

THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA:
ASSESSING COMPLIANCE FROM GLOBAL HEALTH DONORS

by

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Submitted in partial fulfilment of the requirements
for the degree of Master of Arts

at

Dalhousie University
Halifax, Nova Scotia
March 2016

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ABSTRACT

The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) has a formidable position in the global health architecture owing to the significant resources it has garnered from major donors, and its influence in shaping the global health agenda. This thesis seeks to understand its role in global governance. To do so, it employs compliance theories from the International Relations and International Law literatures to determine why three distinct but crucial actors, the United States government, the Chevron Corporation, and the Bill and Melinda Gates Foundation, invest in, and comply with, the GFATM. The thesis adopts a two-pronged approach: Chapter 3 applies Mitchell's (1996) conceptualization of a compliance system to understand what is inherent to the GFATM that induces compliance by donors, and Chapters 4 and 5 apply March and Olsen's (1998) logics of consequentialism and appropriateness to understand why the selected actors support and comply with the GFATM. Since the selected donors could invest in other funding mechanisms or channels, and since there are aspects of the GFATM's operating mechanisms that run contrary to their approaches to development, this thesis will shed light on why these donors continue to comply with, and invest in, the GFATM.

LIST OF ABBREVIATIONS USED

BRICS: Brazil Russia India China South Africa

CCM: Country coordinating mechanism

CSO: Civil society organization

CSR: Corporate social responsibility

DOS: Department of State

Gates Foundation: Bill and Melinda Gates Foundation

GATT: General Agreement on Tariffs and Trade

GF: Global Fund to Fight AIDS, Tuberculosis and Malaria

GFATM: Global Fund to Fight AIDS, Tuberculosis and Malaria

GHG: Global health governance

GHI: Global Health Initiatives

GHP: Global Health Partnership

HSS: Health systems strengthening

IL: International Law

IR: International Relations

LFA: Local Fund Agent

LMICs: lower middle income countries

IOs: International organizations

M&E: Monitoring and evaluation

MoH: Ministry of Health

NGO: Non-governmental organization

PBF: Performance-based funding

PEPFAR: The U.S. President's Emergency Plan for AIDS Relief

PD: Paris Declaration

PPPs: Public-private partnerships

SWAp: Sector-Wide Approach

TB: Tuberculosis

TRIPS: Trade Related Aspects of Intellectual Property Rights

UN: United Nations

UNSC: United Nations Security Council

WHO: World Health Organization

WTO: World Trade Organization

ACKNOWLEDGMENTS

I would like to first thank my Supervisor, Dr. David Black of the Political Science department at Dalhousie University. Dr. Black was incredibly supportive over the course of my degree, and I am grateful for the guidance and advice I had with the writing this thesis. Dr. Black was always very encouraging of my ideas, and his reassurances of my arguments, and his sound advice when I required direction, was always greatly appreciated.

I would also like to thank my committee members, including Dr. Brian Bow as the second reader, and Dr. Ruben Zaiotti as the external examiner. I am grateful for the time they took to engage with my work, and their valuable comments on this thesis.

I would also like to thank the Social Sciences and Humanities Research Council and the Killam Trust for their support. I am very grateful to these funding entities for giving me the opportunity to focus on my course work and thesis over the completion of my M.A degree.

I would also like to thank Tracy Powell and Shannon Langton for their support, kindness, and friendship throughout the course work and the completion of this thesis for my M.A.

Finally, I would like to express my profound gratitude to my parents, siblings, and friends for providing me with unwavering support and encouragement throughout this degree and the writing and completion of this thesis. This accomplishment would not have been possible without their love and support.

CHAPTER 1: INTRODUCTION

The global health architecture is a complex area of international development, consisting of several types of actors with competing mandates, struggling to claim a portion of this landscape in their attempts to make a difference and improve health outcomes (Schieber et al., 2007; Ulbert, 2008). Within this multifaceted environment, the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) has emerged as a prominent funding mechanism for communicable diseases, garnering the support of key donors, such as the Gates Foundation, the United States government, and the Chevron Corporation. Upon examining the GFATM's role in global health governance, a major question that emerges is: why do these donors choose to invest in this funding mechanism? Inevitably, there are numerous channels for donors to direct their investments towards, including bilateral assistance and other Global Health Initiatives (GHIs). Furthermore, there are aspects to the GFATM that are at odds with the aforementioned global health donors' mandates. Nevertheless, these donors continue to invest and promote this funding mechanism. For example, its health systems strengthening (HSS) grants run counter to the Gates Foundation's neoliberal approach, yet the Foundation continues to be a major advocate of the GFATM (McCoy et al., 2012; Storeng, 2014). While the discussion of compliance in regards to development initiatives typically focuses on beneficiaries, compliance within the donor community is an equally important concern as the GFATM is entirely dependent on voluntary contributions from donors and thus relies upon the compliance of donors in order to ensure its continued existence. Consequently, an examination of what is particular to the

GFATM that would convince major donors to invest in it is needed in order to fully understand the GFATM's role in global health governance.

Incorporating compliance theories from the International Relations (IR) and International Law (IL) literatures, this thesis will present two arguments to answer this question. First, Chapter 3 will demonstrate that following the 2011 corruption crisis the GFATM has been able to attract donors owing to its reconfigured compliance system (Mitchell, 1996). This moment of crisis for the GFATM was crucial in persuading states to comply, as following reports of corruption in recipient countries, several donors chose to freeze their funding and did not commit resources for 2011–2013 (Usher, 2011). In turn, the GFATM had to follow the recommendations of donors and the international High-Level Independent Review Panel and restructure its mandate and operating mechanisms in order to ensure their continued compliance and in order for them to release their committed resources (Usher, 2011). Second, Chapters 4 and 5 will present explanations as to why the aforementioned donors would choose to invest in the GFATM. The latter two chapters will reveal that given the range of different donors, there is a diversity of motivations for actors' compliance with the GFATM, conforming with a logic of consequences and appropriateness, respectively.

The Scale-Up in Global Health & Global Health Initiatives

Beginning in the late 1990s, a period of “public health activism” enveloped the global health landscape with the incredible response towards communicable diseases (Kapilashrami & Hanefeld, 2014; Lidén, 2013; McCoy et al., 2012, p.7). This scale-up was characterized by several “innovations”, including the shift in focus from investing in primary and system-level health care towards a selective and “problem-focused”

approach (Lidén, 2013, p.5; McCoy et al., 2012). This shift was coupled with what Lidén (2013) coins “demand-driven funding” (p.5), as resources were mobilized and dispersed to developing countries most in need in order to mitigate the destruction cause by pandemics such as HIV/AIDS, and to provide treatment and support (Fan et al., 2013). In addition, this scale-up witnessed the incorporation of “the private sector, private philanthropy and civil society” into policy-making and health governance (Lidén, 2013, p.5). In particular, the rise of “philanthrocapitalism” has been a noticeable trend in the global health and broader development landscape (McGoey, 2014; Morvaridi, 2012, p.1191). According to Morvaridi (2012), this type of philanthropy is driven by individual capitalists, and is “both politically and ideologically committed to market-based social investment through partnerships, to make the market work... better for capital” (p.1191).

The inclusion of the private sector and the rise of “neoliberal capitalist philanthropy” (Morvaridi, 2012, p.1191) have also brought about an emphasis on “outcome/ results” and “evidence-based decision-making” (Lidén, 2013, p.5; McGoey, 2014). Biehl and Petryna (2013, p.8) refer to this as “[the] dominant regime of veridiction and falsification”, in which “interventions [are] cost-effective and scalable” with the increasing presence of for-profit institutions as “purveyors of services”. In turn, global health initiatives are not designed to be compatible with individual country contexts, but to implement one-size-fits-all models (Biehl & Petryna, 2013, p.8).

This period has also witnessed profound change in the composition of the international aid architecture. A central driving force in this transformation has been the emergence of GHIs (Kapilashrami & Hanefeld, 2014; Lidén, 2013; Spicer et al., 2010). As defined by Spicer et al. (2010), a GHI is “a blueprint for financing, resourcing,

coordinating and/or implementing disease control across at least several countries in more than one region of the world” (p.2). With this global mandate to better health outcomes around the world, GHIs can have several different governance configurations and include both private and public actors (Spicer et al., 2010).^{1,2}

As Kapilashrami and Hanefeld (2014) describe, GHIs “are regarded as the backbone of this global response” (p.160). Rather than rely on state-led interventions, GHIs create global responses to health issues by generating an unprecedented amount of funding and bringing new actors into the global health dialogue, including civil society and private actors (Bruen & Brugha, 2014; Brugha, 2009).

The Impact of GHIs for Global Health Governance

The scale-up for combating communicable diseases and the advent of GHIs have facilitated major changes in global health governance (Brugha, 2009; Biehl & Petryna, 2013).³ Throughout the 20th century, authority in the global health agenda rested with the state in terms of determining and implementing international health priorities and programs, and with the World Health Organization (WHO) acting as a coordinating body for these initiatives (Brugha, 2009; Biehl & Petryna, 2013, p.3). As Biehl and Petryna (2013) note, with the creation of the Millennium Development Goals (MDGs), health became recognized “as an essential value and as a key pillar of development” (p.6). Concurrently, “interests and practices of the private sector began to play a larger role in global public health” (p.6). As such, this has had major implications for global health

¹ As Brugha (2009) describes, private actors can include “representatives of philanthropic trusts and for-profit and nonprofit private sector actors on their [GHI] governing boards” (p.131).

² For example, the United States President’s Emergency Plan for AIDS Relief (PEPFAR) is a bilateral organization, whereas the Global Fund to Fight AIDS, Tuberculosis and Malaria is a public-private partnership (Brugha, 2010; Spicer et al., 2010).

governance, as more actors have been able to influence the global health agenda (Brugha, 2009). McCoy et al. (2012) describe the resulting global health landscape as “a crowded and multi-nodal global health complex” (p.7). This reconfiguration of the global health system has forced traditional multilateral organizations, such as the United Nations (UN), to redefine their roles (Bruen & Brugha, 2014; Brugha, 2009).

Given the competing mandates of GHIs operating in the global health landscape, it is recognized in the literature that there is an overall “lack of an effective system of global governance” (Schieber et al., 2007, p.927; Ulbert, 2008). Scholars have characterized the consequent global governance landscape in health in various ways: Schieber et al. (2007) refer to it as “unstructured plurality” given the competing mandates of international initiatives (p.927), while Whyte et al. (2014) refer to it at the country-level as “‘projectified’ landscapes of care” (as quoted in Biehl & Petryna, 2013, p.6). Although GHIs have produced some significant advances in the international response to particular health challenges, the diffusion of power from the central coordinating authority of UN organizations and states has inevitably led to increased disorder and a lack of accountability within the global health landscape (Bruen & Brugha, 2014; Brugha, 2009).

The Global Fund to Fight AIDS, Tuberculosis and Malaria

The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) is an influential GHI composed of private and public actors that was created “to attract, manage, and disburse additional resources worldwide” for the prevention and treatment of HIV/AIDS, tuberculosis (TB) and malaria (Bennett & Fairbank, 2003; Brugha et al.,

³ For definitions of ‘global health governance’ and ‘globalization’, see Appendix A.

2004, p.95; Brugha, 2009; McCoy et al., 2012). Since 2002, it has disbursed approximately U.S. 27 billion dollars (Esmail, 2015). Through the immense amount of funding and support it has generated, the GFATM claims that as of December 2014, GFATM grants have allowed “7.3 million people [to be] on antiretroviral therapy [ART] for AIDS, have tested and treated 12.3 million people for TB, and have distributed 450 million insecticide-treated nets to protect families against malaria” (GFATM, 2015).

Creation

The GFATM was created in January 2002 in the context of the emergence of GHIs and the scale-up in the international community to rapidly mobilize resources to combat communicable diseases (Brugha, 2009; Feachem & Sabot, 2006; McCoy et al., 2012). In April 2001 at a summit in Abuja, Nigeria, African leaders came together and called for greater resources for these communicable diseases, with United Nations (UN) Secretary General Kofi Annan asking for a “war chest” of financial resources to combat HIV/AIDS (Feachem & Sabot, 2008, p.537). In June of that year, the UN General Assembly’s Special Session on AIDS committed to a new funding mechanism, and subsequently at the Group of 8 (G-8) summit in Italy in July, heads of state agreed to an initial commitment of U.S. 1.3 billion dollars to create this fund by the end of 2001 (Radelet, 2004).

There were several structural and agential influences within the international system that were responsible for the Fund’s creation. First, as Lidén (2013) notes, there were various emerging factors within the global development discourse, including the emergence of the MDGs, the “fear of rapidly spreading AIDS pandemic and the outrage over the lack of access to life-saving AIDS treatment”, and the international recognition

that mobilizing resources for health could serve the dual purpose of combating poverty (p.6). Second, its establishment was heavily influenced by the United States (U.S.) government, and in particular the drive to have a “new delivery system” for disbursement that was independent of the UN system” (Kickbusch, 2002, p.136; McCoy et al., 2012; Radelet, 2004). Indeed, the semblance of a new, ostensibly depoliticized funding mechanism in the global health landscape was very attractive to donors owing to the inefficiency of the UN system (Kickbusch, 2002; McCoy et al., 2012). Third, the perceived HIV-security nexus that emerged at the beginning of the 2000s, with HIV/AIDS becoming recognized as a threat to security and international peace, prompted support for the GFATM (Ingram, 2005; McInnes & Rushton, 2010).⁴ As will be discussed in Chapter 4, starting in the mid-1990s, global health concerns became framed as security threats by U.S. policymakers due to the fear of the spread of infectious disease and the possibility of bioterrorism (Kickbusch, 2002). As a result, the creation of the GFATM and the commitment of resources to combating HIV/AIDS was perceived as a way for western countries to mitigate these security threats (McCoy et al., 2012).

Operation

As a GHI, the GFATM pursues a “hands-off approach” by acting as a financing mechanism rather than an implementing agent (Radelet, 2004, p.4). As a result, national actors from recipient countries design and implement projects funded by GFATM grants, and there are no GFATM staff operating in the recipient country (Radelet, 2004). In order to apply for a grant, a country must create a Country Coordinating Mechanism (CCM), which incorporates stakeholders from civil society, government, the private

⁴ For further explanation of security reasons behind investing in the GFATM, refer to Chapter 4.

actor, and representatives of multilateral and bilateral agencies (Feachem & Sabot, 2006; Tanzania Commission for AIDS, 2009). The GFATM's financing is performance-based (PBF) (Aveling, 2010; Fan et al., 2013), whereby a continuation in funding is dependent "on a country achieving the results specified in its proposal" (Radelet, 2004, p.4).

McCoy et al. (2012) attribute the GFATM's performance-based approach to the presence of weak recipient health care systems in developing countries as a result of the debt crisis of the 1980s and 1990s and the subsequent imposition of structural adjustment programs (SAPs). As such, PBF is a way to ensure compliance with the "demand-driven approach" of the GFATM to disperse resources to countries most in need (Fan et al. 2013, p.2). In addition, McCoy et al. (2012) explain that the incorporation of PBF is reflective of the shift toward selective health care and the emphasis on "cost-effectiveness analysis as a basis for international health priority-setting" (p.7).⁵

The GFATM is headquartered in Geneva, and its Board consists of 19 voting and 5 non-voting members. It includes recipient and donor governments, as well as private actors (Brugha et al., 2004; Brugha, 2009). In line with the objective to ensure that the GFATM is detached from UN politics, the WHO, the World Bank (WB) and the United Nations International Children's Emergency Fund (UNICEF) are represented but only hold minor positions (Brugha, 2009; Kickbusch, 2002).^{6,7}

In comparison to traditional funding approaches, the GFATM is an innovative mechanism that has proven to be adaptive since its inception in 2002 (Feachem & Sabot, 2006; Radelet, 2004). The innovative nature of the GFATM can be traced to its creation

⁵ For a more in-depth overview of PBF and its relation to compliance, refer to Chapter 3.

⁶ The WHO, UNAIDS and the World Bank, along with a Swiss representative, make up the non-voting group on the GFATM Board. Each UN agency is allowed three representatives to sit as a part of this group (Jönsson, 2010).

and its mandate to respond to existing failures in global health governance and to link “policy effectiveness to inclusive participation” (Brown, 2009, p.170). According to Brown (2009), this normative underpinning was established in the two commitments underlying its Framework Document: to multisectoral partnership “between governments, civil society, the private sector and affected communities”; and to decisions that “should represent those most in need” (Brown, 2009, p.170).

As a result of these commitments, the GFATM has a unique structure. First, as Radelet (2004) explains, the “open and participatory approach”, with the emphasis on multisectoral participation through the CCM, is quite exceptional in comparison to traditional funding approaches.⁸ As a result of this business model of incorporating national actors, grant proposals are designed to incorporate local contexts and capacity (Brown, 2009; Radelet, 2004). Second, the GFATM is very flexible in terms of how its funds are transferred (Radelet, 2004; USAID, 2013). It has been able to support pre-existing disbursement channels, such as Mozambique’s SWAp in 2013, or provide budgetary support to governments (Radelet, 2004; USAID, 2013). Third, unlike other funding entities that have dominated the global health landscape, it has a “small bureaucracy” and lighter administration, with a staff of 80 members (Radelet, 2004, p.1). Fourth, as Feachem and Sabot (2006) describe, in comparison with other GHIs, the GFATM’s grants are “uniquely flexible” as they can be utilized for several different aspects of health, such as financing drugs and funding human resources and salaries. Finally, unlike other funding channels such as the U.S. Millennium Challenge

⁷ For a list of current GFATM Board members, refer to Appendix B.

⁸ As Radelet (2004) explains of the traditional approach to funding: “donors were perceived to be determining priorities and then entering into discussion with government to agree funding levels for these priority areas” (p.4).

Corporation (MCC), the GFATM funds both fragile and non-fragile states (Bornemisza et al., 2010, p.2; Lu et al., 2006; Nowels, 2003).⁹

The GFATM has also demonstrated that it is a very adaptive and responsive mechanism. As Kapilashrami and Hanefeld (2014, p.164) describe, the GFATM “considers itself a ‘learning organisation’” as, since its creation, it has continuously “undergone several independent evaluations to monitor its performance.” As Brown (2009) states: “[what is] impressive about the GF [GFATM] is its ability to learn from critical evaluation and to rethink its institutional practice” (p.174). For example, the GFATM has responded to criticism over the dislocating impact of its funding on recipient health systems by introducing grants for health system strengthening (HSS) activities in Round 5 of funding in 2005 (Brown, 2009; Atun & Kazatchkine, 2009, p.S67; GFATM, 2015; Ooms et al., 2008). Moreover, the GFATM has maintained this commitment: by 2009, 35 per cent of its investments were going towards HSS, and by 2013, the GFATM had signed US 760.0 million dollars for HSS grants (Atun & Kazatchkine, 2009, S67; GFATM, 2015).

Reflecting this adaptability, following the 2011-2012 “triple crisis”, in 2013 the GFATM launched a new financing strategy, *Investing for Impact – the Global Fund Strategy 2012 – 2016* (Heilprin, 2011; Kapilashrami & Hanefeld, 2014, p.162).¹⁰ This

⁹ The creation of the MCC was rooted in the belief that economic development is instrumental to poverty reduction, and can only occur in a seemingly conducive environment with good governance and economic policies (Nowells, 2003). In order to be eligible to receive a five-year grant, or a Compact, prospective low and lower-middle income countries must score above the median in half of the sixteen selected indicators, which are classified under three categories: “promoting economic freedom, ruling justly, and investing in people” (Nowells, 2003; Millennium Challenge Corporation, 2015). In addition, passing the corruption indicator is mandatory, and democracy has become a *de facto* mandatory indicator (Stubbs, 2009).

