPIs
The Capacity Assessment Tool	Deployed by Global Fund secretariat	Used for assessing the capacity of principal recipients (before signing of grant agreement with the Fund) to successfully undertake programme implementation

Sources: Structure of table adopted from Collins (2012:31). Database and data collection and reporting systems compiled from Global Fund Ghana Audit Reports (2012d, 2015, 2019j); Global Fund (2017d, 2017e); Global Fund (2019l, 2019k); USAID (2015).

Therefore, this study takes the position that the Global Fund's focus on data and indicators (as exemplified in Table 7.2 above) creates a level of micromanagement that empowers the Global Fund to manage the programme implementation process. Furthermore, through the use of this wide range of databases and data collection and reporting systems, the Global Fund endeavours to instil new norms of programmatic and financial accountability conduct which shape in-country programme implementation. In this way, data bases and data collection and reporting systems are therefore key instruments for delivering financial value and accountability to the Global Fund for its programmatic grants in Ghana, rather than accountability to the government or its citizens.

7.4.6. Quantitative or qualitative targets and country ownership

Respondents from the business sector seemed comfortable with the emphasis of the Global Fund on measurable quantitative targets and indicators as it spoke to the business values that underpin practice in the private business sector.[51] However, other respondents argue that the PBF places too much emphasis on measurable quantitative targets and indicators, and pays little or no attention to qualitative indicator.[52] According to this view, the lack of attention given to qualitative indicators makes it difficult to measure improvements in tackling the social determinants of health such as poverty that drives the spread of diseases like HIV/AIDS. For example, while there are quantitative targets related to vulnerable groups (e.g. the number of orphans or the number of HIV-positive pregnant women on anti-retroviral therapy), the indicators used define vulnerability in the context of health status, but not with regards to prevailing social or economic marginalisation.

The focus on quantitative measures means that the Global Fund does not encourage principal recipients to take into consideration qualitative measurements like the social determinants of health. The focus is on quantitative outputs which can provide numbers and unambiguous results. This undermines country-level responsibility and accountability to citizens affected by the diseases and negates their ownership of the response.

[51] Interview 17 May 2018 private business sector respondent 1; Interview 21 May 2018 private business sector respondent 2; Interview 23 May 2018 private business sector respondent 3.
[52] Interview 8 Mar. 2018 government respondent 1b; Interview 16 Apr. 2018 academic respondent 1.

7.4.7. Sustainability of disease programmes and country ownership

There was considerable concern among respondents with regards to the government's sustainability plans post donor withdrawal from financing the national HIV/AIDS response in the wake of global economic uncertainty. Some respondents were concerned about the fate of infected Ghanaian citizens currently on HIV/AIDS anti-retroviral treatment programmes.[53] Talking about this issue, one respondent asked:

> What will happen to citizens who are on anti-retroviral treatment if financing becomes unsustainable? Citizens on HIV/AIDS treatment program are to take antiretroviral drugs for life. What will be their fate in the face of dwindling government revenues and the practical possibility of unsustainable donor financing capacity? Who will they hold accountable for the supply of these life saving drugs in the context of such eventuality?

Respondents' concerns speak to the Global Fund policy on co-financing and sustainability (Global Fund 2016c). The thrust of the policy is to engender greater domestic investment in health programmes. Recipient countries are expected to provide a minimum amount as counterpart funding at the start of a grant cycle. The Fund specifies what this minimum amount should be and applies a 15% 'incentive' to the main grant allocation to motivate countries to achieve or surpass the co-financing target (Global Fund 2016c; Armstrong, 2018). Countries must generate new domestic finances for health over the three-year grant cycle (Armstrong, 2018). These requirements were a cause of concern among respondents.

Available evidence demonstrates that Ghana's HIV/AIDS response is funded principally by donors (see Chapter 4.4.3 and 4.5). This study takes the position that sustainability is crucial to ownership. The collective expense of these programs may be difficult for Ghana to sustain without donor support (as is the case in nearly all countries across sub-Saharan Africa with the possible exception of South Africa). It is important to note that Ghana is currently leveraging on a credit facility of $918 million from the International Monetary Fund (IMF) facility to meet its financial obligations to its citizens. This is an indication of the fiscal challenges underpinning government revenue position (Brown, 2017).

Brown (2012) argue that due to the structural inequalities that underpin the neoliberal world order, many states in the developing world are unable to finance antiretroviral therapy for their

[53] Interview 16 Apr. 2018 academic respondent 1; Interview 23 Apr. 2018 academic respondent 2; Interview 18 Apr. 2018 academic respondent 4.

citizens and are thus dependent on rich bilateral donor countries (operating through global health agencies like the Global Fund). As Barnes et al. (2014) explain, African actors such as governments of recipient countries (such as Ghana) will most likely constantly tailor their grant proposals to donors (e.g the Global Fund and the programmatic grants embedded in them) to reflect what they think might be acceptable to them. As they further noted, such acts negate national health priorities (Barnes et al, 2014) and implicitly ownership.

7.4.8. Parallel structures and country ownership

Some respondents observed that the Global Fund's PBF practice was not aligned with national systems. As one respondent pointed out, the fragmentation of M&E systems along disease lines (HIV/AIDS, Tuberculosis and Malaria) has generated parallel structures at country-level in Ghana.[54] Talking about this issue, another respondent noted that the Global Fund's introduction of disease-specific reporting systems has created a parallel system which undermines Ghana's own district health information management system (DHIMS).[55] The respondents' observations speak to the fact that Ghana, some years ago, had invested in this DHISM which was launched by the Ministry of Health (MOH) under the auspices of its service delivery agency, the Ghana Health Service (GHS), in 2007 (Atun et al., 2011).

The DHMIS captures both facility (hospitals) and community-level data of citizens using health services in Ghana. While it appears that there has been progress in relation to the coordination and alignment of activities, the data system space remains crowded with various data systems in place. For example, Global Fund grants often focus on a specific disease and entail the use of data systems designed to address this specific disease (see Table 7.2). The use of such a wide gamut of information gathering and reporting systems undermines accountability to the government or those affected because these systems are deployed by the Fund for its own accountability requirements.