¹⁰ The “fiduciary” element of the crisis involved reports by the Associated Press in January 2011 of misuse of funding and corruption in four recipient countries that had been accepting GFATM funding: Mali, Mauritania, Zambia and Djibouti (Boseley, 2011; Gerson, 2011; Heilprin, 2011). As a result, this prompted a financial crisis as several donors withheld funding, including Germany, Denmark and the European Commission, totaling U.S. 457

strategy, with its emphasis on “investing strategically,” will be discussed in Chapter 3 in order to demonstrate how the GFATM is responsive to its donors and to recommendations from the High Level Panel in order to ensure their compliance (Kapilashrami & Hanefeld, 2014).

Overall, the structure of the GFATM as a single financing source for combating HIV/AIDS, TB and malaria is an attractive mechanism for donors. As Salaam-Blyther and Kendall (2013) outline, the GFATM “allows donors to pool and leverage their resources, reduces overlaps in programming, and has fewer overhead costs” (pp.17-18). In addition to reducing costs, this pooling of resources mitigates risk for donors and is a much more flexible way to disperse development aid than through bilateral programs (Salaam-Blyther & Kendall, 2013).

The GFATM as a Public-Private Partnership (PPP)

This thesis begins from the premise that the GFATM is best understood as a public-private partnership (PPP). A PPP is an institution formed between states and a variety of private actors designed to “fill gaps in global governance”, complement existing public policy institutions, and assist states and IOs in a number of different aspects, including being “more responsive to their constituents, and promot[ing] change within bureaucracies” (Bull & McNeil, 2008, p.xiii; Nelson, 2006).

million dollars (Heilprin, 2011). These reports also created criticism amongst the international community that the GFATM lacked the proper “oversight systems” to avoid the “misused of funding at the country level” (USAID, 2013). The GFATM responded to these criticisms by appointing a high-level review panel and underwent a series of “organizational and managerial improvements” (USAID, 2013). These reforms were accompanied by a change in leadership: in February 2012 Gabriel Jaramillo was brought in as a General Manager to coordinate these reforms, and in 2012 Dr. Mark Dybul became the New Executive Director (USAID, 2013).

Within the literature, the GFATM is predominantly classified as a PPP (Buse & Harmer, 2007; Reich, 2000).¹¹ The GFATM was created in order to address the global governance issue of the lack of response to these devastating communicable diseases, and to provide a collective public good –better health outcomes and treatment and prevention services for HIV/AIDS, TB and malaria (Aveling, 2010; Brugha et al., 2004; Schaferhoff et al., 2009; Smith & Mackellar, 2007). In addition, as Aveling (2010) notes, the central focus of its mandate is to establish recipient government, private, and non-governmental organization partnerships. As Radelet (2004) confirms: “[through the] Board, its funders, the CCMs, and its implementing partners, the GF [GFATM] combines the public and private sector in a way that few other institutions do” (p.7).

Focus of this Thesis

As a PPP, the GFATM has had a major impact in global health governance in terms of shaping the global response to, and providing substantial resources for, improving health outcomes as they relate to HIV/AIDS, tuberculosis and malaria (Aveling, 2010; Brugha et al., 2004; Feachem & Sabot, 2006; Gerson, 2011; Schaferhoff et al., 2009; Smith & Mackellar, 2007). Through its promotion of a global health agenda based on “evidenced-based medication” and impact for investment (Eyben & Napier-Moore, 2010, p.295), its presence has been noted as challenging traditional global health actors for financial resources and moral authority (Shiffman, 2014; Szlezák et al., 2010). This thesis will seek to unpack one portion of the GFATM’s position in global health

¹¹ Other forms: However, as Newton (2010) describes, according to its international legal classification, it is “an independent Swiss Foundation” and was designed to “enjoy the rights and benefits afforded to international organizations”¹¹ (p.10). Other authors such as Ruggie (2004) classify the GFATM as “a hybrid international entity” (p.517), whereas Utting (2002), in describing PPPs as they relate to Corporate Social Responsibility, refers to them as “multistakeholder initiatives” (p.2)

governance by examining why a variety of global health actors, including a donor state, the United States, a corporation, the Chevron Corporation, and a philanthropic initiative, the Bill and Melinda Gates Foundation, choose to invest in and comply with its mandate and operating mechanisms.¹² As mentioned above, these donors could choose to invest their global health budgets through different means, including bilateral transfers or other GHIs. In addition, as will be described in the Vectors of Influence section in Chapter 4, there are aspects to the GFATM mechanism, including HSS grants and the lack of promotion of patent drugs, that the selected global health donors do not agree with; yet they continue to finance this PPP. In particular, in the case of patent drugs, when the GFATM was designed, largely with the support of the U.S. government, it was created with the intention that it would protect patent drugs (Bartsch & Kohlmorgen, 2007; Fleet, 2003; Hwenda et al., 2011). However, even when the Board decided that the GFATM would not promote the use of patent drugs in GFATM-financed programs early on in its tenure, the U.S. government continued to pledge significant resources and support this PPP (Lidén et al., 2013). Therefore, by understanding compliance within the donor community and the diverse motivations for compliance, this study can begin to shed light on the reasons for the GFATM's crucial position within global health governance.

In order to address this question, this thesis will look at two aspects of compliance. First, Chapter 3 will adopt Mitchell's (1996) framework of a compliance system to understand the GFATM's various mechanisms that induce compliance or allow for non-compliance.¹³ In addition, Chapters 4 and 5 will present explanations as to why the

¹² For a description of the case studies, refer to the end of this Chapter.

¹³ The application of Mitchell's (1996) compliance system model is appropriate as treaties can be regarded as soft law and hard law instruments. According to Boyle's (1999) analysis of the relationship between treaties and soft law, the former can be an instance of both hard and soft law depending on the nature of the

selected global health actors comply with the GFATM based on the logic of consequences and appropriateness.

I have not tried to produce a definitive discussion of *whether* the selected actors comply with the GFATM for a number of reasons. First, due to the inability to conduct primary field research, it is much more feasible to generate explanations as to *why* various global health donors comply rather than firmly establishing and identifying the degree to which they comply. Second, given the discrepancy in the literature regarding the definitions of effectiveness and compliance respectively, it is difficult to ascertain with some degree of certainty the compliance of global health donors to the GFATM (Haas, 2000; Mitchell, 1996). Third, the selected case studies - the U.S. government, the Bill and Melinda Gates Foundation, and the Chevron Corporation - all have a proven track record of compliance: they have been major benefactors in donating to the GFATM since its inception.¹⁴ As the GFATM is a financing entity and not an implementing agency, the answer to the question of whether they comply is apparent from their commitment to the GFATM through the provision of resources in the case of donors. While this represents case selection bias as actors that have a strong history of compliance were chosen, this is appropriate for examining why global health donors choose to comply. As an extension of this project, future research should examine actors that chose to withhold funding and thus not comply with the GFATM, such as Germany, to understand their non-compliance. Finally, the author chose to make this distinction

treaty. As Boyle (1999) discusses, while a major distinction between hard and soft law is between rules and principles, treaties can also invoke norms and principles. As such, it is the content of the treaty that determines its nature as either a soft or a hard law instrument. In addition, as Boyle (1999) argues, both soft law and treaties as hard law instruments can influence state behaviour and mobilize “a consistent, general response on the part of states” (p.904). As a result, Boyle (1999) notes, soft law mechanisms are not legally irrelevant and states cannot necessarily disregard soft-law mechanisms.

and examine why global health actors comply as it is a much more interesting topic (Haas, 2000; Mitchell, 1996; Shelton, 2000). The question of why they comply in terms of pledging funding and putting in place the necessary protocols and processes to disperse the committed resources is a much more significant discussion than whether the actors comply, given the various influences and factors weighing on their decision (Haas, 2000; Mitchell, 1996; Shelton, 2000).

The discussion of compliance presented in this thesis is important to both the field of global health and International Relations (IR) theory. In terms of the former, this thesis will seek to challenge the glowing assessments of the GFATM by examining its operation and its relationship with other global health actors (AIDSPAN, 2015). Similar to Shiffman's (2014) observation that the normative and epistemic power of global health actors has been unchallenged and should be scrutinized, by assessing why global health actors comply with the GFATM, this thesis will in turn be analyzing the influence of this global funding mechanism in the international aid architecture. Through its disbursement of nearly 27 billion dollars since its creation, and the involvement of major state powers such as the United States, influential philanthropic initiatives such as the Gates Foundation, and major corporations such as Chevron, the GFATM can be seen to be a very powerful entity in the field of global health and international development (Esmail, 2015; GFATM, 2015). As such, global health donors' compliance with the GFATM should be examined in order to understand and appreciate the financing mechanism's power and influence in determining the direction and agenda of global health. As noted in the literature, the advent of new governance mechanisms in the global health landscape

¹⁴ For a description of the amount of resources either committed or accepted by the chosen global health actors, refer to the description of the case studies at the end of this Chapter.

are displacing traditional global health actors as sources of authority, including the WHO and recipient states (Shiffman, 2014). In this regard, examining compliance will provide a unique lens into the GFATM's influence as its power is relational: its ability to help transform the global health landscape is dependent on its relationship to other global health actors and the fact that they perceive the GFATM to be a source of influence and an appropriate vehicle through which to commit resources.

An analysis of the influence and power of the GFATM in the international arena and its relationship to traditional authorities is also important for IR scholarship. As will be described in Chapter 2, due to the internal sovereignty challenges facing states on account of globalization and the increasing presence of private actors, PPPs are playing an increasingly significant role in global governance and the attainment of public goods (Bull & McNeil, 2008; Ulbert, 2008; Witte & Reinicke, 2005, p.16). Consequently, the examination of the GFATM is important in enabling us to better understand evolving power dynamics in the international arena. In terms of the PPP literature and compliance theory, as Schaferhoff et al. (2009) contend, the application of compliance theory to PPPs can be utilized “to conduct more theory-based comparative research” in order to “specify the conditions under which PPPs are effective and legitimate governance tools” (p.452). In turn, by employing the lens of compliance theory in relation to the GFATM, the analysis will shed light on the broader discussion of PPPs as governance mechanisms and the conditions under which they can be effective and/or legitimate. In addition, a major gap in the compliance literature is its application to non-state actors: while the role of non-state actors in impacting the compliance of states to international laws, norms and IOs has been examined, the literature generally lacks an analysis of how and why non-

state actors will comply with these international entities, regulations and norms (Börzel, 2000; Shelton, 2000). By examining the Bill and Melinda Gates Foundation and Chevron Corporation, this thesis will provide insights to help close this gap.

Theoretical Perspectives

In order to examine compliance with the GFATM, this thesis will employ the PPP literature and compliance theory. As discussed above, it will adopt the position that the GFATM is a PPP, and the premise that compliance theory can be applied to PPPs as governance mechanisms (Buse & Harmer, 2007; Schaferhoff et al., 2009). Compliance theory, which draws on March and Olsen's (1998) logics of appropriateness and consequentialism, seeks to ascertain why states comply with international institutions, laws and treaties (Mitchell, 1996). The bridge between compliance theory and the PPP literature is derived from Schaferhoff et al. (2009), who argue that PPP regulations can act as soft law. As these authors contend, by extending the literature that applies compliance theory to intergovernmental soft law regulations, compliance theory can also be "used to examine PPPs as transnational governance institutions" (p.461). As a result, by employing compliance theory, Chapters 4 and 5 will generate hypotheses as to why the selected actors comply with the operating mechanisms and mandate of the GFATM as a governance institution.¹⁵

While compliance theory typically focuses on the compliance of states, this thesis will draw on Börzel (2000) to extend its application to non-state actors. In addition, as Schaferhoff et al. (2009) argue, compliance theory can "serve as a theoretical basis to

¹⁵ For a full description of the actors under examination, refer to the Case Study section at the end of this Chapter.

derive and test hypotheses concerning the nexus between institutional design and PPP effectiveness” (p.463). As a result, this perspective can help generate hypotheses concerning the relationship between the design of the GFATM and its effectiveness (Schaferhoff et al, 2009). This contention will be especially useful in Chapter 3 in identifying the institutional mechanisms that comprise the GFATM compliance system.

Chapter Summaries: Research Questions and Hypotheses

Chapter 2: Literature Review and Theoretical Framework

Chapter 2 will present a review of the relevant IR and IL literatures as they relate to the arguments presented in Chapters 3, 4, and 5. From this overview of the literature, it will explain the theoretical framework, including the application of compliance theory to the GFATM, and the neoliberal institutionalist underpinning of the thesis. It will also provide the frameworks for understand the compliance system of the GFATM in Chapter 3, and the logic of appropriateness and consensualism in Chapters 4 and 5. Finally, it will provide an overview of the literatures to support the arguments in Chapters 4 and 5, including the HIV-Security Nexus, corporate social responsibility, and philanthrocapitalism.

Chapter 3: Compliance System of the GFATM

This thesis will adopt Mitchell’s (1996) conceptualization of a compliance system in order to identify the GFATM’s compliance system. It will also seek to understand what the GFATM has done to increase the compliance of recipient governments, donor governments, private actors, and philanthropic organizations in light of the 2011 corruption crisis and the resulting 2012 – 2016 Strategy.

In regards to the first objective, this chapter will argue that the GFATM has a robust compliance system, consisting of a primary rule system based on the principles of country ownership, inclusiveness and partnership, and performance-based funding (PBF); a compliance information system that includes Local Fund Agents (LFAs), and PBF; and a non-compliance information system that includes several strategies, including facilitating compliance through the structure and presence of the GFATM Secretariat, the implementation of innovative funding mechanisms, the creation of the new strategy, and preventing violations by instituting pre-monitoring control measures.

In terms of identifying what the GFATM has done to increase the compliance of recipient governments, donor governments, private actors, and philanthropic organizations, this chapter will demonstrate that the GFATM initiated several reforms. In terms of the primary rule system, the new strategy focused on “invest[ing] more strategically” (2012 – 2016 Strategy, p.8), and replaced the rounds-based system with the funding streams model. In terms of the compliance information system, the 2012 – 2016 strategy strengthened its monitoring and evaluation processes, enhanced the PBF mechanism, reconfigured the Board’s standing committees and its indicators, gave the Secretariat a more active role, and reprogrammed existing GFATM investments. Finally, the non-compliance information system was altered through strengthening sanctions for violations with the creation of the Code of Conduct for Suppliers, preventing violations through the imposition of the financial safeguards in the Amended Comprehensive Funding Policy, and strengthening fiduciary controls.

Chapter 4: Compliance Through the Logic of Consequentialism

This chapter will adopt Mitchell's (1996) logic of consequentialism to determine why the selected global health actors comply with the GFATM.

In turn, this chapter will offer several explanations as to why a global health donor state would comply with the GFATM, including influence at the Board level, the HIV-security nexus, patent laws and intellectual property rights, and the interdependent self-interested calculation that donating will persuade other states to follow suit. A philanthropic organization, such as the Bill and Melinda Gates Foundation, would comply with the GFATM in order to increase its economic and political influence (McGoey, 2014; Morvaridi, 2012). Finally, a corporation, such as the Chevron Corporation, would choose to invest as an epidemic poses a serious threat to profitability and the environments in which their operations are based, and by investing in the GFATM, the Corporation can have greater impact than it could on its own (Lisk, 2009).

This chapter will also include a discussion on "Vectors of Influence," to determine the vectors of influence between the Gates Foundation, the U.S. government, and the GFATM. Inevitably, due to the pivotal position of these organizations in the global aid architecture and their influence in the GFATM, a discussion is warranted regarding the vectors of influence: whether the GFATM sets the rules with which the Gates Foundation and the U.S. government feel compelled to comply, or whether the two donors set the rules for other donors to comply with in the GFATM.

Chapter 5: Compliance Through the Logic of Appropriateness

This chapter will adopt March and Olsen's (1998) logic of appropriateness to build on Chapter 4 and provide a comprehensive understanding of global health donors'

compliance to the GFATM. It will argue that within the perspective of the logic of appropriateness, there are several explanations as to why a global health donor would comply with the GFATM, including the normative dimensions of country ownership and aid effectiveness; the neoliberal underpinning of the GFATM; and the moral underpinning of health.

Methodology

This thesis will consult both secondary and primary sources including peer-reviewed articles, GFATM reports and statements, government, corporate and GFATM websites, and Project Grant proposals. In order to obtain this data, databases including Google Scholar, JSTOR, as well the Dalhousie Library database, will be consulted.

Case Study Selection

In order to fully gauge compliance with the GFATM, it is important to include all relevant types of global health donors that operate within or influence the GFATM. Representatives of the various types of these actors that will be examined include a private actor, Chevron Corporation; a donor country, the United States; and a non-government partner, the Bill and Melinda Gates Foundation. This research design was selected not to find similarities between actors but to reveal a diversity of motivations for compliance with the GFATM.

Chevron Corporation

Listed as a “private sector and non-government” partner on the GFATM website, the energy conglomerate Chevron has donated U.S. 60 million dollars towards GFATM

initiatives in the Pacific Rim and Africa since January 2008 (GFATM, 2015). Chevron's donations to the GFATM are tied to the communities where it has energy interests, and consequently it funds projects in South Africa, Angola, Nigeria, Thailand, Vietnam, the Philippines and Indonesia (GFATM, 2015). Chevron is one of the GFATM's largest corporate partners, and has subsequently been crowned its Corporate Champion (Chevron, 2015). On the Chevron website, it boasts that its contributions to the Global Fund has saved 9.6 million lives (Chevron, 2015).

The inclusion of Chevron Corporation to analyze compliance with the GFATM is necessary for several reasons. First, as a corporation, Chevron has a different cost-benefit analysis concerning compliance with the mandate and operating mechanisms of the GFATM than a donor country, as it is accountable towards corporate stakeholders and customers rather than constituents. As noted in the literature, the private sector has become increasingly involved in the development agenda, with businesses becoming "development agents" in the pursuit of development goals (Blowfield & Dolan, 2014, p.22; Soederberg, 2007). Soederberg (2007) explains that global governance is not comprised of "social actors ... existing on a smooth and even plane" (p.504), as it is immersed in the structural inequities inherent to the neoliberal capitalist system. As such, the business community has been investing in voluntary-based corporate social responsibility (CSR) in order to confront the "general backlash against corporate forms of neoliberal capitalist restructuring in the global South", and to protect their reputations and image (Soederberg, 2007, p.507). In addition, as Mitchell (1996) notes, corporations, who are influenced by efforts to increase their sales, "may seek out and promote compliant technologies, independent of any governmental or inter-governmental efforts".

Therefore, the rationale behind Chevron continuing to choose to fund the GFATM's projects in these select communities and to acquiesce in its operating mechanisms and mandate can be hypothesized to reflect this need to maintain and defend its reputation. As Mark Dybul, Executive-Director of the Global Fund has stated: “[i]ncreasingly, private sector companies like Chevron recognize that the health of their business is inextricably linked to the health of the communities where they operate” (GFATM, 2015). As a result, by helping to improve the health outcomes of the communities in which they are invested, this not only ensures that Chevron has a viable work force, but also bolsters their image as being a socially-responsible corporation in the international community.

In addition, an examination of Chevron is beneficial in uncovering which mechanisms the GFATM includes in its compliance system in order to ensure continued funding from Chevron, and whether/how these differ from those that would entice a state to comply (Mitchell, 1996).

The United States Government

In analyzing donor countries' compliance with the GFATM, the U.S. government is a critical case study as it is a major benefactor of the Fund (USAID, 2013). By the end of 2013, it was the GFATM's top country donor, providing 33 per cent of all GFATM contributions (USAID, 2013), and in December of that year it hosted the GFATM Replenishment Conference (GFATM, 2015). To date, the U.S. government has contributed over 8.5 billion dollars to the GFATM (USAID, n.d.). Most recently, President Obama requested 1.3 billion dollars in his 2017 budget proposal for the GFATM (GFATM, 2016).

In addition, as mentioned above, the U.S. government played a fundamentally important role in the foundation of the GFATM, both as a “new delivery system” independent of the UN system, and in promoting its establishment, given the U.S. government’s preoccupation with the HIV-security nexus (GFATM, 2015; Kaiser Family Foundation, 2013; Kickbusch, 2002, p.136; Radelet, 2004). Furthermore, the U.S. government also finances technical assistance for the implementation and oversight of GFATM grants (USAID, n.d.).