Still on the topic of the creation of parallel systems, one respondent stated that irrespective of existing national programmatic structures already implementing the HIV/AIDS responses in the Ministry of Health (MOH), the Fund insisted that the Ghana Health Services (GHS) create a separate program management unit (PMU) independent of the MOH program management unit

[54] Interview O8 Mar.2018 government respondent 1b.
[55] Interview 14 Mar. 2018 government respondent 2b.

and which was to be dedicated solely to the management of the Fund's funded programmes.[56] He posited that the creation of the PMU undermined country ownership because the demand emanated from the Fund and not the government. Another respondent complained that the Global Fund does not adapt to local realities and a third pointed out that the Global Fund had resorted to the same procedure in other African countries.[57] However, providing an alternative view, one respondent argued that weaknesses in existing national management systems led the Global Fund to set up a parallel system to speed up programme implementation.[58]

At its inception, the Global Fund accepted that countries should solely determine the financial and programmatic management structures of its funded programmes (Global Fund. 2001). However, as the discussion above has demonstrated, this is not the case. The Fund could have made do with existing accountability structures under the Ministry as the GHS is an agency under the Ministry. According to one respondent, the GHS PMU was simply an accountability mechanism for Global Fund money.[59]As stated by him:

> In order to prove performance to be eligible for continued funding, you need to report on how monies have been spent, for example for the ART [antiretroviral drugs] for the HIV program or for the malaria and TB programs. That is simply the job of this unit. To track how Global Fund money is spent and provide documentation for it. This is just the way the Global Fund wants to manage its monies.

Parallel structures go against the objective of the Paris Declaration which enjoins donor to operate within prevailing structures. It demonstrates the Global Funds hands-on managerial approach in programme implementation which ensures accountability to the Fund rather than to the government of Ghana. As shown earlier (see Section 7.3), the creation of parallel structures in its practice in African countries is not new. The studies discussed earlier attest to the Global Fund's practice of insisting on creating country-specific programme management units for the management and oversight of programmes financed by the Global Fund. My findings in Ghana support those of these studies in showing how the Global Fund creates parallel structures in Ghana.

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[56] Interview 8 Mar. 2018 government respondent 1b.

[57] Interview 14 Mar. 2018 government respondent 2b; Interview 23 Apr 2018 academic respondent 2.

[58] Interview 6 Mar 2018 civil society respondent 1.

[59] Interview 8 Mar.2018 government respondent 1b.

7.4.9 CSOs, programme implementation and country ownership

Certain respondents expressed dissatisfaction with the prominence of civil society principal recipients (PRs) in programmatic arrangements in the national response. Some felt that the response should be a solely state-led and state-dominated operation.[60] Another noted that while these principal recipients (PRs) CSOs are nationally registered in Ghana, their origins are external to Ghana and they are funded by foreign donors in their operations rather than the state or any other national entity.[61]The specific non-state PRs mentioned by these respondents are the Planned Parenthood Association of Ghana (PPAG), and the Adventist Development and Relief Agency (ADRA), both of which are prominently involved in HIV/AIDS activities in Ghana. These respondents contend that the prominence of these CSOs, which they perceive as foreign entities, negates country ownership of the response.

When evaluating ownership, what should be of concern is whether the operations or activities of these PR CSOs are representative of the grassroots communities who are supposed to be beneficiaries of their activities. However, findings in Ghana shows that CSOs partaking in the national response as sub-recipients to the PRs tend to be domiciled in urban centres like Accra and Kumasi. Furthermore, most of these urban-based CSOs have little contact with their rural communities, constraining the amount of accessible and timely programme implementation information reaching beneficiary communities. This creates accountability challenges with regards to their ability to respond to community observations, concerns and requirements of affected citizens in the process of programme implementation. Consequently, there is a lack of a sense of community ownership of the programme by affected citizens which impacts on local level community participation and accountability.

7.5. Discussion and Conclusion

This chapter has addressed the second research objective of this study by assessing how the Global Fund's understanding of accountability works itself out in practice in Ghana, in particular in relationship to its implications for country ownership of national HIV/ AIDS response policy. Chapters 6 and 7 form a couplet of chapters which examines the second research objective of this

[60] Interview 8 Mar. 2018 government respondent 1b; Interview 14 Mar. 2018 government respondent 2b.
[61] Interview 24 Apr. 2018 academic respondent 3.

study. While Chapter Six analysed governance accountability in relation to this research objective, this chapter examined programmatic and financial accountability with regards to the research objective.

The study shows that contradictions exist between the roles of the office of the inspector-general (OIG) of the Global Fund, and the Ghana CCM. The relationship between the OIG and the CCM demonstrates how a non-state agent acting on behalf of a non-state entity (in this case, the Global Fund) can investigate the fiduciary and financial responsibilities of a state agency like the health ministry involved in the response and hold it to account, while the agent (OIG) itself and its principal (Global Fund) are not accountable to the government or to the citizens of Ghana. The OIG is accountable and reports solely to the Board of the Fund and not even to the Fund secretariat, or the CCM.

The study also found that contradictions also exist between the role and responsibilities of the local fund agent (LFA) and the CCM in the PBF process of programme implementation. The CCM has oversight over grants, but in reality the CCM does not have the power to suspend or cancel any grant awarded to a principal recipient (PR). The Global Fund appoints an LFA to monitor grant implementation by PRs as the Fund does not have in-country offices. It is germane to point out with regards to the accountability relations that the Global Fund signs grant agreements (contracts for the release of awarded grants) under the PBF process directly with PRs. The agreement is not signed with the CCM (to which these PRs belong to) or with the government. This applies to all PRs, both state and non-state. Thus while accountability accrues to the Fund Secretariat and ultimately to the Board through the LFA, there is no clear line of programme accountability to the government or to Ghanaian citizens affected by the diseases by the LFA. The position of the LFA in the PBF process is a donor condition, rather than a request of recipient countries like Ghana requested for it.

In relation to health workforce development, the study highlighted that the Global Fund's recruitments in the context of programme implementation of the national response are not connected to a broader strategic effort to strengthen the health system for long term sustainability. The Fund's emphasis on recruiting for specific disease programmes has led to sub-systems strengthening rather than the entire system. This creates a difficult context through

which to address health system strengthening (in terms of health workforce development) and drive country ownership of health policy processes such as the national response in Ghana.

Furthermore, the study noted that the Global Fund imposes 'conditional compliances' on target selection by steering CCMs to adopt targets aligned to the focus of key performance indicators (KPIs) favoured by the Global Fund's monitoring and evaluation (M&E) toolkit. This toolkit is the Fund's standard and procedural guide for selecting and measuring KPIs in recipient countries. Operating within these pre-established indicators raises questions of country ownership (and implicitly accountability) as the official policy of the Fund is not to impose indicators and targets on countries, but rather to allow countries to own and lead their national developmental strategies in policy and practice.

Moreover, the PBF and the audit culture that it produces deepen the Global Fund's ability to control and manage programmatic implementation in Ghana from a distance. Through the use of a wide gamut of databases and data collection and reporting systems, the Global Fund endeavours to instil new norms of programmatic and financial accountability, thereby shaping in-country programme implementation. In this way, databases, tools and reporting systems become key instruments for delivering financial value and accountability to the Global Fund for its programmatic grants in Ghana, rather than accountability to the state or its citizens.

This study also discovered that the Global Fund does not encourage PRs to take into consideration qualitative measurements like the social determinants of health that exacerbate ill health. The focus is on quantitative rather than qualitative outputs. This result in gaps in country-level accountability to those citizens affected by the diseases and negates their ownership of the response. In relation to concerns regarding the government's post-donor funding of the national response, the study found that the structural inequality that drives relations in the global political economy has created a situation where recipient countries are unable to finance their national response. Economic conditions matter and the need for donor funding is a function of the structural dependence of African economies on the industrialised nations of Europe and North America

This study also highlighted the proclivity of the Global Fund to create parallel structures, despite its official acceptance of the view that countries should determine the programmatic and financial management structures of their programmes. The Fund recommended the creation of a

programme monitoring unit (PMU), while some respondents felt it could have made do with the resource mobilisation unit (RMU) used by the Ghanaian Ministry of Health as the PMU and RMU perform the same functions. Parallel structures go against the objective of the Paris Declaration which urges donors to operate within prevailing structures.

In relation to the role of CSOs in programme implementation, findings in Ghana shows that CSOs serving as sub-recipients of funding tend to be based in urban centres, yet are appointed to implement programmes in far-flung rural, remote districts. Furthermore, many of these urban-based sub-recipient CSOs had little contact with their rural communities, constraining the amount of accessible and timely programme implementation information reaching beneficiary communities. This creates accountability challenges with regards to the CSO's ability to respond to community observations, concerns and requirements and hinders the creation of a sense of community ownership of the programme.

When all the findings of this study as articulated above are taken together, I argue that contrary to its claim that it encourages recipient countries (Ghana in this study) to take control of their developmental policy strategies, the Global Fund engages in the micromanagement of the PBF process that drives programme implementation. Through the policy choices, preferences and decisions it makes, the Global Fund Board is pushing the Fund closer to the era of conditionality (symbolised by the SAPs promoted by the World Bank and IMF) in a supposedly post-conditional era in which the notion of country ownership is key. These policy choices, preferences and decisions include the roles assigned to the OIG and LFA in the PBF process, the provision of bilateral and multilateral technical assistance for its grant recipients, and the imposition of conditional compliances such as the standardised monitoring and evaluation (M&E) toolkit which favours certain types of key performance indicators (KPIs). Other policy choices, preferences and decisions include an audit culture structured around databases, tools and data systems that creates and promotes technological dependence and micromanagement by the Global Fund, the focus on quantitative rather than on qualitative measurement indicators; and the creation of parallel structures for programme implementation.

Due to these policy choices, preferences and decisions, Global Fund grants under the PBF are infused with conditionalities. In pointing out the paradox of country ownership in a so-called post-conditionality context, Faust (2010), states that despite the mantra of country ownership

espoused by donors, they continue to condition their assistance to donor policy requirements. The underlying logic then is to try to reconcile ownership with conditionalities which creates tensions between a paternalistic and a partnership logic.

I posit that the question of power relations underpins both the paternalistic and the partnership logic evident in the Global Fund's discourse and practice. It is in this context of power relations that I situate the unresolved tension between the proclaimed policy goals of the Global Fund for country ownership in Ghana on the one hand and the institutional structures and procedures of the Fund on the other. This study therefore aligns with the positions of Barnes (2012) and Saliba-Couture (2011) (as discussed in Chapter 5.3.3) who argue that while the performance-based funding system appears apolitical and technical in nature, it is in reality political. Technocratisation obfuscates dynamics of power relations inherent in the political processes of the delivery of aid in the national response.

In sum, while the Fund professes to promote country ownership in practice in recipient countries, country ownership in Ghana is conditional ownership because the PBF process for prograame implementation in Ghana is a function of power relations. These power relations are expressed in terms of the policy choices, preferences and decisions of the Global Fund board which manifest as varying kinds of conditionalities which the Ghana CCM has to accept and abide by in order to obtain and sustain funding from the Global Fund. These conditionalities invariably shape in-country programmatic grant implementation practices and determine the nature and character of country ownership, and shape how accountability is worked out.

CHAPTER EIGHT

CONCLUSION

8.1. Introduction

This thesis has examined the institutional accountability policy and practice of the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) in the context of its partnership programme in Ghana. The Global Fund is a global public-private partnership (GPPP) in health engaged in public health policy processes worldwide in specific contexts of global health. The policy mandate that underpins its construction as a GPPP in global health obliges it to go into partnerships with aid recipient countries to finance their national health policy responses and strategies to Fight AIDS, Tuberculosis and Malaria. In undertaking the examination of the institutional accountability policy and practice of the Global Fund, I was guided by a critical political economy approach. As such, the study proceeded from the position that globalisation, conceptualised as a 'globalising market civilisation' has profoundly changed the traditional state-centric system of the international health regime by catalysing a paradigm shift to a multi-actor global health regime. As explained by Brown (2012), this change relates both to the health issues that now exceed the territorial limits of states and to the approaches to resolving these health issues which now formally incorporate non-state actors such as global public-private partnerships (GPPPs) in health, non-governmental organisations, philanthropic organisations and private business interests. These non-state actors now undertake formal and authoritative governance actions which were hitherto the exclusive reserve of state and inter-state institutions.