The U.S. is also a noteworthy case study of donor government compliance as it highly values performance-based funding (Kaiser Family Foundation, 2013). Starting in 2006, Congress has repeatedly authorized the Secretary of State to withhold 20 per cent of funding until the “GFATM ... [can] demonstrate improved oversight and accountability in grant disbursement” (Kaiser Family Foundation, 2013). Due to the influence of the U.S. government in the GFATM, the inclusion of the U.S. government as a case study should provide critical insight into the GFATM’s compliance system for recipient countries and the incorporation of performance-based funding.

The Bill and Melinda Gates Foundation

The Bill and Melinda Gates Foundation is a significant sponsor and advocate of the GFATM. To date, it has committed U.S. 1.4 billion dollars in pledges and contributions (GFATM, 2015). Its involvement with the GFATM extends much further than financial commitments however: it also participates on the Board and provides support for “related advocacy and fundraising efforts” (GFATM, 2015). Within the literature, given the overwhelming influence of the Gates Foundation on the GFATM’s agenda and priority setting, there is concern with regard to the considerable impact of the Gates Foundation

on the future direction of the Fund, particularly in terms of its emphasis on “technological and market-led solutions” and its uncertainty about the effectiveness of HSS (McCoy et al., 2012, p.15).

Similar to the justification for the inclusion of Chevron Corporation, in order to gauge the full spectrum of actors complying with the GFATM, it is imperative to include the Bill and Melinda Gates Foundation to understand why non-governmental bodies support the GFATM. As per the reasoning outlined for the Chevron case, the Gates Foundation also has a different cost benefit calculus than countries and corporations in relation to its involvement with the GFATM. As mentioned above, the Foundation’s impact and role in global health is a leading exemplar of the emergence of “philanthrocapitalism” (McGoey, 2014, p.111). As such, the Gates Foundation, with its focus on “technological and market-led solutions” for HIV/AIDS, TB, and malaria (p.15), inevitably has a different rationale for compliance with the GFATM than another global actor such as Chevron does. In addition, due to the Gates Foundation’s tremendous support for the GFATM, this analysis will also shed light on the mechanisms that the GFATM has had to adopt in order to ensure that it has the support of the Foundation. Furthermore, owing to its influence in the international health aid architecture (McGoey, 2014), the Gates Foundation can also influence other actors involved with the GFATM to comply with its mandate and operating mechanisms.

Conclusion

Drawing on the IR and IL compliance theories, the following Chapters will engage with the debate on the impact of GHIs in the scale-up towards communicable diseases and their role in global governance. Chapter 2 will present a literature review,

examining the literature on PPPs literature and on compliance theory to establish a theoretical framework. The next two chapters will apply Mitchell's (1996) compliance system framework to the GFATM in order to assess the institutional mechanisms inherent to the GFATM that induce compliance and address non-compliance (Chapter 3), and present hypotheses as to why the selected global health actors comply with the GFATM's mandate and operating mechanisms (Chapters 4 and 5).

CHAPTER 2: LITERATURE REVIEW AND THEORETICAL FRAMEWORK

In order to understand the role of the GFATM in global health governance, this Chapter will first provide an overview of the IR and IL literatures as they relate to global health governance, public-private partnerships (PPPs) and compliance theory. Second, through this assessment of the relevant scholarship, it will outline the theoretical framework of this thesis.

Global Health Governance and PPPs

Since the late 1990s, the international community has witnessed a transformation in the governance of global health (GHG) (Lee & Kamradt-Scott, 2014; Lidén, 2013; Ulbert, 2008). As mentioned in Chapter 1, throughout the 20th century, the international health agenda was determined by states, with the WHO acting as a coordinating body to achieve internationally determined targets and implement programs (Brugha, 2009; Biehl & Petryna, 2013). However, processes of globalization, along with the “public health activism” of state and non-state actors in the late 1990s and early 2000s (McCoy et al., 2012, p.7) culminated in what Lee and Kamradt-Scott (2014) describe as the “perceived need for global governance” (p.6). As a result, there was a refocusing from international to global health, and non-state actors became increasingly incorporated in this global agenda in order to address pressing health issues (Lee and Kamradt-Scott, 2014; Ulbert, 2008). As Lee and Kamradt-Scott (2014) note, while there are several ontological variations in the GHG literature, there are several commonalities, including that global governance is not “considered synonymous with global government” (p.3), and that non-state actors play an important role and governments are expected to work with them to

ensure “representation, accountability, and transparency” (p.3)¹⁶. Other common threads within the GHG literature include that it describes the emergence of “innovative institutional arrangements”, that it refers to a space from the local to the supranational levels, and that there is a perceived notion of “good” global governance (Lee & Kamradt-Scott, 2014, p.3).

From this discussion of GHG and the role of private actors, the public-private partnership (PPP) literature seeks to account for the rise of innovative partnerships between states and private actors that have been created in order to deal with global governance issues (Bull & McNeil, 2007; Witte & Reinicke, 2005; Schaferhoff et al., 2009). As Witte and Reinicke (2005) describe, with the advent of globalization and the increasing lack of distinction between internal and external differences in political borders, the internal sovereignty of states is being challenged as the “spatial symmetry between the ‘public’ and the ‘private’ upon which internal sovereignty depends is disappearing” (Witte & Reinicke, 2005, p.82).^{17,18} As a result, states are unable “to project their power over the total space within which production and consumption organize themselves” (Witte & Reinicke, 2005, p.82). In turn, at the international level, there is a perceived inability of states and international organizations to deal with global governance issues (Bull & McNeil, 2008; Witte & Reinicke, 2005; Schaferhoff et al., 2009). Ruggie (2004) argues that with this “spatial [re]configuration of the global governance agendas”, private actors have been expanding their influence, and as a result there has been the “emergence of a global public domain beyond the sphere of states”

¹⁶ According to Lidén (2013), the involvement of non-state actors in global health has included private-sector philanthropic foundations, civil society and academics.

¹⁷ For a definition of globalization, refer to Appendix B.

(p.509).¹⁹ As a result of this “spatial [re]configuration”, partnerships have formed between private actors, including commercial interests and civil society actors, as well as governments in order to “fill gaps in global governance” and attain these public goods (Bull & McNeil, 2008; Witte & Reinicke, 2005, p.16). Thus, as a PPP, the GFATM seeks to deliver a public good, that of health improvement and mitigating the spread of infectious disease (Schaferhoff et al., 2009; Smith & MacKellar, 2007). As mentioned in Chapter 1, these partnerships complement existing public policy institutions and assist states and IOs in a number of different aspects, including being “more responsive to their constituents, and promot[ing] change within bureaucracies” (Bull & McNeil, 2008, p.xiii; Nelson, 2006).

As it pertains to global health, owing to the variation of definitions attributed to global health partnerships (GHPs), there is considerable disagreement amongst scholars as to how many GHPs exist.²⁰ Brugha (2009) notes that there has been a “mushrooming” of PPPs, with the creation of over 90 partnerships by 2003 (p.129). However, Lorenz (2007) argues that as of 2007, there were 70 in existence, and Schaferhoff et al. (2009) note that as of 2009, there were 100 such partnerships.

¹⁸ According to Witte and Reinicke (2005), internal sovereignty can be defined as the “relationships between the state and civil society” (p.81).

¹⁹ Ruggie defines this “global public domain”, as an “institutionalized arena of discourse, contestation, and action organized around the production of global public goods” (p.571).

²⁰ For the purposes of this thesis, there will be no distinction made between a GHI and a GHP. Within the literature there exist several definitions of GHIs and GHPs, and the definitions do involve several of the same elements, involving the incorporation of public and private actors (for a definition of a GHP, see Appendix A) (Buse & Harmer, 2007; Spicer et al., 2010). In addition, there are sources that make a distinction between a GHI and a GHP, such as the WHO. However, even with these distinctions established, there is still a large degree of inconsistency across sources. For example, on the WHO website, the Roll Back Malaria (RBM) is listed as a GHI. However, according to the RBM website, this “GHI” refers to itself as a public private partnership, and thus would be considered a GHP. Due to this ambiguity in the literature and the fact that this thesis is utilizing the broad definition of a GHI provided by Spicer et al. (2010), no distinction made between the two concepts. Consequently, the work of authors who may refer to GHPs (Buse & Harmer, 2007) will be used to support arguments made by the author in relation to “GHIs”. For clarity, the author will simply refer to GHIs for the remainder of the thesis.

Effectiveness of PPPs

A major point of contestation within the literature is how to define and identify the effectiveness of PPPs as governance mechanisms (Raustiala & Slaughter, 2002). In their comprehensive overview of the PPP literature, Schaferhoff et al. (2009) reason that a PPP's effectiveness can be measured at any stage of Easton's system theory (output, outcome and impact). In their respective articles, Pattberg et al. (2012) and Ulbert (2008) agree with Schaferhoff et al.'s (2009) use of Easton's system theory as a gauge of PPP effectiveness. Ulbert (2008) makes a valuable contribution to this discussion by describing how output, outcome and impact relate to a PPP by identifying structural and process factors that contribute to PPP effectiveness.²¹ While this rationalization allows for a study of effectiveness to be undertaken at any stage of Easton's classification, it is simultaneously very elusive, as it infers that a PPP can be effective even if it is recorded at the output stage - the lowest stage in Easton's system. As such, several authors, including Börzel (2000), argue that effectiveness must be linked to impact, or "the effect of the policy on the socio-economic environment" (p.3). In turn, as Börzel (2000) contends, effectiveness is attributed to the "problem-solving capacity of a regime or policy" (p.3). Furthermore, as Börzel and Risse (2002) note, it is very difficult to measure effectiveness as the research conducted in the field typically examines successful PPPs rather than failed attempts at these institutional arrangements.

²¹ As Ulbert (2008) defines, structural factors involve "the type of partnership (funding, research network or standard-setting), the tasks and goals, and the membership of governance structures" (p.6). Process factors involve the "management of a PPP", including evaluating and monitoring, in addition to the degree and depth of stakeholder participation (p.6).

Application of Compliance Theory to the GFATM

Given the contested discussion of the effectiveness of PPPs, Schaferhoff et al. (2009) make a valuable contribution to this debate that serves as this thesis' starting point for examining the compliance of state and non-state actors with the GFATM. As the authors describe, other IR theories, such as compliance theory, should be applied to provide insight into the conditions under which PPPs are effective and legitimate governance mechanisms. By examining the compliance of state and non-state actors to the GFATM, we can shed light on the effectiveness of the GFATM as a GHG body.

Despite the similarities between effectiveness and compliance when describing whether a PPP is effective (Ulbert, 2008), it is important to differentiate between the two concepts. As Haas (2000) notes, whereas the former refers to the attainment of a goal, the latter refers to whether there is behavioural change in order to achieve international objectives. Indeed, the terms can be mutually exclusive as compliance can occur without effectiveness, and vice-versa (Haas, 2000). Furthermore, as Raustiala and Slaughter (2002) argue, compliance can occur without implementation: it is not a necessary or sufficient precursor for effectiveness, and its presence or absence may “indicate little about international law’s impact on behaviour” (p.539). This is in contrast to Ulbert (2008), who argues that compliance is a determinant for effectiveness. Finally, Mitchell (1996) also makes the valuable point that an actor’s compliance is not absolute, in that there can be varying levels of compliance a different times and that it is a fluid concept.

Therefore, given the contested nature of effectiveness and the difficulty in assessing it without the ability to conduct sufficient primary research, it is much more practical for the purposes of this thesis to examine the compliance of state and non-state actors to the principles and practices of the GFATM. This examination of compliance is

important in order to understand why global health actors choose to comply with the GFATM as a global health governance mechanism. In turn, this can shed light onto its position as a governance institution in global health (Schaferhoff et al., 2009). As mentioned above, Schaferhoff et al. (2009) argue that the application of compliance theory can shed light onto the conditions by which the GFATM is an effective and legitimate governance institution.

PPP Regulations as Soft Law

In terms of the application of compliance theory to PPPs, Schaferhoff et al. (2009) argue that the regulations of a PPP act as soft law, and that similar to the literature that applies compliance theories to intergovernmental regulations [soft law], compliance theory can be applied to PPP regulations. This statement serves as the basis of this thesis' examination of compliance theory and the application of GFATM regulations as soft law. In this sense, the study is interdisciplinary as it draws on scholars from international relations, comparative politics and international law (Haas, 2000; Raustiala & Slaughter, 2002; Shelton, 2000).

Similar to the debate on the effectiveness of PPPs, the question of how to measure the compliance of an actor with a PPP is contested in the literature. In her seminal article examining the compliance of non-state actors to international institutions, Börzel (2000) argues that the output and outcome stages of Easton's systems theory are pertinent to gauge compliance. Börzel (2000) argues that this "entails a procedural understanding" which prevents the binary conceptualization of compliance versus non-compliance. Shelton (2000) shares a similar understanding of compliance: while the author argues that it involves implementation, it also refers to "... whether countries in fact adhere to the

provisions of the accord and to the implementing measures that they have instituted” (p.5).²²

This conceptualization differs from Ulbert (2008), who argues that compliance is only properly connected with outcome, or behavioural change. It is important to note that Ulbert (2008) is writing from the perspective of the study of GHPs, and that compliance is an indicator of the effectiveness of a GHP. However, this thesis is taking a focus similar to that of Börzel (2000), who is writing from the perspective of the various global actors and why they comply with international institutions. Therefore, Börzel’s (2000) association of output and outcome with compliance is more applicable to this thesis, as it is seeking to examine compliance with the GFATM from the perspective of the selected global health donors.

Shelton (2000) makes a valuable contribution to the discussion of compliance by explaining how the compliance of state and non-state actors involves “complex and holistic determinations,” and that the incentives and disincentives that impact compliance cannot be quantified (p.17). This assertion of how difficult it is to decipher the compliance of actors is consistent with this thesis’ approach, as outlined in Chapter 4, to focus on hypothesis generation rather than providing definitive conclusions as to why global health actors comply with the GFATM.

²² While Shelton (2000) does argue that compliance includes more than simply implementation (as Börzel argues), upon examination of Börzel’s measures of output and outcome in terms of compliance and Shelton’s definition of compliance, the two are in effective agreement. Shelton argues that it involves implementation, or “incorporating them [rules] in domestic law through legislation, judicial decision, executive decree, or other processes” (p.5), and also involves the “factual matching of state behaviour and international norms [defined above]” (p.5). While Börzel does argue that it is simply related to implementation, in one of the two measures for outcome in terms of compliance, the author notes: “the target actors take the necessary action to make their behavior consistent with the requirements of the rule” (p.4). As such, this measure for output and Shelton’s insistence that there has to be similarity in terms of state behaviour and the international norm, or rule of conduct, correspond.

As mentioned in Chapter 1, it is imperative to note that this thesis's focus is why global health donors comply with the GFATM rather than establishing whether they do comply. However, it is important to establish a definition of compliance and in turn acknowledge that when discussing why the selected global health donors comply, the basis of their compliance involves Börzel's (2000) procedural definition of both output and outcome.

Neoliberal Institutional Underpinning

By establishing the GFATM as a PPP that can facilitate compliance, this thesis is adopting the neoliberal institutionalist position that international institutions can independently induce compliance. As Mitchell (1996) describes, while a neoliberal institutionalist perspective understands that the "structure of international power and interests underdetermines a treaty's compliance system", it also acknowledges that treaty rules can impact the compliance of actors (p.4). This assumption of independence attributed to international institutions is in opposition to realist assumptions, who posit that states always act according to national interests and treaty rules are always subject to power dynamics in the international system (Mitchell, 1996).

While the GFATM is subject to the interests of donors, it is also an independent entity that can impact behavior. Inevitably, as the GFATM's existence is reliant on donor funding, it is always subject to the interests of its donors. For example, as reflected in the Global Fund's New Funding Model document, the predictability of funding for the 2012 – 2016 Strategy is ultimately controlled by donors as they "are in a position to commit to providing substantial resources in the most predictable manner possible" (GFATM, 2013, p.6). However, the GFATM as an institution can also alter behavior. As Bartsch and

Kohlmorgen (2007) describe, the institutional context of the GFATM is especially critical to its ability to act independently. As the authors (2007) describe, within this context, there is a “stronger necessity to enter compromises and modify strategies than purely state-based forms of governance, where actors are able to act more autonomously” (p.21). Indeed, within the institutional context, the GFATM has been able to act as an independent institution and induce the compliance of other actors. For example, during the GFATM’s creation it was understood by major states that it would protect pharmaceutical companies by using patented drugs (Bartsch & Kohlmorgen, 2007). However, as will be discussed in Chapter 4, the GFATM’s Board of Directors refused to get involved with the protection of patent drugs (Fleet, 2003). Therefore, despite pressure from major benefactors such as the U.S., the GFATM was able to pursue an independent course.

The Compliance System of the GFATM

In order to provide a comprehensive overview of the compliance of global health donors to the GFATM, it is necessary to first examine the GFATM’s mechanisms that help to induce compliance. In Chapter 3, this thesis will adopt Mitchell’s (1996) conceptualization of a treaty’s compliance system to identify the GFATM’s compliance system.²³ According to Mitchell (1996), a compliance system is: “[a] subset of the treaty’s rules and procedures that influence the compliance level of a given rule” (p.17).

²³ As per Boyle (1999), treaties can act either as hard or soft law instruments, depending on the nature of the treaty. As a result, it is not inconsistent to apply Mitchell’s compliance system to the GFATM’s regulations as soft law instruments.

Mitchell (1996) clarifies that compliance with a treaty is “a behaviour that conforms to such rules *because of* the treaty’s compliance system” (p.17).²⁴

Mitchell (1996) outlines that a compliance system encompasses three stages: Primary Rule System, Compliance Information System, and the Non-Compliance Response System. A primary rule system consists of the “actors, rules and processes related to the behaviour that is the substantive target of the regime” (p.18). In terms of how this relates to compliance, it “determines the degree and sources of pressures and incentives for compliance and violation” (p.18). The Compliance Information System involves the “actors, rules and processes that collect, analyze and disseminate information regarding the instances of, and parties responsible for, violations and compliance” (p.19). The last element of Mitchell’s conceptualization, the Non-Compliance Response System, “consists of the actors, rules, and processes governing the formal and informal responses undertaken to induce those identified as in non-compliance to comply” (p.20). Chapter 3 will systematically go through each stage in the context of the 2011 “triple crisis” and the resultant 2012 – 2016 Strategy (Kapilashrami & Hanefeld, 2014, p.162). Bennett and Fairbank’s (2003) examination of the grant-making process, the “strategies and content of approved proposals”, and the impact that the activity or strategy has on the health care system will be very valuable in identifying Mitchell’s (1996) conceptualization of the primary rule system (p.v).

A subsection of the global health literature that will be useful in clarifying the GFATM’s compliance information system is the work on performance-based financing

²⁴ The adoption of Mitchell’s compliance system within the context of a treaty is not inconsistent with this thesis as treaties can be regarded as soft law instruments (Boyle, 1999). As a result, this argument can be applied to the GFATM’s regulations as, according to the argument by Schaferhoff et al. (2009), PPP regulations can act as soft law instruments.

(PBF) (Low-Beer et al., 2007; Fan et al., 2013). As Fan et al. (2013) define, PBF occurs when “future payments are conditioned on predefined performance or achievement of results *ex post*” (p.1). Funding is dependent on the achievement of performance measures in order to ensure value for money and “technical efficiency” (p.1), as well as to increase accountability between recipient governments and donors. Fan et al.’s (2013) analysis is very helpful in relation to Chapter 3 as they describe the GFATM’s use of PBF before and after the 2012 strategy. In particular, the authors outline the benefits and weaknesses associated with the updated strategy’s PBF: while its reliance on fewer and more downstream indicators may create “stronger incentives and generate greater value for money” (p.5),²⁵ by allocating funding based on disease burden this will result in countries “reporting a higher disease burden” (p.18). Despite being an older publication, Low-Beer et al. (2007) also provide valuable insight into the GFATM’s PBF that will be used in Chapter 3.