The emergence of these GPPPs means that accountability for public health policy processes is understood differently in the global health regime than it was in the international health regime. Although accountability is often spoken of in global health literature, there is insufficient reflection in this literature on how these GPPPs understand accountability in policy and how such policy understanding informs and affects their practice. Neither has sufficient attention been given to how such policy understanding of accountability is received and applied in practice on the ground by country level stakeholders in specific settings of global health. As such, despite contestation around the Global Fund's accountability, the literature has had little to say on the question of how the Global Fund understands accountability in policy and how such policy understanding informs and affects its practice. Furthermore, the Global Fund lays claim to

country ownership as a core principle of its accountability practice in aid recipient countries. Nevertheless, there has been a lack of scholarship investigating how the Global Fund's policy understanding of accountability works itself out in practice, in particular in relation to its implications for country ownership of health policy such as the national HIV/AIDS response policy in Ghana.

In order to address these gaps in this literature, this thesis has examined how accountability is understood in the Global Fund's policy documents and how this understanding informs or affects its accountability in practice, in particular in terms of its implications for country ownership of health policy in Ghana. Thus, the central goal of this thesis has been to investigate the accountability policy and practice of the Global Fund in the global health regime. To achieve this overarching goal, this thesis had two specific objectives:

(a) To determine how the Global Fund understands accountability in its policy documentation and what structures and procedures it has put in place to address accountability concerns.

(b) To investigate how the Global Fund's policy understanding of accountability works itself out in practice in Ghana, in particular in relation to its implications for country ownership of the national HIV/ AIDS response policy.

8.2. Summary and Findings of the Study

In order to address these research objectives, the thesis was divided into eight chapters. Section 8.2.1 will summarise the preliminary chapters of the study (Chapters One to Four) which provide the conceptual, theoretical, and methodological dimensions of the thesis, while Section 8.2.2 will summarise the substantive chapters of this study (Chapters Five to Seven) which directly engage with the research objectives and provide their findings.

8.2.1. Reflections on the Preliminary Chapters of the Study

The conceptual and theoretical basis of the study was provided in Chapter Two, where I explain that the entire thesis is embedded in a critical political economy approach. This approach assists in explaining the structural and normative transformations that led to the shift from an international to a global health regime, the emergence of global public-private partnerships (GPPPs) in health, and the implications of the emergence of these GPPPs for the way in which accountability is understood. I argue that an approach rooted in the critical political economy

tradition enables us to understand that the shift from an international to a global health regime is a complex and historically mediated developmental process conditioned by social relations. GPPPs and the question of GPPPs policy understanding of accountability as well as their accountability practice are situated in the context of these relations. Since accountability refers fundamentally to the arrangements underpinning policy and practice relations, accountability in relation to GPPPs in health is therefore about who is accountable to whom, how and why in the developmental space. In other words, it is about the relations of power.

Chapter Three examined how a globalising market civilisation can account for the emergence of the Global Fund. It does this by situating the emergence of the Global Fund in a specific historical context and providing an account as to how and why it emerged as a GPPP in the global health regime. In concluding the chapter, I argued that the global policy response to HIV/AIDS was underpinned and driven by neoliberal discourses. These discourses promote a technical understanding of the morbidity and mortality of HIV/AIDS and entrench the powers of donors and the private business sector in global health policy processes.

In Chapter Four, I analysed how a globalising market civilisation impacted Ghana through structural adjustment programmes (SAPs). The study argued that SAPs have influenced the contemporary structure and orientation of the Ghanaian political economy and its health sector. The chapter provides an understanding of the socio-economic context in which the Global Fund practice and its implications for country ownership of the national HIV/ AIDS response policy in Ghana, is situated and analysed in Chapters Six and Seven.

8.2.2. Final Reflections on the Accountability Policy and Practice of the Global Fund in Ghana

Chapters Five, Six and Seven are the substantive chapters of this study that directly engage with the research objectives and provide answers to them. Chapter Five engages with the first research objective of the study which is to determine how the Global Fund understands accountability in its policy documentation and what structures and procedures it has put in place to address accountability concerns. In order to examine the Fund's policy documentation, the study adopted a critical interpretative approach. According to this approach, knowledge is socially constructed and shaped within society by power relations and ideology. This approach highlights the dynamics of ideology, power, and knowledge that informs social practices (such as the policy

documentation of the Global Fund which articulates its institutional policy and practice arrangements). Chapter Three (on the origin of the Global Fund) provided a backdrop for Chapter Five. As argued in that chapter, the global policy response to HIV/AIDS, which is couched in neoliberal discourse, defined the standards by which current health policy responses are appraised and has entrenched the powers of donors in global health policy processes.

Through a critical reading of the Global Fund policy framework documentation, (particularly its foundational partnership framework document which details its institutional policy and practice arrangements), this study found that the Global Fund recognises three spheres of policy understanding of accountability. These are the governance, financial and programmatic policy spheres of accountability which informs the Global Fund's practice when it undertakes health policy processes in specific settings of global health. The study found that the language used in discussion of these three policy spheres of accountability is reflective of neoliberal discourses and also entrenches the power of donors. For example, the emphasis of governance accountability policy is on the governance architecture, in particular the Global Fund (e.g. the Board and the Country Coordinating Mechanisms (CCMs).

The Board is the governance mechanism of the Fund at the global level, while the CCM is the governance instrument of the Fund at country level to drive country ownership. While the Board's operational practice supposedly promotes participatory decision-making processes, there is limited inclusivity in terms of meaningful participation of developing countries' representatives in decision-making processes, resulting in the Global Fund Board being a donor-dominated space. As the CCM is the country-level governance instrument for the realisation of country ownership, its activities cut across all the other spheres of accountability and is discussed in the context of the national HIV/AIDS response in Ghana in Chapters Six and Seven.

The financial sphere of accountability policy is focused on the financial procedures, regimes and standards operational in the Global Fund. The study found that the financial sphere of accountability policy reflects the material capabilities of donors. Material capabilities refer to donor dominance of the centres of power in the global political economy (centres of global production, politics, finance, knowledge and technologies). These material capabilities imbue donors with clout in organisational settings such as the Global Fund and are reflected in two ways in the institutional setting of the Fund. Firstly, donors' material capabilities play a role in

the ‘replenishment cycle’ (fund-raising cycle) during which donors make pledges and donate to the Global Fund financial coffers. Secondly, donors exercise power by withholding financial support from the Fund as a sanctioning mechanism to pressure the Fund to align with donor demands.

As Chapter Five also illustrated, fundamental to programmatic accountability policy are the actors who participate in the performance-based funding (PBF) process; the frameworks and specific targets for evaluating programmes; and the structures, systems or tools which shape and determine programme implementation. In this context, the study found that donor influence is expressed in depoliticised and technocratic language such as quantification, efficiency, effectiveness. The highly technical process of performance-based funding which underpins programmatic activities is reflective of this language. Indeed, as shown by Barnes (2011), this emphasis on technical criteria favours efficacy and efficiency in the delivery of health aid and gives little or no consideration to the complex and multifaceted issues that account for ill health in specific settings of global health. Technocratisation thus imposes a narrow framework for the analysis of political processes such as PBF. That is, technocratisation obfuscates dynamics of power relations inherent in the political processes of the delivery of aid.

When the findings in Chapter Five are taken together, this study submits that accountability in the Global Fund comprises relations between large numbers of partners with unequal levels of power. This supports my argument throughout the thesis that the term partnership should be understood as a specific modality of power relations. Looking at partnership in this way draws attention to the dynamics of power relations in partnerships rather than simply accepting the assumption of ‘collaborative decision making’ or ‘equally shared and mutual power’ implied by the term partnership. Thus, this study concluded Chapter Five by positing that accountability in a partnership like the Global Fund must be understood as context-specific and as a function of relations of power. The mechanisms put in place to realise accountability (such as the Board, the CCM or the PBF) either reinforce existing power relations or could potentially act as agents of change (e.g. by promoting country ownership) in practice. It then becomes imperative to carefully examine these mechanisms (underpinning policy spheres of accountability) in practice to better understand their impact when worked out in a specific context of public health such as in Ghana.

Chapters Six and Seven addressed the second research objective of the study which was to investigate how the Global Fund's policy understanding of accountability works itself out in practice in Ghana, in particular in relation to its implications for country ownership of the national HIV/AIDS response policy. While Chapter Six analysed the Global Fund's governance accountability practice in relation to this research objective, Chapter Seven examined financial and programmatic accountability practice with regard to the same research objective. The analysis in both chapters is informed by a field study undertaken in Ghana between February and May 2018. The chapters drew on an interpretive analysis of observation of meetings, interviews with stakeholders in the national response and on documentary evidence (see Chapter 1.7.3.2). In conducting this fieldwork, my interest was in exploring how various country-level actors interpret the Global Fund's accountability policy measures in practice, in particular in relationship to its implications for country ownership of the HIV/AIDS response policy in Ghana.

As mentioned in the paragraph above, the focus of Chapter Six is on the governance accountability practice of the Fund. The emphasis of governance accountability policy is on the governance architecture (e.g. the Board and the CCM) in relation to who is included (or excluded) from participating in the governance functions such as agenda-setting and decision-making. The CCM is the country-level governance instrument of the Global Fund for the realisation of country ownership. It is in practice at country level in Ghana that the claim of the Global Fund to promote country ownership of health policy is potentially brought to life. Therefore, in appraising the activities of the CCM in relation to the ownership of the HIV/AIDS response in Ghana, it was imperative to examine who the CCM assigned a say (voice) and a role (participation) in how the HIV/AIDS response agenda is shaped and set. Also important was the interaction of the CCM with other institutional structures of the Global Fund engaged in the HIV/AIDS response.

The study found that CCM practice of country ownership in Ghana is reflective of conditional ownership. It is imperative to point out that some government and some civil society officials felt empowered by the CCM governance practice process. Some government officials felt empowered as the Ghanaian government has formal leadership of the CCM. In turn, some civil society officials credit the Global Fund for creating a broad-based participation platform that

opens up the decision-making space to marginalised groups such as civil society organisations and Ghanaians affected by the diseases. These are groups that have been historically side-lined in state health policy decision-making and coordination bodies in Ghana. To the CSO officials, the CCM represented a downward shift in power relations because entities outside government circles can now participate in public health agenda-setting and policy-making activities hitherto closed to them.

However, this study took the position that the CCM agenda-setting practice process does not ultimately grant the Ghanaian government and civil society significant ownership because the CCM practice is undermined by the Global Fund's reporting structures and /institutional arrangements. For example, a fundamental contradiction exists between the Global Fund's claims to promote country ownership and their practice of bypassing the government coordination mechanisms already coordinating Ghana's HIV/AIDS response. The Global Fund itself in its policy documentation states that it will build on existing coordination mechanisms in aid-recipient countries, but in practice in Ghana, it has not done so. The study shows that there were pre-existing national coordination mechanisms already coordinating Ghana's HIV/AIDS response which were bypassed by the Global Fund.

Furthermore, the findings indicate that contradictions remain between the rhetoric of country ownership and the powerful role of principal head office accountability structures of the Global Fund, such as the technical review panel (TRP). The powers of the TRP to approve, reject, amend and revise country proposal gives the TRP an overarching influence on recipient country agenda-setting activities. As the evidence demonstrates, the TRP exerts influence in shaping Ghana's health agenda from outside, yet it is not accountable to the CCM even though it can itself, hold the CCM to account via its role in the application process. The TRP is also not accountable to the Global Fund secretariat or even the government of Ghana or her citizens affected by the diseases. It is solely accountable to the Global Fund Board.

The study noted that the Ghana CCM assigns a role to a wide gamut of state, non-state, national and international actors who are not accountable to the Ghanaian government or Ghanaians citizens. The multilateral partners are accountable to their governing boards, while the bilateral agencies report to their home governments. Other institutional structures of the Global Fund that are involved in the CCM practice process, such as the Global Fund Ghana country team, are

solely accountable to the Fund Secretariat, and the Secretariat itself is accountable to the Fund Board. While these bilateral and multilateral institutions are on the CCM mainly as technical assistance providers, this study finds that technical assistance provides a channel to influence agenda-setting. As noted by Chelsea (2014), technical assistance allows donors to exhibit their expertise and thereby impose their authority. It thus the door for 'outside' influence to shape agenda-setting and limit the influence of the Ghanaian voice, raising questions with regards to notions of ownership and accountability. Furthermore, the study finds that the Global Fund's move into health systems strengthening (as a consequence of its adoption of new funding model which embeds a national strategy approach) imbues the CCM with influence which extends into broader governance of the response thereby raising questions with regards to who governs the HIV/AIDS response. Neither the Global Fund nor the CCM as a body is accountable to the government of Ghana or to Ghanaian citizens.