Logics of Consequentialism and Appropriateness

Once it has been understood what mechanisms are inherent to the GFTAM that induce compliance, it is necessary to identify the various reasons why key donors choose to comply. In the literature, several authors have identified possible factors explaining why private actors and states comply with an international treaty. Raustiala and Slaughter (2002) identify explanatory variables for compliance, including problem structure, solution structure, solution process, norms, domestic linkages and international

²⁵ Within the global health literature, upstream refers to indirect results, whereas downstream refers to direct results (USAID, 2007). For example, a downstream, or direct, indicator is how many people are receiving treatment, versus an upstream, or indirect, indicator is general system support to combat the disease (USAID, 2007).

structure. Similarly, Börzel (2000) presents hypotheses regarding “whether and how private actors matter to compliance with international rules” by adopting different theoretical perspectives, including neorealism, neoliberal institutionalism and liberalism (p.14). In addition, Mitchell (1996) presents several self-interested interdependent and independent reasons as to why actors comply with a treaty.

At the basis of these various explanations are March and Olsen’s (1998) logics of appropriateness and consequentialism (Börzel, 2000; Ulbert, 2008). March and Olsen (1998) examine how and when political orders are “created, maintained, changed and abandoned” from an organizations perspective (p.943).²⁶ The authors explain that changes in political orders can be assessed through two mechanisms: bases of action and historical efficiency. With regard to the former, March and Olsen distinguish between the Logic of Expected Consequences and the Logic of Appropriateness (p.949).²⁷ The Logic of Expected Consequences, or the Logic of Consequentialism, is an agent-centred perspective which understands that rational actors, who are informed by their interests, evaluate the consequences for “personal or collective objectives”, and are aware that other actors are conducting the same assessment (p.949; Finnemore & Sikkink, 1998). In turn, with the Logic of Appropriateness, the authors argue that rather than act according to rational interests, actors adhere to “rules that associate particular identities to particular situations” (p.951). Finnemore and Sikkink (1998) describe how these social structural constructions that determine behavior include “norms of behavior, social institutions, and the values, roles, and rules they embody” (p.913).

²⁶ The authors note that they are presenting this argument as “students of organizations” rather than IR scholars (p.943)

²⁷ March and Olsen (1998) distinguish that there are two questions when examining bases of action: the normative, or “whether one logic leads to a better society than the other”, and the descriptive, or why one

Therefore, in explaining why global health actors comply with the GFATM and pledge funding to this financing mechanism, this thesis will adopt and apply the logics of consequentialism and appropriateness to Chapters 4 and 5, respectively. This is related to Börzel's (2000) and Ulbert's (2008) integrativist approach, which recognizes that there are different rationales at work for why an actor will comply that cannot be exclusively explained by one logic.

The application of both logics is essential to this thesis because, as March and Olsen (1998) argue, there are several limitations associated with each logic. For example, the consequentialist logic assumes that preferences are “stable, consistent and exogenous”, and it presupposes that there is hierarchical decomposition amongst political systems, in that a political system can be understood as “relatively autonomous subsystems” that are linked hierarchically (p.950). However, this perspective does not allow for fluidity in the interests of political actors, nor does it account for the complex and multifaceted relationships within a political system. Thus, the use of both logics provides a comprehensive overview of why an actor would choose to comply (March & Olsen, 1998). As March and Olsen contend, while the logics are interconnected,²⁸ it is important to understand them as “separate explanatory devices” as they provide valuable and “different explanations for action and different bases for institutional change” (pp. 953-954).

Since this seminal work by March and Olsen (1996), several authors have explored the relationship between the two logics, and in particular the connection between the

logic rather than another serves as “the basis for actual behaviour” (p.949). In their examination of the history of international orders, the authors focus on the descriptive.

²⁸ March and Olsen present four interpretations based on the literature to demonstrate the relationship between the two logics.

logic of appropriateness and rationalism. For example, Finnemore and Sikkink (1998) deconstruct previously held assumptions about the divisions between rationalism and constructivism, and argue that they are more closely related than the narrow perspective offered by rationalists. The authors maintain that rational choice does not require a material ontology, that norm entrepreneurs are rational actors, and that empirical studies demonstrate that rationality plays a large role in the construction of “highly politicized social construction of norms, preferences, identities, and common knowledge” (pp.910-911).²⁹ In turn, the authors introduce the concept of “strategic social construction”, which establishes that “processes of social construction and strategic bargaining are deeply intertwined”. The authors illustrate this relationship between constructivism and rationalism through the debates on materialism, utilitarianism, choice and persuasion. In their discussion of utilitarianism, Finnemore and Sikkink (1998) present a valuable contribution to this thesis’ theoretical framework by explaining how norms are relevant to both logics. In particular, the authors argue that the underlying logic of rational choice is utility maximization and actors “construct and conform to norms because norms help them get what they want” (p.912). Checkel (2000) shares this perspective and argues that unlike previous constructivist explanations, “individualist ontologies and consequential choice mechanisms” from rationalism are important in these understandings (p.558). This further investigation of the logic of appropriateness and the constructivist argument expands the simple dichotomy outlined by March and Olsen (1998) that associates appropriateness with constructivism and norms, and consequentialism with rationalism.

²⁹ According to Finnemore and Sikkink (1998), a norm entrepreneur is the actor who drives the acceptance of the norm forward throughout the norm “life cycle” of norm emergence, the “norm cascade”, and norm

In turn, the arguments made by Finnemore and Sikkink (1998) and Checkel (2000) regarding the relationship between rationalism and constructivist explanations will be beneficial to demonstrating how norms can play a role in both the logics of consequentialism and appropriateness. For example, by adopting Finnemore and Sikkink's (1998) utilitarian explanation described above, both Chapters 4 and 5 will be able to incorporate corporate social responsibility (CSR) to explain Chevron's compliance with the GFATM.

Interdependent and Independent Self-Interest

Another useful source for the logic of consequences arguments in Chapter 4 is Mitchell's (1996) differentiation between independent and interdependent self-interests as bases for compliance. In particular, the notion of interdependent self-interest and how actors take into account the impact that their compliance will have on others is particularly novel. Mitchell outlines how this can be understood through either collaboration or coordination games, which will provide insight into the relationship between various global health donors.

HIV-Security Nexus Literature

The descriptions of the logics of consequentialism and appropriateness in Chapters 4 and 5 will incorporate key themes and ideas from various literatures. Chapter 4 will incorporate the notion of the HIV-Security nexus from the late 1990s and early 2000s as the securitization of a health issue was a main motivator behind the creation of the GFATM and the early compliance of donors (Elbe, 2010; Mitchell, 1996). McInnes and

internalization (p.896).

Rushton (2010) outline the place of HIV/AIDS within the national and international security discourse. Of particular use is the background explanation they offer concerning the incorporation of HIV/AIDS within security, and how it increasingly came onto the radar for U.S. policymakers throughout the 1990s. This description clarifies how the UN Security Council (UNSC) meeting in January 2000 was the catalyst for the incorporation of HIV/AIDS within the international security discourse (McInnes & Rushton, 2010). In addition, McInnes and Rushton's (2010) analysis of the impact of identifying HIV/AIDS as a security concern will be useful for this section. In particular, they highlight that by framing HIV/AIDS in this manner, policymakers and global leaders wanted to draw attention to the disease and change how states were thinking about and acting on the pandemic. In turn, by pointing to the increase in funding and attention to the disease by major states, including the U.S., the authors demonstrate how the securitization of HIV/AIDS did in fact create policy change.

Hwenda et al. (2008) also discuss the significance of securitizing health. As the authors (2008) describe, securitization "takes an issue beyond the usual rules of politics, and calls for urgent and extreme measures to respond" (p.7). As such, in regards to health, it became accepted as a central pillar of national security and by being recognized as a global concern, states were much more willing to engage in multilateral cooperation (p.7). Hwenda et al. (2008) also note that wealthy nations, who dictate the global public health security agenda, favour a shared responsibility approach due to their "need to maintain the integrity of the global system" (p.6). This is particularly useful for this thesis as it helps to explain why major global health actors, such as the U.S. government, invest in multilateral funding mechanisms such as the GFATM.

The authors (2008) also note that there is a “codependence” between national and global health security. As noted above with the shift from international to global health, there has been a simultaneous association between national and global health security, owing to “a myriad of globalization processes and the concomitant increased interaction between them” (p.5). As a result of this codependence, there has been an increase in the “geopolitical importance of global health security”, and the need for multilateral responses (Hwenda et al., 2008, p.5). This explanation further helps to explain major states’ interests in investing in communicable diseases that predominantly impact populations in the developing world.

Corporate Social Responsibility

Another body of literature that will be useful in identifying reasons why global health donors comply with the GFATM is the Corporate Social Responsibility (CSR) literature. Kyle and Ruggie (2005) highlight how processes of globalization and interconnectedness have created “novel sources of uncertainty and risk” for businesses operating at the global level (p.1). As will be described in Chapter 4, social risk has emerged as a foremost concern for businesses, with stakeholders pressuring corporations regarding particular social issue areas (Kyle & Ruggie, 2005). As a result, corporations, especially those with recognizable brands, have had to anticipate managing these risks within their business strategies by establishing CSR policies (Kyle & Ruggie, 2005). Lee (2010) also describes how, since the 1950s, CSR has become increasingly institutionalized, rationalized and recognized as a good business strategy.

Du and Vieira (2012) add to this understanding by outlining that companies operating in controversial industries want to affirm their legitimacy by investing in CSR

policies. In addition, controversial industries such as oil have to prove the credibility of their CSR efforts (Du & Vieira, 2012). The authors' description of the various ways in which these industries establish their credibility will be useful in identifying how Chevron seeks to affirm its legitimacy through participation in the GFATM.

Philanthrocapitalism

Finally, a body of literature that will be useful in Chapter 4 and the focus on the Bill and Melinda Gates Foundation is philanthrocapitalism. Morvaridi (2012) provides a detailed explanation of the emergence of this phenomenon, and why capitalists are increasingly investing in philanthropic endeavours. The authors clarify that capitalists' involvement in philanthropy differs from private individuals giving to charity as they are seeking to increase their power and influence. The authors adopt Gramsci's interpretation of philanthropy "as an instrument of hegemony by which the capitalist class maintained its control of the market, workers and peasants" as well as Bourdieu's extension of this thinking in terms of how capital philanthropists are also seeking to increase their symbolic capital. This notion that capitalists are investing in philanthropy in order to increase their economic and symbolic clout is useful in uncovering the reasons why a private foundation, such as the Gates Foundation, would heavily invest in philanthropy.

McGoey (2014) adds that capitalists are willing invest in philanthropy in order to "make it a more lucrative industry in itself" (p.111). As she describes, by promoting a "cost-effective and results-oriented" approach (p.111), private philanthropic organizations are able to "do good by doing well," ensuring a return on investment through providing much-needed welfare services to marginalized populations (p.16).

This form of social investment is embodied in the “California consensus”,³⁰ according to which private aid, generated and administered through partnerships between philanthropists’ initiatives and public-private partnerships,³¹ is considered “more effective than official development assistance” (p.1192).

Of particular use to the context of this thesis is McGoey’s (2014) application of this phenomenon to the Bill and Melinda Gates Foundation. As McGoey (2014) explains, Bill Gates adopted the management techniques from Microsoft to the Foundation in order to “transform philanthropy into a more efficient and lucrative industry” (p.110). This detailed account of how the Gates Foundation reflects philanthrocapitalism will be valuable to identifying the reasons why the Foundation invests in the GFATM.

Conclusion

The chapters that follow will apply this theoretical framework to understand global health donors’ compliance with the GFATM. The next chapter (Chapter 3) will launch this inquiry by examining what the GFATM does to increase the compliance of actors within the context of the 2011 corruption crisis and the resultant 2012 – 2016 Strategy. The subsequent chapters (Chapters 4 and 5) will apply the lenses of consequentialism and appropriateness to provide explanations for why global health donors choose to comply with the GFATM.

³⁰ The “California consensus” is coined by Desai and Kharas (2008) as several of the philanthropists involved made their wealth in the “Silicon valley and dot-com boom” (p.158).

³¹ Refer to the sub-section in this chapter, The Private-Public Partnership Literature.

CHAPTER 3: COMPLIANCE SYSTEM OF THE GFATM

Since the 2011 “triple crisis”, the GFATM has restructured and strengthened its strategy in order to ensure the support of its donors and compliance from its recipient governments (Kapilashrami & Hanefeld, 2014, p.162; Mitchell, 1996). This chapter will apply Mitchell’s (1996) model of a compliance system to the GFATM to identify how the GFATM has improved its strategy in order to regain the confidence of traditional donors and attract new creditors. It will first provide an explanation of the crisis and a brief description of the GFATM’s response.³² It will then systematically review each aspect of Mitchell’s (1996) compliance system as it relates to the GFATM in the context of the 2011 crisis and the aftermath.³³

2011 “Triple Crisis”³⁴ and the GFATM Response

In 2011, the GFATM underwent a “triple crisis (fiduciary, financial and managerial)”, as a result of several compounding factors (McCoy et al., 2012, p.6). First, within the context of the 2008 – 2009 global recession, several donors did not commit funding for the tenth pledging round (2011-2013) (Usher, 2011). In contrast to an increase in funding for global health by 17 percent between 2007 and 2008, between 2009 and 2011 the growth rate was a mere 4 percent per year (Leach-Kemon et al., 2012). Consequently, the GFATM was unable to mobilize the required resources to maintain progress towards its targets and issue new grants (Usher, 2011). Second,

³² The 2012-2016 strategy will be explained in more detail throughout the course of the chapter.

³³ Mitchell (1996) argues that it is instrumental to examine specific treaty provisions rather than compliance with a treaty as a whole as actors may comply with certain aspects of a treaty while violating other sections. However, for the purposes and length of this thesis, this chapter will examine compliance with the entirety of the GFATM. Future research should focus on examining specific regulations of the GFATM to demonstrate compliance.

³⁴ McCoy et al. (2012), p.6.

following a report by the Associated Press in January 2011 of corruption within the GFATM, several donors withdrew or froze their disbursements (Heilprin, 2011; Usher, 2011). Allegations of fraud and corruption were reported in Mali, Djibouti, Mauritania and Zambia, and approximately U.S. 53 million dollars went unaccounted for (Heilprin, 2011).³⁵ As a result, large donors such as Germany,³⁶ Sweden and the European Commission froze their funding (Boseley, 2011). Due to the inability to mobilize the necessary resources owing to the global recession and the corruption allegations, the GFATM suspended issuing new funding rounds until 2014 (Harman, 2014; Leach-Kemon et al., 2012).

In response to this crisis and demands from its donors for investigation into its activities and for reform, two immediate measures were taken (Usher, 2011). First, an independent international panel, or the High-Level Independent Review Panel on Fiduciary Controls and Oversight Mechanisms of the GFATM, was created in early 2011 in order to “assess the risk of fraud and misappropriation in the GF portfolio, and the robustness of the GF’s existing systems control” (Usher, 2011, p.472). This independent panel revealed that there was an “urgent need for reforms” within the GFATM (Usher, 2011, p.472). In addition, the GFATM created the Global Fund Comprehensive Reform Working Group (U.S. Senate, 2011). This working group was asked to identify reforms that could be made to “address recent shortcomings in fiduciary responsibilities and transparency” (U.S. Senate, 2011).

³⁵ According to Heilprin (2011), the allegations included “fraud, undocumented spending, and ineligible expenses”.

³⁶ At the time, Germany was the fourth largest donor to the GFATM, and froze its funding pledge of \$285 million for 2011, only releasing half of the amount following the announcement of the results from the High Level Independent Review Panel in June 2011 (Usher, 2011).

As a result of the findings from the Panel and the Working Group and recommendations from donors, the GFATM initiated several reforms (Bliss, 2013; GFATM, 2012; Kapilashrami & Hanefeld, 2014, p.162). First, it underwent structural changes, including increasing the budget and staff numbers for the Office of the Inspector General, replacing the Executive Director,³⁷ and reducing its standing committees from four to three (GFATM, 2012).³⁸ Second, from the findings of the Working Group, it introduced a new strategy and funding model focused on “investing strategically” and “invest[ing] for impact” (Kapilashrami & Hanefeld, 2014, p.162). This strategy, *Investing for Impact – the Global Fund Strategy 2012 – 2016*, which will henceforth be referred to as the 2012 – 2016 Strategy, will be described in the following sections (GFATM, 2012). The GFATM also implemented several recommendations from its donors. For example, as Salaam-Blyther and Kendall (2012) describe, a recommended reform by the U.S. government was that lower-middle income countries that become upper-middle income, such as China, should not receive grants. As a result, in May 2011 the Eligibility, Counterpart Financing and Prioritization Policy was approved which “limits how much funding middle-income countries could receive through the fund”³⁹. This policy was implemented in November 2011.⁴⁰

³⁷ Michael Kazatchkine was replaced by Mark Dybul in 2011 (Holmes. 2013).

³⁸ The three standing committees include Strategy, Investment and Impact Committee; Finance and Operational Performance Committee; and Audit and Ethics Committee (“Committees”, 2015).

³⁹ This policy also required that “all countries... contribute to national disease and health strategies and demonstrate increased funding for these activities annually” (p.23).

⁴⁰ While the policy issued that “G20 upper middle income countries will no longer be eligible for grant renewals”, they could receive funding if “they have an extreme disease burden, as defined by the Fund” (pp.23-24).

Primary Rule System

As described in Chapter 2, a primary rule system consists of the “actors, rules and processes related to the behaviour that is the substantive target of the regime” (Mitchell, 1996, p.18). In terms of how this relates to compliance, as Mitchell (1996) describes, it “determines the degree and sources of pressures and incentives for compliance and violation” (p.18).

Since its inception, the GFATM has conveyed a clear primary rule system designed to ensure the compliance of its recipient governments and donors. Schaferhoff et al. (2009) argue that the policy formulation function of a PPP is to create “norms and standards that are supposed to regulate state or business behaviour” (p.327). The primary rule system of the GFATM is governed by three main, interrelated principles (Kapilashrami & McPake, 2014). First, country ownership entails that the GFATM acts as a financial entity rather than an implementing agency (Bennett & Fairbank, 2003; Kapilashrami & McPake, 2014). A CCM is established in each country to act as a “broad-based coalition”, incorporating stakeholders from government, civil society, development partners, and private actors to manage the applications for GFATM grants (Bennett & Fairbank, 2003, p.11). The inclusive nature of the CCM and the grant application process empower country-level actors to have a role in GFATM grants (Brown, 2009; Radelet, 2004).

Second, inclusiveness and partnership is stressed (Kapilashrami & Hanefeld, 2014). As Aveling (2010) describes, the impetus behind this principle is to “build... existing community strengths... [to promote] a sense of local ownership and responsibility” (p.1588). Indeed, it has been found that the CCM has increased the participation of stakeholders in decision-making processes who had previously not been included (Brown

et al., 2013; Kapilashrami & Hanefeld, 2014). As Kapilashrami and Hanefeld (2014) describe, “[the] fund is credited for being one of the first international mechanisms to directly fund civil society... thereby enabling participation of actors who have hitherto been peripheral to national policy spaces” (p.629). For example, according to Feachem and Sabot (2006), in 2006, 40 per cent of the membership of the CCM in Zambia was from civil society.

Finally, performance-based funding (PBF) is a major cornerstone of the GFATM primary rule system (Kapilashrami & Hanefeld, 2014). PBF is a method of allocating funding whereby future disbursements are dependent upon meeting pre-determined performance targets (Fan et al., 2013; Kapilashrami & Hanefeld, 2014). As Kapilashrami and Hanefeld (2014) note, it is distinct from traditional funding methods as it focuses on the “achievement of clear and measurable results and timely implementation rather than inputs and processes” (p.629). In turn, it has been adopted by global health funding mechanisms and agencies, who, according to Fan et al. (2013), want “to achieve ‘value for money’” (p.1).⁴¹ The GFATM’s PBF model will be further described in the second component of Mitchell’s (1996) compliance system, the Compliance Information System.

The primary rule system is instrumental to compliance as the selection and formulation of rules will be instrumental in determining the overall level of compliance (Mitchell, 1996). Thus, the degree of transparency within the primary rules can determine the ability to detect violations, and lessen an actor’s uncertainty about non-compliance by informing the actor about other actors’ behaviour (Mitchell, 1996). In

⁴¹ According to Fan et al. (2013), value for money refers to “technical efficiency”, or “when cost is minimized and impact per dollar maximized for a given intervention”; and “allocative efficiency”, or “when investments are optimally focused on the right mix of interventions to the right target population in order to achieve a maximum social or health goal” (p.1).

addition, the specificity of rules can also increase compliance in two respects (Mitchell, 1996). First, specific rules will reduce uncertainty for actors in terms of what is expected of them to comply (Mitchell, 1996). Second, for actors that are susceptible to non-compliance, “precise treaty language removes the excuse of inadvertence and misinterpretation from actors when they must account for non-compliance” (Mitchell, 1996, p.19).

Prior to the 2012 strategy, it was increasingly evident that there were several issues with the primary rule system which created opportunities and incentives for non-compliance amongst both donors and recipient governments. While the problems associated with the primary rule system predominately impact the compliance of recipient governments,⁴² ultimately it is the robustness of the primary rule system and the degree to which recipients are complying which determines whether donors choose to invest in the GFATM.

First, owing to the way in which the CCM was established in recipient countries, there was an overall lack of aid effectiveness (Bennett & Fairbank, 2003). As Bennett and Fairbank (2003) describe, with the CCM acting as a parallel structure to recipient country systems, there was a “verticalization of service delivery” and an overall lack of support for strengthening health systems (Bennett & Fairbank, 2003, p.xvi; Spicer et al., 2010). As Spicer et al. (2010) explain, the presence of several HIV/AIDS coordination bodies within a country system have “challenged effective governance of HIV/AIDS programmes” (p.8). In addition, it was reported that there was a lack of clarity for CCM members regarding their role within the structure (Brown, 2010; Spicer et al., 2010). As

⁴² As outlined above, the primary rule system and its central normative tenets are designed to influence the behavior of recipient governments, and the relationship between the GFATM and these governments.

Kapilashrami and McPake (2012) describe concerning their findings on a case study in India, the partnership between the government and corporate sector representatives, NGOs, and people living with HIV/AIDS, “emerged as weak and activities developed across multiple service delivery sites with little demarcation of roles and increasing conflict among interests” (p.630).⁴³ Spicer et al. (2010) also found this in their study of the impact of GHIs on national and subnational HIV/AIDS coordination bodies, with distrust being created between different country HIV/AIDS organizations owing to “competitions of scarce resources” (p.9). As a result, this led to local actors being unwilling to share information, which limited “local oversight of programmes and delivery systems thereby undermining monitoring and evaluation and the application of evidence ... to improve programme delivery” (Spicer et al., 2010, p.13). Therefore, with the implementation of the CCM, there was an overall lack of clarity, transparency, and partnership, which created incentives for conflict (Kapilashrami & McPake, 2012; Spicer et al., 2010).

Second, the application process and the monitoring and evaluation (M&E) components of a grant had major repercussions for partnership and ownership (Spicer et al., 2010). In order to apply for the rounds-based funding, Ministry of Health (MoH) staff were spending exorbitant time and resources on grant applications and required status reports to the GFATM (Brugha et al., 2005; Kapilashrami & McPake, 2012). As well, there was confusion and chaos in implementation owing to the structure of the rounds-based system and the overlap between separate rounds (Kapilashrami & McPake, 2012). Furthermore, as Brugha (2005) explains, during the application process,

⁴³ As Kapilashrami & McPake (2012) note, during the funding round and the application for a grant, this process was imposed on sub-national levels without clarifying the intent of partnership, resource allocation

governments were contracting out short-term external consultants and using “long-term donor-funded country-based technical assistance” (p.4). In turn, the MoH staff’s involvement was limited to the end of the process, where their role resembled “little more than a ‘signing ceremony’ group” (Brugha et al., 2005, p.5). In addition, typically these applications were created “in parallel to routine planning processes” and there were delays in implementation as the consultants were not involved in the implementation phase (Brugha et al., 2005, p.4). Furthermore, the application process was treated like a competition between countries and within countries, which prevented the “sharing of lessons and learning from others” (Brugha et al., 2005, p.4; Spicer et al., 2010).⁴⁴ Finally, national and subnational governments selected certain CSOs to take part in the CCM, which inherently excluded others (Spicer et al., 2010). Overall, the time and resources required for GFATM applications had major implications for government capacity and ownership, and prevented Ministry staff from being able to focus on coordination and implementation (Bennett and Fairbank, 2003; Brugha et al., 2005; Kapilashrami & McPake, 2012).

Consequently, the 2012 – 2016 Strategy was designed to deal with several of these limitations in order to create greater transparency, remove roadblocks for recipient government compliance, and ultimately to ensure the continued support of donors. The Strategy was created under the guise of “invest[ing] for impact” to ensure that the allocation of funding was much more efficient and effective (GFATM, 2013).

among partners and defining lines of authority and arbitration in case of failures” (p.633).

⁴⁴ As Kapilashrami and McPake (2012) observed in India, there was considerable competition between Civil Society Organizations (CSOs) for funding from the PR of the GFATM. In turn, this had negative implications for partnership. As these authors (2012) noted, this impacted the “organic nature of partnership building, result[ing] in competition and affect[ing] the continuity (sustainability) of programmes in the funding cycle” (p.633).

The Strategy outlines five strategic objectives: (i) “invest more strategically” (p.2); (ii) replace the rounds system and “refocus... existing investments” (p.2); (iii) support the implementation of grants; (iv) “promote and protect human rights” (p.2); and (v) “sustain the gains, mobilize resources” (p.2). Overall, there are several key features of this model (GFATM, 2012). First, “invest more strategically” involves focusing on “highest-impact countries, interventions and populations while keeping the GF global”, in addition to allocating “funding based on quality national strategies and through national systems” (GFATM, 2012, p.8).^{45,46} This re-focusing of GFATM efforts is designed to ensure that it is maximizing the impact of the GF investments and ensuring aid effectiveness (GFATM, 2012). This objective is a response to a criticism made by the 2011 High Level Panel report that the GFATM had a “lack of focus on value for money in decision-making” (Duran & Silverman, 2013, p.15). For example, in order to maximize GFATM investments, proposals for “graduate countries” who can now fund their own TB, malaria and HIV/AIDS programs have been promoted (Bliss, 2013). These countries, including South Africa, India and Thailand, were previous recipients of funding who now were able to fund their own programs (Bliss, 2013).

Second, the rounds-based grant allocation system was replaced by two funding streams: indicative and incentive (GFATM, 2012). With the former, applicants will know how much funding they receive due to a “[b]oard-approved allocation

⁴⁵ According to the 2012 – 2016 Strategy document, investing in high-impact countries will be determined by introducing “a differentiated investment approach whereby funding decisions are guided by considerations of potential for impact, including the global distribution of disease and key specifics of individual country situations (such as financing gap, income level, absorptive capacity, risk, relative impact of the GF) for the relevant disease” (p.9).

⁴⁶ The funding for national strategies and systems (initial funding, grant renewal, and reprogramming) will be based “on national strategies through the National Strategy Applications approach and the Health Systems Funding Platform pilot” that were created through the GVI Alliance, WB, and WHO (p.9). It is

methodology” (GFATM, 2012, p.3).⁴⁷ Applicants compete for the latter, which is designed “to reward ambitious, high-quality expressions of full demand” (GFATM, 2012, p.3). In order to apply for funding, CCMs must submit a “concept note” on the online Grant Management Platform of the GFATM website to be evaluated by the Technical Review Panel.⁴⁸ Finally, a key feature of the new Strategy is “strategic dialogue” and an improved focus on partnership (GFATM, 2013, p.3). According to the 2012 – 2016 Strategy document, this feature aims to “ensure general agreement on the strategic direction of the program/ project, to reduce waiting time and to improve the overall success rates of applications” (GFATM, 2012, p.4). Overall, this new strategy seeks to increase transparency, clarity and individual country-focuses within GFATM activities in relation to recipient governments and donors (GFATM, 2013).

Reconfiguring the strategy to “invest for impact” and strengthening or modifying the mechanisms to its primary rule system was indicative of the GFATM wishing to ensure the continued support of its donors. For example, for the first time the GFATM included goals in the strategy, including “to save up to 10 million lives and prevent 140-180 million new infections over 2012-2016” (GFATM, 2012, p.7.). As per the 2012 – 2016 Strategy document, establishing such goals “reaffirms the GF’s commitment to align and coordinate with the disease-control priorities set by partners, building on evidence-based demand articulated by countries” (p.8). As such, donors have

important to note that national strategies refer to government and non-government systems, including private systems.

⁴⁷ According to the 2012 – 2016 Strategy document, this allocation methodology is “based on disease burden and ‘ability to pay’” (GFATM, 2012, p.3).

⁴⁸ The concept note requires four main sections: Country Context; Funding Landscape; Funding Request; and Implementation and Risk. For more information, refer to <http://www.theglobalfund.org/en/fundingmodel/process/>.

considerable influence in terms of the overall direction of this strategy, as will become evident throughout the remainder of this chapter.

This strengthening of its operating procedures is related to Mitchell's (1996) notion of positive inducements that can elicit compliance in the face of pressures for non-compliance. In particular, Mitchell (1996) argues that "clarify[ing] treaty requirements and identify[ing] strategies for compliance" is a positive inducement for eliciting compliance (p.14). As a result, in light of several donors freezing their funding and consequently not complying with the GFATM, the establishment of goals and the reconfiguring and clarifying of strategic objectives can be understood as reflecting the GFATM's attempts to prompt compliance by donors.

Compliance Information System

As described in Chapter 2, the Compliance Information System involves the "actors, rules and processes that collect, analyze and disseminate information regarding the instances of, and parties responsible for, violations and compliance" (Mitchell, 1996, p.19). As Mitchell (1996) describes, the major purpose of this system is to "maximize transparency", which involves monitoring "both the amount and quality of the information collected ... as well as the degree of analysis and dissemination" (p.19).

The GFATM has a robust compliance information system involving several elements. First, a Local Fund Agent (LFA) is established by the GFATM in a recipient country to act independently and evaluate the country's ability to disperse and administer funds, oversee "grantee-reported data", and advise the GFATM on future disbursements (Bennett & Fairbank, 2003; Kapilashrami & McPake, 2012; Lu et al., 2006, p.484). In addition, the LFA also evaluates the PRs as implementing agents (Wafula et al., 2014).

A major issue reported with the LFA is its lack of technical capacity (Brugha et al., 2005; Wafula et al., 2014). As Brugha et al. (2005) explains, while the LFAs are “meant to be the Fund’s ‘eyes and ears’ in country, [they] generally had less technical expertise and insight into countries’ health systems” (Brugha et al., 2005, p.6). This finding is confirmed in Wafula et al.’s (2014) study of PRs in 69 countries, where it was discovered that “LFAs ... [had] inadequate expertise to oversee health programs”, and acted as accounting firms while not taking into account the opinions or wishes of the recipient governments (p.6). As a result, the ability to collect, analyze, and disseminate information that Mitchell (1996) identifies as instrumental to the compliance information system was lacking with LFAs.

While not directly addressing the role of the LFA, the 2012 – 2016 strategy has sought to strengthen its M&E processes in order to ensure greater impact for its investments by emphasizing partnership and increasing transparency. In the 2012 – 2016 Strategy Document under Objective 3: Actively Support Grant Implementation Success, the GFATM recognizes that “partnerships at country, regional, and global levels face substantial challenges, particularly in relation to lack of clarity around mutual accountability” (p.16). Thus, in order to strengthen partnerships, the GFATM has committed to creating “specific partnership arrangements”,⁴⁹ which involves clarifying “roles and responsibilities of the GF and partners, and develop[ing] clear, outcome-specific frameworks for coordination, communication, collaboration, and accountability” (p.16). In turn, these arrangements would support national strategies, provide technical

⁴⁹ As the 2012 – 2016 Strategy Document outlines, the “specific partnership arrangements” involves “collaboration with CCMs, country, regional and global partners” (p.16).

support during proposal development, and assist with resolving “implementation and communication obstacles” (p.16).

The second main element of the GFATM’s compliance information system is PBF. As Fan et al. (2013) describe, the GFATM has “long aspired to ‘link resources to the achievement of clear, measurable and sustainable results.’”⁵⁰ The GFATM has identified that there are several purposes to its adoption of PBF, including “link(ing) funding to... country-owned objectives and targets”, and ensuring “that countries spend on ‘delivering services for people in need’” (p.5).⁵¹

The GFATM’s adoption of PBF proceeds as follows. Proposals for funding are reviewed by an independent technical panel of experts and voted on by the Funding Committee.⁵² Successful grants are dispersed through a Principal Recipient (PR) in the recipient country that is responsible for the implementation of the grant, and become Grant Projects that last for five years (Bennett & Fairbank 2003; Fan et al., 2013; Tanzania Commission for AIDS, 2009). All grants have an initial commitment for “phase 1” of two years, at which point a performance assessment is completed (Lu et al., 2006). In order for funding to be continued, disbursements are issued every 8 months at which time they are rated and assigned a “composite metric of performance” (Fan et al.,

⁵⁰ The GFATM maintains that in addition to focusing on achieving measurable results, it also focuses “‘due priority to the most affected countries and communities, and to those countries most at risk’” (Fan et al., 2013, p.2).

⁵¹ According to Fan et al. (2013) other objectives of the GFATM’s PBF mechanism are: “to ‘encourage learning to strengthen capacities and improve program implementation’”; “to ‘invest in measurement systems and promote the use of evidence for decision-making’”; “to oversee and monitor grants”; “and to reallocate ‘resources from non-performing grants’ to ‘programs where results can be achieved’” (p.5).

⁵² Prior to being approved by a vote from the Funding Committee, they are reviewed by the Technical Review Panel, and recommended by the Board to advance to the Funding Committee (Bennett & Fairbank 2003; Fan et al., 2013).

2013, p.2).⁵³ As Bornemisza et al. (2010) note, this grant rating is based on several components, including “the achievements made against the grant targets ... contextual considerations and the efforts that have been made to improve performance where needed” (Bornemisza et al., 2010, p.3). Following Phase I, or the first two years of the grant, there is an extensive review of performance to determine whether the grant continues for Phase 2.⁵⁴ As Low-Beer et al. (2007) describe, these grant ratings have been used to terminate funding, as in the case of Nigeria, South Africa, Senegal and Pakistan, or to reduce or to accelerate funding. In addition, countries with high-performing grants can apply for the Rolling Continuation Channel (RCC), in which they can extend the term of the grant for a maximum of 6 years (Fan et al., 2013). It is important to note that, as Low-Beer et al. (2007) describe, performance is based on the individual country context and is “measured against what is realistic to achieve in country in a specific timescale” (p.1309). As a result, countries are not evaluated against the performance of other countries’ grants or country statistics (Low-Beer et al., 2007).

The GFATM’s donor community is very supportive of PBF and the focus on impact and effectiveness-based grant disbursement. Indeed, the GFATM’s promotion of performance measures and PBF was included in part to appease donors (Radelet, 2004; Fan et al., 2013). As Radelet warned in 2004: “to maintain the support of major donors ... there is little chance that the GFATM will continue to receive significant support if it is unable to show that the interventions it finances are making headway” (p.33). PBF has two main benefits for donors as outlined by Fan et al. (2013): (i) it increases

⁵³ The grant rating of the GFATM in order of decreasing strength: A1 (exceeded expectations); A2 (met expectations); B1 (performed adequately); B2 (potential demonstrated); C (unacceptable) (Bornemisza et al., 2010).

accountability of recipient governments and donors to their citizens “by linking payments to specific outcomes that can be externally observed”; and (ii) it “increase[s] the mutual accountability between the donor and country by focusing contract terms on shared goals and verified results” (p.2). In addition, PBF is seen as preferable to the traditional approach to funding,⁵⁵ as the latter “does not necessarily improve performance on shared goals” and involves large transaction costs (Fan et al., 2013, p.2). Overall, investing in a program that promotes PBF is a better investment for donors.

Prior to the 2012 – 2016 strategy, the targets and grant rating system of the PBF mechanism did not reflect the local context and were not working towards ensuring maximum output (Fan et al., 2013). As Brown et al. (2013) describe of global health funding agencies’ incentive to adopt PBF: “PBF will promote reform in a way that is locally owned and accountable, given that performance targets and indicators will be developed through active participation of local actors” (p.3). Low Beer et al. (2007) emphasize the importance of the fact that targets are created by recipient countries so that “poorer countries, fragile countries, and countries with weaker health systems are not penalized” (Low Beer et al., 2007, p.1308). However, prior to the 2012 – 2016 strategy, targets were imposed from above and not locally determined or owned (Fan et al., 2013). For example, as Fan et al. (2013) describe, in a 2014 AIDSPAN Survey, “only 34 [percent] of PRs feel that ‘the grant rating system accurately reflects performance’” (p.5).⁵⁶

⁵⁴ According to Bornemisza et al. (2010), the time period for Phase 2 lasts for three years after the initial phase.

⁵⁵ According to Fan et al., (2013), this traditional approach involves “expenditure tracking and direct operational controls” (p.2).

⁵⁶ AIDSPAN is a non-profit organization based in Kenya that serves as a watchdog to the GFATM and the grant implementers (AIDSPAN, 2015).

This lack of recipient ownership over target setting has several negative repercussions for the PBF system. First, as Fan et al. (2013) note, within the country, this can impact the ability to achieve better health outcomes, as “PRs do not feel that performance is accurately measured or tied to future disbursements” (p.5). Second, relations of dependence are created as local actors become accountable to donors and their targets (Aveling, 2010). In turn, this does not produce greater impact as during the grant reporting and evaluation stages, there is an increased focus on quantitative outputs rather than the quality of community participation (Aveling, 2010).

The new strategy commits to enhancing the PBF mechanism in order to achieve greater impact (GFATM, 2012). As per the 2012 – 2016 Strategy document, the strategy seeks to strengthen the PBF mechanisms by investing in “high-quality data through baseline and progress surveys, data modeling, and require[ing] increased transparency of financial data” (GFATM, 2012, p.15). It also works to mitigate the earlier challenges with PBF in several ways. First, as mentioned above, the funding model was overhauled to remove the two funding phases (Fan et al., 2013). Second, a Performance Framework was included in the Grant Agreement between the PR and GF. As per the GFATM website (2015), this framework is a “statement of intended performance and impact, to be reported to the GF over the grant term... includes an agreed set of indicators and targets consistent with the programmatic gap analysis submitted in the concept note”. As a result, country ownership is promoted, as the PR has input and responsibility over the targets and indicators used to assess its grant’s performance (GFATM, 2015). The decision to continue funding is based on the progress towards meeting the targets as outlined in the Performance Framework (GFATM, 2015).

Third, as a part of the reconfiguring of the Board's standing committees, one – the Finance and Operational Performance Committee - deals with PBF directly (GFATM, 2014). While monitoring the performance of the Secretariat, the Committee also oversees “the financial management of Global Fund resources” (GFATM, 2014, p.2). With this latter purpose, it exercises several functions relating to the PBF of the GFATM, including adopting “key performance indicators and methodology for assessment” of “the financial management of GF resources”, and “the performance in the operations and corporate management of the Secretariat” (GFATM, 2014, p.2).