In relation to the CCM governance practice and ownership of the HIV/AIDS response by those affected by the diseases, this study finds that claims that civil society organisations (CSOs) are accountable or responsible to broader communities of affected citizens in Ghana are overstated. Evidence adduced shows that the discursive commitments to wider participation through engagement with civil society has not led to the voices of the marginalised being heard in decision making in the Ghana CCM agenda-setting activities. Constituents require consistent communications channels with their CCM representatives and also information on their performance on the CCM to hold them to account and influence agenda-setting. The technical nature of Global Fund policy documents limits the participation of broader communities. In addition, CSOs' ability to interpret and disseminate such information is limited. Channels of communications and information dissemination are crucial conduits of accountability for holding representatives to account.

The absence of such accountability conduits constrains the bottom-up and inclusive approach that is supposed to reflect the voice of grassroots communities of affected citizens and stifles the possibility of their input in agenda-setting. The marginalisation of key affected population representatives also constrained their voice in decision-making because agenda-setting was driven by the technical competence of members rather than by their lived experiences. The 'closed old boys network' nature of CCM membership meant that accountability was more

horizontal (between them) than to the constituents they claim to represent. As discussed, CSO representatives are principal recipients of the Fund who undertake grant implementation. As will be discussed in Chapter Seven, the Global Fund signs grant implementation agreements directly with the principal recipients and not with the CCM or the government. This ensures that the CSOs are directly accountable to the Global Fund.

When the findings highlighted above are considered together, it can be said that the Ghanaian situation is reflective of conditional ownership. Crucial to understanding how the reporting and institutional arrangements of the Global Fund conditions country ownership, and ultimately accountability, is the agency and power of the Global Fund Board. The agency and power of the Board is crucial for understanding the power relations and context within the Fund and its consequences for country ownership and accountability outside the Fund. The Board of the Fund retains substantial scope for flexibility with regard to policy preferences, focus areas or choices. One way it does this is by exercising significant power in determining which country grant proposals to accept, revise or reject through the TRP that reports solely to it. In addition, the Board has influence over the types of treatment regimes to be supported, the balance of funding between the three diseases, the composition of CCMs, and other important aspects crucial to the CCM practice. Describing the relationship between donors and recipient countries as a partnership (as detailed in the Paris Declaration) obfuscates the question of power relations and neglects the context of strong economic and fiscal dependence of aid recipient countries such as Ghana on donors.

This study thus takes the position that these policy choices, preferences, or focus areas enunciated by the Board to guide grant applications are akin to conditionalities. As Saliba-Couture (2011) points out, a key issue mediating country ownership and accountability is conditionality, especially when such conditions emanate from donors. Conditionality creates tensions between a paternalistic and a partnership logic in a supposedly post-conditional era implicit in the notion of country ownership. The irreconcilability between country ownership and conditionality results in the depoliticisation of the concept of country ownership.

While Ghanaian government agencies may take formal leadership of the CCM (e.g. the Ministry of Health holds the chairmanship), country ownership is conditional ownership. The practices which would allow for country ownership to be affirmed and for the relevant actors to be held

accountable are mediated by the Global Fund's funding stipulations and conditionalities which must be heeded by the Ghana CCM if it is to maintain its financial relationship with the Global Fund. The mediating role of conditional finance in the relations between the Global Fund and Ghana (through the CCM) enables the Global Fund Board to govern the HIV/ AIDS response from a distance without being present in Ghana.

On the whole, however positive the concept of country ownership may seem, the findings of this study suggest that the Global Fund practice through the CCM instrument is insufficiently participatory and representative, resulting in conditional country ownership and limited accountability. This impacts on the ability of the Ghanaian government and citizens to truly own (lead, design and control) their developmental policies and strategies. Thus, despite the rhetoric of country ownership, donors continue to call the shots in the design and implementation of aid delivery. Therefore, governance accountability instruments such as the CCM are not politically neutral, nor indifferent. Rather, they are context-specific and a function of power relations.

Chapter Seven examined financial and programmatic accountability practice. Programme and financial accountability are undertaken in practice through the CCM as the governance instrument to underpin and drive country ownership. The Global Fund implements programme and financial accountability through a performance-based funding (PBF) system (see Chapter 5.3.3). Put clearly, the PBF is the financial regime that underpins programme implementation. So the financial and programmatic accountability policy spheres are inextricably linked in practice when undertaken by the CCM. As Chapter Five illustrated, germane to financial and programmatic spheres of accountability are the financial procedures, regimes and standards operational in the Global Fund (e.g. the PBF), the actors who participate in the PBF process, the frameworks and specific targets for evaluating programmes, and the structures, systems or tools which shape and determine programme implementation (see Chapter 5.3.2 and 5.3.3).

In this respect, the study finds once again that country ownership in Ghana is conditional ownership. This is because contrary to its claim of allowing recipient countries (such as Ghana) to take control of their developmental policy strategies, the CCM practice of PBF undermines country ownership. The reporting structures and institutional arrangements related to PBF are determined by the policy choices, preferences and decisions of the Global Fund board. Such policy choices include the roles of the OIG and LFA in the PBF process, and the focus on short-

term gap-filling in terms of the recruitment of health workforce (which undermines sustainable health systems strengthening). It also includes the imposition of conditionalities through the standardised M&E toolkit which favours certain types of key performance indicators (KPIs). Other policy choices which undermine country ownership are an audit culture that creates and promotes technological dependence and micromanagement by the Global Fund, and a focus on quantitative rather than on qualitative measurement indicators resulting in the neglect of the socio-economic conditions of those affected by the diseases. Such choices also encompass the proclivity to create parallel structures for programme implementation and issuing guidelines for the composition of the CCM.

Due to these policy choices, preferences and decisions, Global Fund grants under the PBF are infused with conditionalities. This study therefore supports the positions of Barnes (2011) and Saliba-Couture (2011) who argue that while the PBF system appears apolitical and technical in nature, it is in reality political. Thus, while the Fund professes to promote country ownership in practice in recipient countries, country ownership in Ghana is conditional ownership because the PBF process for programme implementation in Ghana is a function of power relations These power relations are expressed in terms of the policy choices, preferences and decisions of the Global Fund board which manifest as varying kinds of conditionalities and stipulations which the Ghana CCM has to accept and abide by in order to obtain and sustain funding from the Global Fund. These conditionalities and stipulations shape in--country programmatic grant implementation practices and determine the nature and character of country ownership in play, and implicitly the accountability relations.