Finally, the GFATM also reconfigured its size and type of indicators. For each disease it funds, as well as HSS, the GFATM dictates a list of indicators that are required for recipients' grant reporting (GFATM, 2015). As Fan et al. (2013) describe, the GFATM greatly reduced its list of indicators and went from upstream to downstream indicators, including disease burden and income levels (Fan et al., 2013). As a result, Fan et al., (2013) argue that this restructured PBF system could create greater incentives for recipients to comply, and overall create “greater value for money” (p.17).

In terms of strengthening its Compliance Information System, the GFATM also included two other major reforms in the strategy. First, the Secretariat took on a more active role in terms of “ensuring funding maximizes impact, and value for money while identifying and mitigating risk” (GFATM, 2012, p.12). The increased role of the Secretariat was included in the recommendations from the United States in 2011 for reform within the GFATM (U.S. Senate, 2011). Second, the GFATM also reprogrammed and refocused its existing investments. As per the 2012 – 2016 Strategy Document, failing to refocus investments in the past had generated perceived

disincentives for recipient governments (GFATM, 2012). As a result, the strategy focuses on applying an “iterative, dialogue-based approach to reprogramming and incentivize reprogramming on the basis of a national strategy” (GFATM, 2012, p.14).

Non-Compliance Response System

The third element of Mitchell’s (1996) compliance system is the Non-Compliance Response System. As described in Chapter 2, this component “consists of the actors, rules, and processes governing the formal and informal responses undertaken to induce those identified as in non-compliance to comply” (Mitchell, 1996, p.20).

There are three strategies included in this system which, according to Mitchell (1996), can increase the likelihood that responses to non-compliance will occur and be effective. First, facilitating compliance strategies work to “influence actors who want, but are unable, to comply as well as providing incentives for countries to re-examine the costs of, and priority given to, compliance” (p.19). Similarly, Raustiala and Slaughter (2002) argue that establishing ex ante processes can promote compliance “by changing internal decision processes or preventing non-compliance” (p.547).

There are a number of aspects inherent to the GFATM structure that work to incentivize donors to further their commitment, and persuade potential donors to comply who previously may have been unable to do so. First, the GFATM’s Secretariat and its organizational structure works to facilitate the compliance of donors. Mitchell (1996) argues that treaty organizations and secretariats are instrumental to this strategy, as by establishing “a set of commitments and correlated expectations regarding contributions from various states ... [they can] increase the likelihood and effectiveness of the positive inducements that states can take unilaterally” (p.20). With the commitments and

expectations established by the GFATM and the presence and role of its Secretariat, bilateral donors have been incentivized to comply as there is an avenue for burden sharing (Kelly & Birdsall, 2010). As Kelly and Birdsall (2010) describe, donors have reduced their bilateral funding arrangements “in the interests of harmonisation and alignment (through pooled funds) and administrative efficiency” (p.1584).⁵⁷

Second, the GFATM also facilitates compliance through the implementation of innovative and strategic funding mechanisms. In 2007, the GFATM announced the Debt2Health Conversion program (Cassimon et al., 2008). With these debt conversion schemes, donors forgive either part, or all of, a loan on the condition that the recipient invests the freed-up resources into GFATM programs (GFATM, n.d.). As Cassimon et al. (2008) describe, supporters view them as “ingenious arrangements that are attractive to all parties involved, simultaneously increasing net financial transfers to poor countries, [and] reducing their indebtedness...” (p.1189). According to the GFATM, under the Debt2Health strategy, debts that have been swapped total close to €170 million (GFATM, n.d.).⁵⁸

Third, as mentioned, the new strategy was designed as a way for the GFATM to ensure the compliance of its donors following the 2011 crisis (Brown & Griekspoor, 2013; GFATM, 2012). As Strategic Objective 5, Sustain the Gains, Mobilize Resources, explains of the impetus behind the new strategy: it seeks to “[c]onvey and demonstrate over time how transforming the GF’s funding model according to this Strategy... delivers better value for money and increases the impact of of donor investments” (p.19). The

⁵⁷ As Kelly and Birdsall (2010) describe, bilateral donors’ involvement with the GFATM has lead to administrative efficiency by reducing the number of funding relationships that require direct management and oversight at the country level

Strategy outlines that it wants to instill in donors that it is the best funding mechanism to invest in, and by moving away from its passive funding model, it will create better impact with investment (GFATM, 2012).⁵⁹ In addition, in order to increase resource mobilization to “maintain and accelerate the gains”, the strategy commits to implementing the reforms advocated by the High-Level Panel (GFATM, 2012, p.19). This promise was in direct response to the demands from donors: in 2011 the United Kingdom Department for International Development issued a statement that its future disbursements would be dependent on the GFATM’s ability to adhere to these recommendations (Mosynzski, 2011). In addition, as mentioned above, the Strategy also took into account the recommendations from its donors, such as the U.S. government’s insistence on ceasing funding to middle-income countries (Salaam-Blyther & Kendall, 2012). Furthermore, Strategic Objective 5 commits to “consider[ing] adapting the GF’s funding policies and governance” in order to ensure better investment from non-DAC public and private donors, and to be innovative in order “to diversify the funding base” (GFATM, 2012, p.19).

The GFATM is also committed to promoting this new strategy in order to educate donors and attract new creditors (Mitchell, 1996; GFATM, 2013, p.20). As Mitchell (1996) explains, “international education efforts targeted at clarifying rules and the means to compliance” are necessary means to facilitate compliance (p.20). As the 2012 – 2016 Strategy document outlines, the GFATM is committed to international education

⁵⁸ The debt swap agreements include: Germany and Indonesia (€50 million); Germany and Pakistan (€40 million); Australia and Indonesia (AUD 75 million); Germany and Cote d’Ivoire (€19 million); and Germany and Egypt (€6.6 million) (GFATM, n.d.).

⁵⁹ The new funding formula is based on: “disease burden, income level, availability of alternative financing, and a consideration of historical funding levels” (GFATM, 2014, p.10).

campaigns in order to incentivize donors to act and support the GFATM over other funding vehicles (GFATM, 2012).

The second strategy outlined by Mitchell (1996) in the Compliance Information System is sanctioning violations. As Mitchell (1996) explains, proponents of sanctions argue that they are an efficient way to “make violations unattractive”, rather than modifying the benefits or costs associated with compliance (p.20). While the GFATM does not have the mechanisms to sanction its donors, as it is reliant on their voluntary contributions, it has threatened recipient countries with the discontinuation of funding as a way to incentivize them to comply. For example, in 2006 Ethiopia received a warning that they were in the red zone and were in danger of losing their funding (Feachem & Sabot, 2006).

In response to the charges of corruption in 2011 and demands from donors for institutional reform, the GFATM created a Code of Conduct for Suppliers. As per the Sanctions Procedures Relating to the Code of Conduct for Suppliers document (2015), this Code ensures ““suppliers’ commitment to maintain the national integrity of Global Fund-financed grant operations and corporate procurement activities” (p.1).⁶⁰ The Code outlines the expectations for Suppliers’ behavior, and provides that the GFATM can sanction a supplier or its successor if they have violated the Supplier Code and have engaged in “corrupt, fraudulent, collusive, anti-competitive or coercive practice in competing for, or in performing under, a GF-financed contract” (p.1). The GFATM has a Sanctions Panel, consisting of three permanent and three independent external members,

⁶⁰ According to the Sanctions Procedures Relating to the Code of Conduct for Suppliers (2015), a supplier can include any of the following: “bidders, suppliers, agents, intermediaries, consultants and contractors and representatives of each of the above” (p.1).

that advise the Executive Director in terms of how to deal with misconduct (GFATM, 2015).

Finally, the third strategy to increase the likelihood that responses to non-compliance will occur and be effective is preventing violations (Mitchell, 1996). As Mitchell (1996) describes of this strategy, “[it] relies on efforts to raise obstacles to, and otherwise prevent, non-compliance in the first instance” (p.21). This is also related to Raustiala and Slaughter’s (2002) notion of incorporating *ex ante* processes to prevent the occurrence of non-compliance. According to Mitchell (1996), there are different measures that can be taken in order to prevent violations. First, there are pre-monitory control measures, or efforts to inspect and survey behavior before violations occur (Mitchell, 1996). The GFATM as a financing mechanism for global health is an attractive venue for donors in order to mitigate risk (Salaam-Blyther & Kendall, 2013). As Salaam-Blyther and Kendall (2012) note of the U.S. government’s position regarding the risk management of the GFATM: “the GF represents a more efficient and flexible funding mechanism than bilateral programs and offers the U.S. the ability to pool funds and share risk with other donors” (p.10).

In the context of the 2012 – 2016 strategy, the GFATM included an Amended Comprehensive Funding Policy, which is “designed to support the implementation of the allocation-based funding model” and includes three financial safeguards to ensure “robust financial management practices at the GF” (p.16). These three safeguards act as pre-monitory measures in order to survey behavior prior to any violations being committed (GFATM, 2012). In addition, the GFATM also made several structural reforms,

including establishing a Chief Risk Officer, and modifying its standing committees and restructuring its mandates (GFATM, 2012).

Second, the “coerced compliance system” involves “finding regulatory chokepoints where limits can be placed on the ability to violate a treaty’s term” (p.22). The 2011 High Level Panel report condemned the GFATM’s “failure to consider risk management in its grant review process” (CGDEV, 2013, p.15). Consequently, the 2012 – 2016 strategy establishes these regulatory chokepoints by adopting the High Level Panel and Comprehensive Reform Working Group recommendations to strengthen “fiduciary controls” by ensuring that “strong risk management procedures are enacted at every step of the grant cycle” (p.21). In addition, the 2012 – 2016 strategy adopts the recommendations of the High Level Panel of having a “risk-differentiated approach to grant management”, which would be integrated into the Secretariat’s framework for “operation risk management” (p.15).⁶¹

Finally, the “deterrence-oriented approach” involves the use of sanctions and the successful “detecting, prosecuting, and sanctioning violations after they occurred to deter them from occurring in the future” (p.23). This strategy is aligned with the creation and implementation of the Sanctions Panel and the Code of Conduct for Suppliers (GFATM, 2012).

⁶¹ This risk-differentiated approach to grant management would involve “a formal country-risk matrix, applying differentiated safeguards to the different categories of countries, and intensifying focus on mitigating other identified risk”; Integrated with “the Secretariat’s new framework for operation risk management” (Mitchell, 1996).

Conclusion

The 2012 – 2016 strategy is indicative of the GFATM’s imperative to regain the confidence of its donors following the 2011 crisis and the resulting cancellation of funding rounds from 2011 to 2014 (GFATM, 2012). While the modified compliance system reflects this push by the GFATM and has been strengthened in several key respects, there are ramifications from the strategy. First, while the strategy stresses the importance of promoting recipient country ownership over health planning, the GFATM’s mandate is still not truly embodying this concept. As Esser (2014) describes, while GHIs use buzzwords such as “ownership”, in fact they represent “politically driven semantic dynamics” (p.43). This use of “ownership” is evident in the 2012 – 2016 strategy with the GFATM’s assertion that it will “fund based on quality national strategies and through national systems” (p.10). In fact, when referring to national systems, this includes both government and non-government systems (GFATM, 2012). While the GFATM’s backing of civil society groups and various non-government stakeholders does support its objective of partnership, this is at odds with the concept of country ownership as these external actors are not accountable to the recipient government (Doyle & Patel, 2008). As a result, the government does not have control over these groups, nor can it ensure participation with national planning (Doyle & Patel, 2008). This was an issue prior to the launch of the new strategy as CSOs became increasingly accountable to the GFATM and were “bypass[ing]” government agencies (Doyle & Patel, 2008, p.1932). Furthermore, due to the increasing involvement of CSOs and the consequential increase in the number of actors operating within the health care sector, confusion was created in terms of the numbers of actors and their priorities (Brugha, 2009).

In addition, the 2012 – 2016 Strategy document highlights how the national system should be “‘jointly-assessed’ through a credible, independent, multi-stakeholder process using internationally-agreed standards” (p.10). Inevitably, having a national system be subject to external review and international standards does not fully adhere to the principle of government ownership. It is also unclear how the recommendations from this panel would be imposed on the recipient government.

Second, there are inherent contradictions throughout its restructured compliance system (Fan et al., 2013). First, as Fan et al. (2013) note, the objective of having PBFs “strengthen capacities” can be at odds with “the goal of ‘reallocating resources from non-performing grants to grants where results can be achieved” (p.5). While the reprogramming of existing grants under the new strategy does mitigate disincentives that can result from poorly performing grants, it can be contradictory to the objective of strengthening the capacity of local actors and processes (Fan et al., 2013). Second, there is an underlying tension between PBF and government ownership (Wafula et al., 2014; Fan et al., 2013). As Fan et al. (2013) describe, while funding is conditional upon performance, “the act of defining ‘performance’ and ‘results’ through shared goals between the two parties is key to PBF’s effectiveness” (p.3). As such, typically this notion of performance is imposed from above (Fan et al., 2013). While the new strategy stresses “strategic dialogue” and the recipient government’s involvement in creating targets, the GFATM has maintained its own set of core indicators (GFATM, 2015). In addition, Wafula et al. (2014) note that this tension is a concern for re-programming funds, and that the GFATM should be careful that targets initially agreed upon between the PR and the GFATM are not adjusted significantly.

Thus, while the restructuring of the GFATM's compliance system was completed in order to regain the confidence of donors and to acquiesce to their mandated reforms, it has had several ramifications in terms of recipient government ownership. The next two chapters will examine the results of the GFATM's compliance system in terms of inducing the participation and compliance of key donors, including the U.S. government, the Bill and Melinda Gates Foundation, and the Chevron Corporation.

CHAPTER 4: COMPLIANCE THROUGH THE LOGIC OF CONSEQUENTIALISM

While a comprehension of the GFATM's compliance system is essential to understanding global actors' compliance with the GFATM, an equally important focus of inquiry is the external motivations behind their compliance. This chapter will focus on the incentives for global health actors to comply with the GFATM according to March and Olsen's (1998) logic of consequentialism. The subsequent chapter will approach this query from perspective of the logic of appropriateness.⁶²

Evidently there is considerable crossover between Chapter 3 and the subject matter of this and the next chapter, as having a robust compliance system is certainly an incentive for global health actors to comply. For example, with the reformulation of the 2012 – 2016 strategy, several donors' contributions, including those of the U.S. and the United Kingdom, were dependent on the GFATM Board adopting the reforms from the High Level Independent Panel (Moszynski, 2011; Salaam-Blyther & Kendall, 2012). Once the GFATM restructured its strategy and primary rule system, funding pledges from donors subsequently increased. For example, while Germany initially froze their funding disbursement in 2011, in January 2013 Germany pledged 1 billion Euros for the 2012 – 2016 period (Schmalzbach, 2013). In addition, as mentioned in Chapter 3, several of the reforms reflected donors' interests as they were recommendations for restructuring the GFATM (Salaam-Blyther & Kendall, 2012). For example, discontinuing funding for upper middle-income countries except in extreme circumstances was a recommendation of the U.S. government that was incorporated into the GFATM's mandate (Salaam-

⁶² As noted in chapter 2, the application of both logics is essential to this thesis as each logic sheds light on different elements of why actors would comply (March & Olsen, 1998). As March & Olsen (1998) explain, political actors are shaped “both by their interests, by which they evaluate their expected consequences, and by the rules embedded in their identities and political institutions” (p.952).

Blyther & Kendall, 2012). Thus, having a robust compliance system that reflects donors' interests and preferences is certainly another incentive for global health actors' compliance.

As mentioned in Chapter 1, this thesis is adopting Shelton's (2000) argument that the compliance of state and non-state actors involves "complex and holistic determinations", in that the incentives and disincentives that influence compliance cannot be quantified (p.17). Therefore, this chapter will draw on the case studies of the U.S. government, the Bill & Melinda Gates Foundation, and the Chevron Corporation, to shed light on the underlying motivations and reasoning for these donors' compliance with the GFATM.^{63,64}

Framework: Logic of Consequentialism

As discussed in Chapter 2, Börzel (200) notes that this logic assumes that states have a set of "given and fixed preferences" (p.11), and will engage in a cost-benefit calculation while "taking into account the (anticipated) behaviour of other actors" (Börzel, 2000, p.11). As a result, instances of cooperation in international relations are due to actors perceiving gains from cooperating with other states and actors (March & Olsen, 1998).

This section will also take as its point of departure Mitchell's (1996) view that compliance can be a result of independent self-interest or interdependent self-interest. As Mitchell (1996) states, the former is the simplest explanation of why a government or

⁶³ As noted in Chapter 2, the compliance of an actor refers to both output, or the "legal and administrative measures required to achieve the policy goal" (Börzel, 2000, p.3), and outcome, or behavioural change. As mentioned in Chapter 1, this thesis is taking the starting position that the global health actors described in this chapter do comply with the GFATM, as evidenced by their proven track record of providing resources.

⁶⁴ For further explanation of the case studies, refer to Chapter 1.

actor complies or behaves, as actors comply in order to advance their interests. In the case of the latter, within their calculation of their self-interest, states “can include their expectations regarding the impact their own compliance will have on others” (p.9). As it pertains to the GFATM, an actor’s awareness of how their compliance will impact others can be explained through coordination games (Mitchell, 1996).⁶⁵ Interdependent self-interest will be applied to the discussion at the end of the Chapter, concerning “Vectors of Influence”.

This section will also utilize the notion of smart power to analyze how global health actors are either using this power to leverage their influence, or to increase their influence in the pursuit of their interests (Lee & Gómez, 2011; Wilson, 2008). According to Wilson (2008), smart power is the combination of hard and soft power “in ways that are mutually reinforcing such that the actor’s purposes are advanced effectively and efficiently” (p.2). Soft power, as defined by Lee & Gómez (2011), is “the capacity to persuade or attract others to do what one wants through the force of ideas, knowledge and values” (p.1). In the field of global health, global health diplomacy represents “an important source of soft power” (Lee & Gómez, 2011, p.3). In contrast, hard power is “coercion... underpinned by military and economic might” (Lee & Gómez, 2011, p.1). Bringing these two elements together, states engage in global health diplomacy and their position in doing so is reinforced by their economic and military might. As Lee and Gómez (2011) discovered in the case of an emerging economy such as Brazil, countries are able to increase their “ability to leverage soft power influence” and increase their credibility in global health diplomacy (p.5).

⁶⁵ Refer to the discussion below: Vectors of Influence.

Donor States

Influence at the Board-Level

One reason why donor states would want to comply out of independent self-interest is their position and influence at the Board (Brugha et al., 2004; Brown, 2010). As described in Chapter 1, the GFATM's Board in Geneva is composed of 19 voting and 5 non-voting members, consisting of recipient and donor countries, and private actors (Brugha et al., 2004; Brugha, 2009).⁶⁶ During the formation of the GFATM, sovereign equality of decision-making was chosen to determine Board-level decisions (Brugha et al., 2004; Brugha, 2009). Designed in the spirit of deliberative democracy and multisectoral participation, this method of voting was chosen to ensure that people living with the disease have equivalent voting weight to major donors, such as the United States (Brown, 2010). As Brown (2010) describes, this “safeguard[s] equal opportunity” by ensuring that “each member is constitutionally guaranteed an equal chance to place items on the agenda and are assured equal time to debate any issue” (p.520).

Despite provisions to ensure the equality of stakeholders, in reality the Board is dominated by major donors (Brown, 2010; Brown et al., 2013). Brown et al. (2013) call this the “colonization of unequal advantage”, whereby “donor states... [wield] an effective veto power over board decisions due to their economic advantage” (p.12). This dominance of donor states is evident in two respects. First, donors have a veto power as they can leverage decisions made at the Board with their future funding disbursements (Brown, 2010). For example, the George W. Bush Administration was known for “withhold[ing] funds until certain programs are eliminated or changed to the Bush administration's liking” (Brown, 2010, p.524).

Second, as Brown (2010) notes, donors often strategize in advance of Board meetings by holding exclusive meetings only attended by donors. As Brown (2010) discovered through his interviews with Global Fund Board members, respondents felt that this gave an unfair advantage to donors, and when recipient governments asked if they could have the financial resources to conduct similar meetings, they were denied. As a result, as Brown (2010) notes, the Board resembles “a process of interest based preference maximization” as donors are able to push forward their agendas (p.523; Brown et al., 2013).

As a result of being able to circumvent the Board’s formal structure of deliberative democracy and having ultimate control over the decision-making body of the GFATM, donors are inclined to comply with the mandate of this PPP. However, this raises the question of why Board decision-making is not determined by weighted voting, which would allow donors to not have to covertly overcome the Board structure. Steinberg’s (2002) analysis of the use of sovereign equality-decision making in the creation of the World Trade Organization (WTO) is useful in shedding light onto why donors comply with this structural feature of the GFATM Board. As he describes, major states complied with sovereign equality decision-making for two main reasons. First, it embraces deliberative democracy and consensus while respecting the sovereignty of states, which legitimizes these processes for domestic audiences (Steinberg, 2002).

Second, by preserving this system of voting from the General Agreement on Tariffs and Trade (GATT), major western states would be able to obtain information regarding developing countries’ preferences and their “risk tolerances” (Steinberg, 2002, p.362). As Steinberg (2002) notes, since the outcomes of weighted voting is determined

⁶⁶ Refer to Appendix A.

by a few powerful states, this deprives “weaker states of an opportunity to convey info about their preferences and could lead to a pattern of outcomes that consistently make weak countries worse off” (p.362). By having a clear understanding of a country’s true preferences,⁶⁷ they can set the agenda accordingly, and dominate the initiative advancement process, proposal development, and the package of proposals (Steinberg, 2002).

The arguments presented by Steinberg (2002) as to why major powers favoured equal sovereignty with the creation of the WTO can be applied to why major donors, such as the U.S. government, would comply with the GFATM’s board structure. In the end, this deliberative and inclusive form of decision-making is attractive for donors’ domestic audiences, which can help the U.S. government to justify their inclusion and investment in the GFATM (Steinberg, 2002). Yet, donors can still control the outcome of the decisions, while doing so under the guise of deliberative democracy and multisectoral participation (Brown, 2010; Brown et al., 2013).

Security

The securitization of health is a major reason why global health donors would comply with the GFTAM (Elbe, 2010; Mitchell, 1996). This association of health with a security threat can be understood in the context of the HIV-Security nexus in the late 1990s and early 2000s, and the transformation from a focus on international to global public health.

⁶⁷ In regards to whether the information that the major states obtains from weaker states in sovereign equality voting is accurate, Steinberg (2002) argues that the information would be sincere as states would not simply be defining their interests for strategic reasons.

Since the end of the Cold War, health has increasingly become a concern on the international security agenda (Elbe, 2010; Hwenda et al., 2011). In particular, as Hwenda et al. (2011) describe, during the 1990s health became associated with a security threat owing to “specific events such as the global pandemic influenza, fears of bioterrorism and of emerging and resurgent disease” (p.8). In terms of infectious diseases, AIDS was at the forefront of this securitization in national and international discourse (Elbe, 2010). As then U.S. Vice-President Al Gore stated in his remarks for the UN Security Council (UNSC) opening session in January 2000: “when a single disease threatens everything from economic strength to peacekeeping – we clearly face a security threat of the greatest magnitude” (Gore, 2000). At this meeting, the UNSC convened for a month-long focus on Africa and the security-HIV nexus. HIV/AIDS became identified as a threat owing to its potentially destabilizing impact on the political and social fabric of a country with a high infection rate, in addition to the high rates of HIV infection among foreign armies (Elbe, 2010). Moreover, it also had serious economic ramifications as it could lead to weakened productivity owing to “worker illness, absenteeism and low morale”, a reduction in external investment and investment within the country, and a potential exodus of capital in countries with high prevalence rates (McInnes, 2006, p.316).⁶⁸

The 2000 UNSC meeting on Africa culminated in the passing of Resolution 1308 in July 2000 (Prins, 2004; McInnes & Rushton, 2010). The Resolution emphasized that if the AIDS pandemic was not addressed, it would “pose a risk to stability and security” (McInnes & Rushton, 2010, p.227; McInnes, 2006; Prins, 2004). As McInnes and

⁶⁸ As McInnes (2006) notes, this weakened productivity is also due to the fact that it has a “disproportionate impact upon workers in which should be the most productive period of their lives” (p.316).

Rushton (2010) argue, the unanimous passage of the resolution was a “powerful securitizing move”, and indicated that the international community recognized AIDS was a security threat (p.228).

Along with this securitization of health, there has also been a transformation from an international focus on health security to an emphasis on global public health (Bunyavanich & Walkup, 2001; Hwenda et al., 2011).⁶⁹ As Hwenda et al. (2011) describe, the former focus typically involved states responding to “health challenges across geopolitical borders”, whereas the latter involves “the entire spectrum of events with potential to undermine health worldwide” (p.2). With this global focus on health security, there is a co-dependence between “sub-national, national and international threats to health”, which in turn creates mutual vulnerability across state borders.⁷⁰ As a U.S. National Security Advisor declared in 2011: “[t]here are now fewer boundaries... countries must deal with health together, just as they do with defense and trade” (Bunyavanich & Walkup, 2001, p.1556).

This shift was propelled by processes of globalization and interconnectedness across state borders (Hwenda et al., 2011; Feldbaum, 2009). As Bunyanavich & Walkup (2001) explain, “[t]he worldwide dynamics of growing markets, modernization, and struggles for national and ethnic identities have become inextricably linked to health care politics” (p.1557). For example, the spread of SARS demonstrated how national health security emergencies can become international public health concerns and have ramifications for the global economy (Elbe, 2010; Hwenda et al., 2011). As Elbe argues,

⁶⁹ According to Bunyanavich and Walkup (2001), this interconnectedness with health entails “the global interconnectedness of people goods, habits, and pathogens has an impact on the health status of individuals and populations” (pp.1556-1557).

“SARS proved that a newly emerging infectious disease outbreak can indeed be only a plane ride away” (2010, p.39). In addition to the public health concerns, this also had major economic ramifications: in 2003, China’s second quarter GDP contracted 5 percent on an annualized basis, and the Asian Development Bank estimated SARS had an economic impact of U.S. 18 billion dollars, or 6 percent of GDP (Elbe, 2010). Furthermore, SARS also shed light on the importance of global health policy for several states. As Labonté and Gagnon (2010) describe, Thailand and the United Kingdom associate the SARS outbreak with their “efforts in global health policy, and their adoption of the ... International Health Regulations” (p.4).⁷¹

Overall, with the diversity of these global challenges and the co-dependence between various levels of health, Hwenda et al. note that this has “raised the geopolitical importance of global health security” (2011, p.5). As a result, it became understood that mitigating global health concerns was a shared responsibility and state and non-state actors had to coordinate their approaches (Hwenda et al., 2011; Labonté & Gagnon, 2010).

While it is understood in international policy circles that mitigating global health risks is a shared responsibility however, in reality the global health security agenda is determined by a few powerful states and the security threats they deem to be the most pertinent (Hwenda et al., 2011). In particular, bioterrorism and the fear of the spreading of a few infectious diseases dominate the discourse (Hwenda et al., 2011).

⁷⁰ According to Hwenda et al. (2011), threats entail “actions or events that could undermine the quality of life of a country’s citizens or threaten to significantly reduce its public and private policy options in contemporary society are considered national security threats” (p.5).

⁷¹ According to the WHO, the International Health Regulations is a legal instrument that is binding on 196 countries across the globe, including all the Member States of WHO. Their aim is to help the international community prevent and respond to acute public health risks that have the potential to cross borders and threaten people worldwide” (WHO, 2015).

The United States is a major architect of the global health security agenda, and in particular with HIV/AIDS, it has utilized its smart power advantage to actualize its interests (Hwenda et al., 2011). While the AIDS-security link appeared as early as 1987 in U.S. intelligence and security circles,⁷² it was during the 1990s that it became a prominent issue for American policymakers (McInnes & Rushton, 2010). In 1996, a U.S. Presidential Decision Directive “called for a greater degree of coordination in the U.S. government’s response to the security threats posed by infectious diseases” (McInnes & Rushton, 2010, p.227). In 2000, the Clinton Administration classified HIV/AIDS as “a threat to the national security of the U.S.” (Elbe, 2010, 34).⁷³

In addition, the U.S. government also played a pivotal role in the development of the concept of global health, as it was a product of U.S. think tanks, universities, and NGOs (Kickbusch, 2002).

More specifically, Resolution 1308 was indicative of the U.S. government seeking to realize its own interests as its passage was largely due to the advocacy of the Clinton administration, and specifically the former U.S. Ambassador to the UN, Richard Holbrooke, engaging in global health diplomacy while being backed by the U.S.’s hard power position (McInnes, 2006; McInnes & Rushton, 2010; Prins, 2004). As per Lee and Gómez’s (2011) classification, Holbrooke engaged in global health diplomacy in two

⁷² According to McInnes and Rushton (2010), in 1987 a U.S. Special National Intelligence Estimate “examined the implications of the AID pandemic for the [African] region in detail” (p.226). This Estimate outlined that there “were clear concerns about the strategic and security implications of AIDS” (p.226).

⁷³ In the same year, the National Intelligence Council released a National Intelligence Estimate on infectious diseases and stated:

“New and reemerging infectious diseases will pose a rising global health threat and will complicate U.S. and global security over the next 20 years. These diseases will endanger U.S. citizens at home and abroad, threaten U.S. armed forces deployed overseas, and exacerbate social and political instability in key countries and regions in which the United States has significant interests.” (<http://fas.org/irp/threat/nic99-17d.htm>).

respects.⁷⁴ First, Holbrooke utilized what Lee and Gómez (2011) characterize as “medical diplomacy”, which “advocates the use of health care as an instrument for furthering foreign policy goals” (p.2). Inevitably, the U.S. government was using the need to address HIV/AIDS in order to realize its own foreign policy interests that HIV/AIDS was a security threat (McInnes & Rushton, 2010). This position was supported by its influential position in the UNSC: as McInnes and Rushton (2010) note, “[c]ertainly no state would want to bear the political costs of unilaterally blocking international attempts to address the pandemic” (p.231). While its position was aided by the support of the director of UNAIDS, Dr. Peter Piot, and the reality that HIV/AIDS was a pressing issue, it was evident that other states would not publicly oppose the U.S. government in the passing of the Resolution (McInnes & Rushton, 2010).

In fact, pushing forward its agenda in this climate is indicative of a smart power approach within this logic of consequences (Wilson, 2008). As Wilson (2008) notes, the decision to carry out a smart power approach is built on several considerations, including the “target over which one seeks to exercise power”; its “self-knowledge and understanding of one’s goals and capacities”; and “the broader regional and global context” (p.115). This is in line with March and Olsen’s (1998) assertion that in a cost-benefit calculation, actors will anticipate the behaviour of others. With its awareness of its influence over other actors, the U.S. government was utilizing its capacity within the UNSC, while working within the regional and global context of an increasingly threatening global epidemic. In fact, as Prins (2004) notes, the other UNSC members

⁷⁴ In addition, the passing of Resolution 1308 and the international recognition and acceptance of HIV/AIDS as a security threat was a part of the U.S. domestic agenda (McInnes & Rushton, 2010). Then Vice-President Al Gore wanted to bolster his support in light of the November presidential election of that

were initially reluctant to acknowledge the linkage between security and AIDS.

Therefore, the U.S. government was able to push this agenda forward by leveraging its soft and hard power advantages (McInnes & Rushton, 2010).

The second way in which Holbrooke engaged in global health diplomacy is was by “harnessing foreign policy actors and processes for the benefit of global health goals” (Lee & Gómez, 2011, p.3). Indeed, it was Holbrooke who, in 1999, had called on former Secretary-General Kofi Annan to have a UNSC meeting on AIDS, to which the Secretary-General replied: “AIDS isn’t [*sic*] a security issue” (Prins, 2004, p.941). By advocating that AIDS appear on the UNSC agenda, Holbrooke and the Clinton administration was clearly trying to garner more attention and support in order to combat the epidemic, while in effect securitizing the issue.⁷⁵

Given the U.S. government’s global health diplomatic efforts in pushing HIV/AIDS as a security issue, and the fact that the GFATM was a product of the early 2000s during the height of the security-HIV nexus, security is inevitably a major interdependent self-interest motive for the U.S. government’s compliance with the GFATM at its creation (Kickbusch, 2002). The U.S. government was a major player in the creation of the GFATM and was able to use its influence to shape its operationalization (Kickbusch, 2002). For example, according to Kickbusch, the U.S. government “demanded the setting up of the ‘a new delivery system’ rather than relying on UN agencies and the World Bank” (2002, p.16). As Bartsch & Kohlmorgen (2007) note, while the official reasoning was that it could act independently from the UN system,

year and Richard Holbrooke wanted the international attention as he was vying to be Gore’s Secretary of State (McInnes & Rushton, 2010).

in turn it was done in order for major states, such as the U.S. government, to realize their own interests and have direct control of the organization rather than surrender part of this control to the UN. Inevitably, given its position within global health governance at the time, as evidenced from its advocacy of Resolution 1308, it was successful in having the GFATM structured as a separate entity from the UN system.

While security was a major reason for the U.S. government's involvement in the creation of the GFATM and its initial commitment to the organization, security is still a major factor. Although the reasoning behind the Security-HIV nexus has been questioned in the literature along with the ramifications of securitizing HIV/AIDS (Barnett & Prins, 2006; McInnes & Rushton, 2010; McInnes, 2006),⁷⁶ the security dimensions of infectious diseases such as HIV/AIDS still remain an issue for donors. Indeed, as Elbe (2010) notes, despite the disputed truth behind the perceived HIV-Security nexus in the first decade of the 2000s, the arguments "were solidly... accepted for several years" (p.37). For example, the 2010 Obama Administration's National Security Strategy (NSS) clearly indicates that security interests are a driving force behind the U.S. government's global health agenda (Labonté & Gagnon, 2010). As per the "Pandemic and Infectious Disease" section of the "Sustain Broad Cooperation on Key Global Challenges" chapter in the 2010 NSS report: "[t]he threat of contagious disease transcends political boundaries, and the ability to prevent, quickly detect and contain outbreaks with pandemic potential has never been so important" (Labonté & Gagnon, 2010; Whitehouse, 2010). The section goes on to outline that due to the interdependence of global health systems, the U.S.

⁷⁵ It should be noted that while the U.S. government was at the forefront of making HIV/AIDS an international security concern, as Elbe (2010) asserts, several actors utilized the framing of HIV/AIDS as a security issue in order to advance the case for combating HIV/AIDS.

government not only has to improve “public health and medical capabilities” on the domestic front, but also “work with international partners to mitigate and contain disease when necessary” (Labonté & Gagnon, 2010, p.49). Inevitably, taking a global approach to addressing health care, justified within this mindset of securitization, is still very much on the U.S. government’s radar.

Patent Laws and Intellectual Property Rights

Another reason why donors complied with the mandate of the GFATM at its creation was the protection of intellectual property rights. The protection of patent drugs falls under the 1994 Trade Related Aspects of Intellectual Property Rights (TRIPS) agreement, which states that WTO member states have obligations “regarding copyrights, trademarks, patents...which includes patent for drugs” (Bartsch & Kohlmorgen, 2007, p.15). As Bartsch and Kohlmorgen (2007) describe, during the 1990s civil society groups, as part of the Essential Drugs Campaign, advocated access to antiretrovirals for poor AIDS victims, and argued that access to these medicines constituted a public health issue. As a result of this advocacy, the adoption of the Doha Declaration at the 4th WTO Ministerial Conference in November 2001 recognizes that “the TRIPS agreement ‘can and should be interpreted and implemented in a manner supportive of WTO Members’ right to protect health and... to promote access to medicines for all” (Quick, 2003, p.281). These provisions allow states to disregard patents when public health

⁷⁶ As McInnes and Rushton (2010) argue, the linkages that were initially discussed in the nexus turned out to be much more complex than originally understood. For example, the link between armed services and prevalence rates involved many more variables than originally anticipated (McInnes & Rushton, 2010).

circumstances are at stake, in order to allow for increased access to drugs (Hwenda et al., 2011).⁷⁷

As a result of processes of globalization and interdependence, northern governments have become more actively involved in the protection of patent laws and intellectual property rights in the field of global health (Hwenda et al., 2011). According to Hwenda et al., these major states argue that the provisions providing flexibility for patent drugs “constitutes a political and regulatory impediment to market access” (2011, p.19). In particular, the United States and the European Union (EU) have both tried to override these flexibilities, and in the case of the U.S. government, they have threatened to impose sanctions.⁷⁸

As mentioned above, the GFATM was designed by major states, such as the U.S., in order to realize their own objectives beyond the purview of the UN system (Bartsch & Kohlmorgen, 2007). In terms of patent medications, as Bartsch and Kohlmorgen (2007) note, when the GFATM was designed, it was assumed that it would protect pharmaceutical companies by predominantly financing patented drugs. As a result, the U.S. government and other major benefactors, by using their economic position, would be able to use global health diplomatic channels while circumventing multilateral surveillance by the UN and international scrutiny over the promotion of patent drugs and national corporations (Bartsch & Kohlmorgen, 2007). Since it operates with a much

⁷⁷ Initially, the Doha declaration stated that countries could override the TRIPS agreement in the case of a public health emergency. However, as Bartsch and Kohlmorgen (2007) describe, in 2003, following conflicts over which diseases could be granted compulsory licenses, “the pharmaceutical industry and the governments from industrialised countries had to accept the authorization of compulsory licenses in the case of health emergencies irrespective of the disease involved” (p.17).

⁷⁸ According to Hwenda, the U.S. government “has actively pursued and threatened trade sanctions against trade partners who have attempted to implement TRIPS flexibilities, notably South Africa, Brazil and Thailand” (pp.18-19).

more top-down approach to combating HIV/AIDS, it was designed so that the U.S. government can have a definitive say over its policies (Bartsch & Kohlmorgen, 2007).

Private Actors

Philanthropic Organization: Bill and Melinda Gates Foundation

The Bill and Melinda Gates Foundation (Gates Foundation) is a major private benefactor of the GFATM in terms of support for the PPP, and total resources pledged (McCoy et al., 2009). According to the GFATM website, the Gates Foundation has “contributed or pledged a total of U.S. 1.4 billion dollars to the Global Fund” (GFATM, 2015). This can be compared to U.S. 33 billion dollars cumulative and fully paid contributions that the GFATM has received as of 2015 (GFATM, 2015).

While the Bill and Melinda Gates Foundation was established with the stated intent of improving the quality of life of its beneficiaries in terms of poverty, health, and education (Gates Foundation, n.d.), the motivations behind its investments have been duly noted in the literature. In particular, the notion of philanthrocapitalism has been used to understand why private actors such as the Gates Foundation choose to invest. As Morvaridi (2012) explains, this form of philanthropy “is both politically and ideologically committed to market-based social investment through partnerships, to make the market work or work better for capital” (p.1191). Whereas philanthropy is traditionally rooted in a moral calculus, capitalists investing in philanthropy typically conduct a cost-benefit calculation prior to pledging resources in the pursuit of increasing their economic and political influence (McGoey, 2014; Morvaridi, 2012).