8.3. Concluding Remarks and Areas for Further Study

There is still a lot more to grasp and understand about the accountability policy and practice of the Global Fund. However, this thesis has begun to address some of the gaps in the literature, thereby contributing to academic knowledge. Chapter Five provides insights into how the Global Fund understands accountability in its policy documentation and what structures and procedures it has put in place to address accountability concerns. This is because despite significant literature and contestation around the Global Fund's accountability, the literature has little to say on the question of how the Global Fund itself (as a partnership organisation) understands

accountability in its policy documentation and how this policy understanding informs its practice when it partakes in health policy processes in specific settings of global health.

Furthermore, there has been a lack of scholarship directly exploring how the Global Fund's understanding of accountability works itself out in practice, in particular in relation to its implications for country ownership of health policy in specific settings of global health such as the national HIV/ AIDS response policy in Ghana. Chapters Six and Seven address this topic. Both chapters present a sustained, reflexive and empirical analysis of how the Global Fund's understanding of accountability works itself out in practice in Ghana and what implications this practice has for country ownership of Ghana's health policy. Also, from a theoretical perspective, while some discussions of global health are insufficiently attentive to questions of power relations, this study, rooted as it is in the tradition of critical political economy has paid particular attention to power relations. In this context, this research aligns with other studies that have considered the crucial historical roots of global public-private partnerships in health.

As has been highlighted in the Ghanaian context, the policy and practice of the Global Fund raise fundamental questions about the role of public-private partnerships in a supposedly post-conditionality era exemplified by the Paris Declaration on Aid Effectiveness to which the Fund is a key signatory. The Global Fund's practices in Ghana through the CCM undermine country ownership and make a farce of accountability to the government and Ghanaian citizens affected. Though the objective conditions and country characteristics of Global Fund operations differ from context to context, the Ghanaian experience with regards to country ownership seems similar to the experiences of other countries with the Global Fund as discussed in the various single and multi-country studies cited in this study in Chapters Six and Seven. In Ghana, we see the undermining of country ownership and the hampering of accountability through the creation of parallel structures, the articulation of standardised key performance indicators, the promotion of an audit culture that creates technological dependence, and the dependence on technical assistance that provides an avenue for sustained donor influence. Furthermore, we see country ownership being further curtailed as a result of the influential roles of the technical review committee (TRP), and the local fund agent (LFA).

It thus becomes imperative to call on African countries to find ways to drive their own health initiatives and 'own' their public health policy and practice. However, the reality is that the

majority of countries in sub-Saharan Africa (such as Ghana) function in a context of strong economic and fiscal dependence on donors. This aligns with the observations of Brown (2012) who averred that when states sign up to neoliberal regulatory agreements and frameworks (like the CCM in Ghana), they relinquish domestic autonomy over national policy choices and planning to the dictates of international forces outside their control. These frameworks also place restrictions on the sovereignty of public authorities in relation to domestic policy choices and preferences. In this vein, there is therefore a need to consider more overtly critical political approaches that can engender a 'transformation of political power' (Benatar et al., 2018:155) between the developed and developing countries in the global political economy.

Such approaches favour the transformation of political power between the developed and developing countries through the promotion of social justice and human rights for the marginalised and the recognition of the essential regulatory and stewardship role of governments (Barnes, 2011; Benatar, 1998). It is imperative to state that this study does not subscribe to a narrow interpretation of human rights that simply lays emphasis only on political and civil rights. Rather it aligns with the views of Benatar (2016) that any conception of human rights must consider the broad gamut of rights inherent in the Universal Declaration of Human Rights (UDHR). The attainment of most of the Human Rights referred to in the UDHR, as Benatar et al. (2018) explain, relies on access to material resources. In the face of systemic economic inequalities that impact not just individuals, but whole communities of people in developing countries around the world, these rights are very difficult to achieve (Benatar et al., 2018). As explained in Chapter 2.4, widespread economic disparities are a function of historical policies that have underpinned global economic processes such as structural adjustment, conflict over mineral resources, colonialism and imperialism. These practices account in one way or the other for the underdevelopment of the political economy of developing states (such as Ghana) and their health sector. As Brown (2012) correctly pointed out, practices such as those aforementioned underpin widespread poverty, undercut governance capacity and ultimately constrain development.

Following from the above, this study posits that the adoption of procedural and incremental changes in the context of the contemporary structure of global economic relations between the northern and southern hemisphere may provide narrow tactical, short term solutions, but not the

broader strategic, long term solutions needed to drive change and as such, will ultimately prove inadequate. Therefore, this study takes the position that in the long-term, what is needed is a re-ordering of the global political economy in order to drive change in the contemporary neoliberal world order in general and global health in particular. Such a re-ordering must take into consideration the global factors and policies that perpetuate inequality, deprivation, ill health and the underlying historical, political and material power structures that shape agency in global health governance (Gill and Benatar, 2017; Brown, 2012). Without fundamental structural changes, it will not be possible to address the widespread poverty that drives ill health in sub-Saharan African states and to chart the way forward.

Until we see such a re-ordering of global economic relations, Ghana (and other sub-Saharan African countries) will continue to be aid-dependent and therefore to play conditional or subsidiary roles in global governance frameworks like the Global Fund. As argued in Chapter 5.5, this unequal power relation is by virtue of aid recipient countries' inferior material capabilities relative to that of donors. Material capabilities include donor dominance of the centres of power in the global political economy (centres of global production, politics, finance, knowledge and technologies). As Chapter 5.5 further explains, the material capabilities of donors imbue them with clout in institutional settings such as the Global Fund which allows them to shape, influence and determine policy. When material power is applied in an institutional setting (such as the Fund), it becomes relational (see Chapter 5.5). Put clearly, material capabilities underpin power relations in the policy and practice of global health institutions such as the Global Fund.

As such, there is the constatnt need for a critical approach and a careful interrogation of the translation of ideas (through words) in policy documentation into practice , thereby alerting us to the role of power and the deeply political and politicised nature of the global aid industry and the ways in which this industry continually reinforces global inequalities. Therefore, by adopting an approach rooted in the critical political economy tradition, the researcher (and the reader) can come to understand that accountability refers essentially to how policy and practice relations are configured and managed. This means that accountability in relation to global public-private partnership (GPPPs) in health like the Global Fund is about who is accountable to whom, how and why in the developmental space. In other words, it is about the relations of power. For

scholars interested in global health in particular and international relations more broadly, the findings of the thesis should be considered as a starting point for further research on the Global Fund. In sum, I hope this research will help catalyse trajectories for future research on the Global Fund, engender thinking on alternative approaches and spur further discussion about ways to examine and research the institutional accountability policy and practice of the Global Fund in relation to country ownership in recipient countries.

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APPENDIX A - Informed Consent Form

RHODES UNIVERSITY
DEPARTMENT OF POLITICAL AND INTERNATIONAL RELATIONS

AGREEMENT

BETWEEN STUDENT RESEARCHER AND RESEARCH PARTICIPANT

I (participant's name) _____ agree to participate in the research project of Onokwai John on Accountability in the Global Health Regime.

- The researcher is exploring the Institutional Accountability Policy and Practice of the Global Fund to Fight AIDS/Malaria and Tuberculosis Partnership programme in Ghana.

- This study is informed by the understanding that globalisation induced shifts in the global political economy has had knock-on consequences for understanding accountability in the global health regime. This is due to the emergence of global public private partnerships (GPPPs) in health and the increased role and prominence of non-state actors (due to their formal incorporation into health policy processes and decision making structures) in the global health regime. The emergence of GPPPs in health and the nature and character oftheir individual policy and practice mandates suggests changes in the ways in which accountability for public health policy processes is currently understood in the global health regime relative to the international health regime. In order to examine the Global Fund accountability, there is therefore the need to understand and respond to what accountability translates to in policy by the Global Fund and how such informs or affects accountability in practice in particular in relationship to its implications for country ownership of health policy in Ghana.

I understand that:

1. The researcher is a student conducting the research as part of the requirements for a PhD degree at Rhodes University. The researcher can be contacted at (+ 27) 0656188368.The supervisor (Prof. Sally Matthews) can be contacted at s.matthews@ru.ac.za or 076 040 8629 if I find I have any concerns about the research.

2. The researcher is interested in exploring the notion of Accountability in the Global Fund for AIDS/Malaria and Tuberculosis Partnership programme in Ghana.

3. The research proposal of this project has been approved by the Humanities Higher Degrees Committee at Rhodes University and has ethical clearance by the Rhodes University Ethical Standards Committee.

4. My participation will involve my responding to an interview or partake in focus group discussion. I reserve the right not to allow the researcher to use her tape recorder if I feel uncomfortable with it.

5. I am invited to voice to the researcher any concerns I have about my participation in the study and to have these addressed to my satisfaction.

6. I am free to withdraw from the study at any time - however I commit myself to full participation unless some unusual circumstances occur or I have concerns about my participation which I did not originally anticipate.

7. The report on the project may contain information about my personal experiences, attitudes and behaviours, but I may request that the report (PhD) omits my name so that I will not be identified by the general reader.

8. A transcript of my interview will be stored on online servers gmail and dropbox for the use in the thesis or publications emanating from this research, and may be used for further research, dependent on permission of the researcher. I reserve the right to request that my interview not be archived.

9. I will not receive monetary compensation for my participation.

Signed on (Date): _____

Participant: _____

Researcher: _____

Witness: _____

APPENDIX B – Interview Guide

(A) Background Core Questions

1. Can you please introduce yourself?

2. Can you tell me more about your organisation in terms of its history, operations, administrative set up, funding and so on.

3. What is your current position in this administrative set up and how long have you been in this position? Describe your role or designated responsibility.

4. Why did your organisation decide to associate or participate in this partnership programme with the CCM for the implementation of the national HIV/AIDS response programme? Can you describe the history?

(B) CCM Practice, Governance Accountability and Country Ownership of the Response

1. How do you view the CCM as an instrument for the governance of health in Ghana with regards to the national HIV/AIDS response programme?

2. Membership composition of the multi-partnership CCM and the representation of all constituencies across sectors.

3. How is participation within the CCM by the various partnership constituencies evaluated and recorded?

4. Can you please describe the CCM agenda setting and decision-making process that determines the health issues that are prioritised and encapsulated in the proposal (later referred to as concept note) submitted as Ghana grant application to the Global Fund.

5. What systems are in place for the dissemination of information for call for proposals and grant applications by CCM members to their various constituencies and the feedback complaints process from constituencies to CCM?

6. As CCM members, what procedures have been put in place by you to undertake coordination meetings with the constituencies you represent in order to make for a more inclusive agenda setting process?

7. How are inputs made into this process by the various partnership constituencies that make up the CCM? Are there those marginalised or excluded from participating in this process in one way, form or the other?

8. How do you perceive the relationship between the CCM and the other institutional structures of the Global Fund such as the technical review panel (TRP), the secretariat, the local fund agent (LFA), the office of the inspector general of the Global Fund (OIG)?

9. What national strategies, policies, or frameworks are in place to govern the national HIV/AIDS response?

10. In your experience, in what ways do you think activities in the Ghanaian health sector in the context of the national HIV/AIDS response has been determined by the Global Fund rather than the Ministry of Health? Please provide instances.

11. Within countries such as Ghana, technical advisers (TAs) appear to be a defining characteristic of Global Fund supported operations or programmes. In the context of your association with the Fund, please, what in your opinion, are the positives and drawbacks in the use of TAs by the Global Fund?

(C) CCM Practice, Programmatic and Financial Accountability and Country Ownership of the Response

1. Do you have any knowledge or experience with the performance based funding (PBF) programmes supported by the Global Fund in Ghana through the CCM? If yes, for how long?

2. What kind of Global Fund related programmes or actions were you involved in within the Ghanaian health sector?

3. To what extent has the the Global Fund through the CCM practice of PBF that underpins programme implementation created opportunities and/or problems, challenges in the Ghanaian health sector?

4. Would you please explain some of the issues, obstacles and impacts that are due to the introduction of PBF driven programmes in the Ghanaian health sector for your organisation and for the health system (or sector)?

5. How has the Global Fund-funded programmes affected or shaped Ghana's national response to the HIV/ AIDS epidemic or what are some of the programmes' significant outcomes in your opinion?

Note: These general questions under A, B and C were expanded in the semi-structured interview format by way of specific follow-up questions to respondent answers and views as the need arises.