In terms of the Gates Foundation’s investment in the GFATM, a potential underlying motivation is its desire to shape the global health agenda and increase its

influence. As a capitalist philanthropic organization, the Gates Foundation has a clear neoliberal underpinning to its operations and the causes it actively promotes (McGoey, 2014). Since its inception, the Foundation has devoted its funding for global health towards research and technologies including medications, with a key emphasis on impact and achieving fast, measurable results (Lidén et al., 2013). As McGoey (2014) describes, Bill Gates has attempted to model the Foundation's operations on Microsoft's management techniques, and "to transform philanthropy into a more efficient and lucrative industry" (p.110). This is evident with the Foundation's promotion of technology, and its results-oriented and cost-effective approach (McGoey, 2014; Morvaridi, 2012). For example, as Birn (2014) describes, with its Grand Challenges in Global Health Initiative, the Gates Foundation finances the work of scientists across the world. However, as Birn (2014) notes, it only provides funding on the condition that "they (grantees) view health in circumscribed, technological terms, not through integrated technical and socio-political understandings" (p.11). As such, the GFATM has a clear neoliberal focus and utilizes its funding to promote this agenda.

With this neoliberal agenda and the vast amount of resources it has at its disposal, the Gates Foundation has been able to shape the international agenda and in turn increase its influence (Birn, 2014; McCoy et al., 2012). The ability of the Foundation to shape the global health discourse and policy environment is reflective of the international acceptance and active promotion of private actors in solving problems and filling gaps in global governance (Bennett & Fairbank, 2003; Labonté & Gagnon, 2010; Schaferhoff et al., 2009; Whitehouse, 2010). As Birn (2014) notes, "the Bill and Melinda Gates Foundation has emerged as the current era's most influential global health... agenda-

setter” (p.1). Throughout the course of the 2000s, the Gates Foundation has been involved in major global health milestones, including the creation of the International Health Partnership, the Roll Back Malaria Initiative, the Global Alliances for Vaccines and Immunization, and several global health partnerships (GHPs) (Buse & Harmer, 2007; Szlezák et al., 2010). Indeed, its investments have been extraordinary: according to Szlezák et al. (2010), in 2007, the Gates Foundation’s spending on global health was equivalent to the WHO’s annual budget. As a result, as Maclean and Maclean (2009) note, given the amount of capital the Gates Foundation has raised for health in sub-Saharan Africa, it “has the ability to sway the direction of research and policy” (pp.365-366).

Given the tremendous funding the Gates foundation has pledged to the GFATM, and its involvement since its inception (Birn, 2014), the Foundation is in a favourable position to influence the agenda of the Fund. It is important to note that PPPs, such as the GFATM, have a mutually constitutive relationship with the Gates Foundation: while PPPs promote the need for private actors and “profit-oriented approaches” to public health, the Gates Foundation is able to modify and empower the PPP model (Birn, 2014). As Dr. Carol Jacobs, the Chairman of the Global Fund’s Board stated in 2006: “[t]he Gates Foundation has played an important role in making the Global Fund the effective and innovative public-private sector partnership it is today” (Gates Foundation, n.d.). As a result, the Foundation has been critical in shaping how aid has been disbursed through these financing mechanisms, including allowing “private interests to compromise the public health agenda”, and fostering the “short term, vertical approaches to disease control, compounded by profit-making imperatives” (Birn, 2014, p.14). Thus, the Gates

Foundation has been able to largely determine the agenda and direction of the GFATM notably through its emphasis on effectiveness and results-based solutions (Maclean & Maclean, 2009). As per the GFATM website, apart from its cash contributions, the Gates foundation actively participates on the GFATM Board and committees, and has been engaged in advocacy and fundraising efforts (GFATM, 2015).

The Chevron Corporation

As noted in Chapter 1, the energy conglomerate Chevron is a major corporate donor to the GFATM: to date it has donated U.S. 60 million dollars towards GFATM initiatives in the Pacific Rim and Africa, and has been crowned the GFATM's Corporate Champion (Chevron, 2015; GFATM, 2015). This section will explain why Chevron would comply with the GFATM in terms of the threat of communicable diseases to its profitability, and in order to comply with principles of CSR.

Threat to Profitability

A main reason why global corporations have chosen to invest in health is that infectious diseases pose a serious threat to profitability and the environments in which their operations are based (Lisk, 2009). As Lisk (2009) describes, infectious diseases such as HIV/AIDS can have direct and indirect consequences for a business. In terms of the latter, "AIDS-related morbidity and mortality" can significantly impact a business' profitability by directly targeting its workforce (Lisk, 2009, p.124; Nelson & Prescott, 2008). As Nelson and Prescott (2008) outline, especially in the case of HIV/AIDS, it "disproportionately affects the most economically productive group in most countries" (p.21). With the former, indirect consequences can include "productivity losses and

higher than normal output costs which impact negatively on enterprise performance” (Lisk, 2009 p.124). For example, “AIDS-related absenteeism” can affect investment and profitability, and there are also other indirect costs such as “support[ing] viable health insurance and pension schemes”, hiring new staff to fill employee gaps, and producing a long-lasting impact on national economies (Lisk, 2009, p.124-126; Nelson & Prescott, 2008).

Thus, while Chevron chooses to invest in the health of the communities in which it operates, it chooses to invest in the GFATM in order to achieve greater reach with its investments and create impact (Lisk, 2009). As Lisk (2009) describes, while companies initially invested in their employees and the workplace, this has been expanded to include their employees’ families and the community in which they operate. As Lisk (2009) describes, corporations “have come to realize that ignoring the healthcare deprivation and poverty in the communities around them is not only bad for their corporate image, but also not good for business” (p.130). Thus, corporations have chosen to invest in PPPs as it allows them access into the community and across the local and national levels that they would not otherwise have (Lisk, 2009; Davies, 2011). As Lisk (2009) describes concerning the use of partnerships to corporations, “aid agencies and CSOs can provide training to local communities, an activity which would be outside the remit of the company” (p.23). In turn, this allows corporations to extend their reach to communities to ensure impact for their investments (Lisk, 2009). As Chevron notes on its website: “we’re committed to using our human, financial and technological resources to support partnership and programs that promote healthy communities and improve access to health care for our employees, their families and the communities where we operate” (Chevron,

2015). As the GFATM encourages the active participation of stakeholders from the local, national, regional and international levels, this allows corporations such as Chevron to have a significantly more expansive reach to communities (Lisk, 2009).

Corporate Social Responsibility

Another reason why the Chevron Corporation complies the GFATM is to demonstrate that it is investing in Corporate Social Responsibility (CSR). This section will adopt Finnemore and Sikkink's (1998) notion of "strategic social construction" (p.910) to demonstrate that corporations, such as Chevron, adhere to norms, such as CSR, in order to realize their objectives. As described in Chapter 2, according to Finnemore and Sikkink (1998), norm entrepreneurs are rational actors who use "strategic social construction", in that they conduct "means-ends calculations about how to achieve their goals" (p.910). This logic will be extended to include the actors who norm entrepreneurs are hoping to influence, such as corporations, and argue that these actors can also make a rational calculation on whether they choose to adhere to a norm. Indeed, as Finnemore and Sikkink (1998) note, in their dissection of the relationship between norms and rational choice, "norm conformance can often be self-interested, depending on how one specifies interests and the nature of the norm" (p.912). This section will first define CSR, and explain why corporations need to invest in CSR initiatives. It will then proceed to identify why the Chevron Corporation complies with the GFATM in order to promote CSR as a way to achieve its objectives.

As Lindgreen and Swaen (2010) define it, CSR is a "continuing commitment by an organization to behave ethically and contribute to economic development, while also improving the quality of life of its employees (and their families), the local community,

and society at large” (p.3). This perceived responsibility of corporations to invest in the communities in which they operate is the result of processes of globalization and interdependence. As Kytle and Ruggie (2005) note, globalization has created “an operating environmental for business leaders that is markedly different from national or local levels” (p.1). With the presence of networked operations, the empowerment of global stakeholders, and the tension between various stakeholders, “novel sources of uncertainty and risk” have been created (Kytle & Ruggie, 2005, p.1). As such, while corporations traditionally faced three levels of risk - economic, political and technological - social risk has emerged as a concern (Kytle & Ruggie, 2005). Kytle and Ruggie explain that social risk “occurs when an empowered stakeholder takes up a social issue area and applies pressure on a corporation... so that the company will change policies or approaches in the marketplace” (2005, p.6).⁷⁹ Thus, stakeholders take advantage of the new vulnerabilities that have emerged as a result of processes of globalization by “apply[ing] pressure on the corporation for behavioural changes” (p.1). In turn, corporations are forced to pay attention to these various demands, and “managing social risks will need to become more fully embedded in corporate strategy” (Kytle & Ruggie, 2005, p.1). For example, in 2002, AIDS activists went after Coca-Cola at the Barcelona AIDS conference as the corporation “has a prominent global brand and one of the largest distribution networks in Africa” (Kytle & Ruggie, 2005, p.8). In turn, these non-state actors influenced Coca-Cola to provide treatment for its employees and the employees of the African bottlers who package their product (Kytle & Ruggie, 2005).

⁷⁹ As Du and Vieira (2012) note, empowered stakeholders include ““communities, employees, regulators, politicians, suppliers, NGOs and even the media” (p.1).

Overall, a corporation's risk management portfolio is extended to include social risk (Kytle & Ruggie, 2005).

As such, corporations choose to invest in CSR for two main reasons. First, it is essential for risk management (Kytle & Ruggie, 2005; Lindgreen & Swaen, 2010). As Kytle and Ruggie (2005) explain, corporations can manage stakeholder relationships “by providing intelligence about what those risks are, and by offering an effective means to respond to them” (p.9). By investing in CSR, corporations can also minimize their vulnerability to risk from the outset by working with social actors to improve “the contextual conditions that pose emerging risks for them in the first place” (Kytle & Ruggie, 2005, p.12).

This risk management is evident in Chevron's investments in global health. On the corporation's website, it states: “when public health issues put employee productivity, the well-being of communities and *supply chain reliability at risk*, they are a business issue, and Chevron strives to take action to help resolve them” (Chevron, 2015). Indeed, by investing in GFATM programs in the countries in which it operates, it is able to mitigate the risk of facing scrutiny from its stakeholders and consumers, such as Coca-Cola faced in 2002 (Lindgreen & Swaen, 2012). Similar to Coca-Cola, while Chevron's operations do not deal directly with HIV/AIDS or health, owing to its recognizable brand and reputation, it is more susceptible to HIV/AIDS activists' pressure (Kytle & Ruggie, 2005). This perceived fear of having their company's operations called into question and the implications this will have for its consumers and stakeholders is related to Börzel's (2000) conceptualization of the dominant compliance mechanism in the logic of appropriateness - that of social mobilization and pressure (Lindgreen & Swaen, 2012). In

short, Chevron's cost-benefit calculation of expenses is altered with the presence of social risk and the potential for non-state actors to influence its decision to invest in CSR policies and programs (Börzel, 2000; Kytte & Ruggie, 2005).

Second, Chevron would want to invest in CSR and the GFATM as it is a controversial industry and wants to affirm its legitimacy (Du & Vieira, 2012). As Du and Vieira (2012) maintain, oil companies' legitimacy is constantly under challenge. As a result, in order to validate their legitimacy, and "counter negative public sentiments [and build] reputational capital", oil companies routinely undertake CSR activities (Du & Vieira, 2012, p.2). Furthermore, owing to their industry's controversial status, in order for oil companies' CSR activities to help legitimize their operations, they have to prove the credibility of their CSR efforts (Du & Vieira, 2012). For example, they can enhance their credibility through communication efforts (Du & Vieira, 2012). As Du and Vieira (2012) illustrate, they can integrate "CSR into the company's mission and slogan", which creates the impression to stakeholders that it is an indispensable part of the company's identity and leads them to consider its CSR engagement as authentic and enduring (Du & Vieira, 2012, p.9). For example, Chevron has incorporated its CSR into its values and its slogan: "Human Energy: Finding Newer, Cleaner Ways to Power the World" (Du & Vieira, 2012, p.9).

Another way to show its credibility in its CSR investments would be to invest in the GFATM. As an internationally recognized organization to combat HIV/AIDS, TB and malaria, an investment in the GFATM (and being recognized as a Corporate Champion) indicates to its stakeholders that it is serious in its investments to create an impact in the communities where it has operations, and signals an interest in broader

global issues. As Rajat Gupta, the Chairman of the Board of Directors in 2008 stated: “Chevron’s long-standing dedication to combatting HIV/AIDS, combined with its needs-based partnership approach to community engagement, made it an ideal first Corporate Champion” (Chevron, 2008). This quote was included in Chevron’s 2008 Corporate Responsibility report, a document intended for the corporation’s stakeholders and the global business community. As a result, this public recognition by the GFATM of the good work of Chevron’s CSR investments and its inclusion in the report clearly signals the company’s desire to enhance its credibility through its CSR investments, which helps in turn to strengthen its legitimacy.

Vectors of Influence

As mentioned in Chapter 1, due to the considerable influence of the U.S. government and the Gates Foundation within GFATM in terms of their role on the Board and their vast resources, it is imperative to examine the vectors of influence in an effort to ascertain whether it is the GFATM, or these donors, who shape the requirements for compliance.

As mentioned above in the sections “Influence at the Board-Level”, and the “Philanthropic Organization: Bill and Melinda Gates Foundation”, a main reason why the Gates Foundation and the U.S. government invest in, and ardently advocate for, the GFATM is to influence the GFATM’s agenda and promote their approach to development. Given their position within the global health aid architecture and the international system more broadly, the U.S. government and the Foundation are able to influence other actors in order to achieve their objectives and set the terms for compliance. For example, as described above, during the creation of the GFATM, the

U.S. government was a major advocate of establishing a separate entity from the UN (Bartsch & Kohlmorgen, 2007; Kickbusch, 2002). In addition, with its security interests, as described above, it had a large role in designing a funding mechanism to help deal with these concerns (McInnes & Rushton, 2010). Furthermore, as McCoy et al. (2012) describe, during the aftermath of the 2011 corruption crisis, the U.S. government played a “central role ... shaping the composition and outlook of the High-Level Panel” (p.15). As mentioned in Chapter 3, this High-Level Panel was very important to the restructuring of the GFATM’s strategy and structure.

Furthermore, in addition to contributing to setting the rules for compliance, the Gates Foundation and the U.S. government also persuade other states to comply with these rules. Mitchell’s (1996) notion of interdependent self-interest is useful in understanding these donors’ promotion of the GFATM in order to achieve their objectives. As described above, Mitchell (1996) notes that interdependent self-interest can be understood through coordination or collaboration games. For the purposes of understanding why the Fund and the U.S. government seek to promote other states’ compliance with the GFATM, this scenario best resembles coordination games.⁸⁰

As argued by Martin (1993), unlike in collaboration games where the equilibrium outcomes are suboptimal, in coordination games there are two equilibrium outcomes with no dominant strategy. As a result, once an equilibrium is reached, as Mitchell (1996) describes, “each actor prefers compliance so long as enough other actors comply”, and while ‘enough’ differs between actors, actors decide to comply based on “the actions, or

⁸⁰ In collaboration games, the equilibrium outcomes are suboptimal, and players have to move away from their dominant strategy (Mitchell, 1996). As such, they have an incentive to defect because it results in immediate payoffs (Mitchell, 1996). As a result, there has to be strict patterns of behaviour (enforcement) so no one cheats (Martin, 1993; Mitchell, 1996). This scenario does not reflect how donors choose to

expected actions, of others” (p.9). In turn, once an equilibrium is established there is no incentive for defection, and as such institutions are not needed to prevent cheating or for surveillance and enforcement (Mitchell, 1996). This scenario very much resembles the situation with the GFATM: while there are two equilibrium outcomes for states and actors seeking to pledge funding for global health (bilateral aid disbursement and disbursement through the GFATM), there is ultimately no dominant strategy and it is dependent on other actors’ ability and willingness to comply or not. Once the actors agree to comply with the GFATM, they really have no incentive to defect, or rather there is no incentive to defect that originates from another player who is also pledging funding. In addition, the structure of the GFATM and its ability to generate large amounts of resources is dependent on donors leveraging funds. As Michael Johnson, Head of Technical Advice and Partnerships at the GFATM, argues concerning this benefit of the GFATM: “[e]ach country that contributes to the GF leverages the funding of many others, so it’s a very effective mechanism to bring money to the table” (Friends of the Global Fund, n.d., p.3).

From policy statements and speeches, it is clear that the U.S. government views its role with the GFATM as partly being to actively encourage other states to pledge funding (Bliss, 2013; Salaam-Blythe & Kendall, 2012). Powerful states in coordination games can be critical in getting weaker states to comply with its preferred equilibrium (Martin, 1993). For example, with the 2013 replenishment process, following the restructuring of the GFATM, the U.S. government took on a major leadership role in persuading other states to pledge resources or to increase their allocations in order to

comply with the GFAM: there is no real enforcement required for the donors, and donors do not necessarily want to deviate/ cheat for immediate payoffs (Mitchell, 1996).

ensure that there was a plentiful replenishment (Bliss, 2013; Igoe, 2013; Salaam-Blythe & Kendall, 2012). Owing to the statutory limit issued by Congress that U.S. contributions to the GFATM cannot exceed “33 percent of the Fund’s budget at any given time” (p.1), U.S. advocates assumed this position in order to ensure that the U.S. government could commit its full pledge to the GFATM. As Bliss (2013) describes of this role: “by the U.S. pledging, it will underscore the government’s confidence in the reformed organization and encourage others to donate” (p.2). As Secretary of State John Kerry exclaimed in his remarks at the Partnership Symposium of the Global Fund’s Fourth Replenishment Conference, owing to the fact that the U.S. government is the GF’s largest donor and the bipartisan support for the GFATM: “that is precisely why we are challenging others to step up their commitments and make this replenishment cycle a huge success” (U.S. Department of State, 2013). As per a Press Release issued in September, 2015 by the White House, the Obama Administration boasts that, over its tenure, it has leveraged over U.S. 13.2 billion dollars from other donors (White House, 2015).

In order to persuade donors to pledge funding or increase their previous pledges, the U.S. government engages in various tactics. As Secretary Kerry outlined in his aforementioned remarks, President Obama announced that the Administration would seek “appropriations from Congress matching 1 [dollar] for every 2 [dollars] contributed by other countries over the next three years” (U.S. Department of State, 2013). Furthermore, as Bliss (2013) outlines in a position paper from the Centre for Strategic and International Studies, amongst the diplomatic options the U.S. government should pursue to encourage traditional and new donors to pledge, American diplomats should promote the new

strategy of the GFATM (Bliss, 2013).⁸¹ Among traditional donors, the U.S. government should remind them of the “success of the 2012 reform process; optimism about the new funding mechanism ... and the potential for significant progress on HIV/AIDS, malaria, and TB if the right investments are made now” (p.6). Indeed, in the remarks to the Partnership Symposium, Secretary Kerry did emphasize the success of the reforms to the GFATM. As the Secretary declared:

“No other international organization has undergone such profound changes in its business model, its management team, and the financial systems... Now, it’s important to underscore the reforms are not cosmetic. They are real. They’re tangible. And they are going to help save more lives, there’s no question” (U.S. Department of State, 2013).

Thus, by showing their strong support for the restructuring of the GFATM, the U.S. government, as a powerful state, was clearly working to get more states to comply with the GFATM and pledge resources in the course of the 2013 replenishment in order to achieve its preferred equilibrium (Martin, 1993). Indeed, through these various strategies to elicit compliance, inevitably the U.S. government is exerting social pressure on these countries to pledge financing (Keohane, 1984). As Keohane (1984) notes, social pressure is one of “the most compelling set(s) of reasons for governments to comply with their commitments” (p.103). For example, given the U.S. government’s central position in the international arena, Secretary Kerry, through his remarks to the Symposium, was predictably applying social pressure on other donors to comply with the GFATM.⁸²

⁸¹ It should be noted that the U.S. government also advocates for other states’ pledges as there is a stipulation issued by Congress on U.S. spending that it cannot exceed one-third of all contributions to the GFATM (Salaam- Blyther & Kendall, 2012, p.20).

⁸² While this situation of the U.S. government persuading other states to comply with the GFATM could reflect a suasion game, it is important to note that it is merely a coordination game as there is no equilibrium outcome where an actor is dissatisfied (Martin, 1993; Mitchell, 1996). As Martin (1993) describes, a suasion game occurs when “the hegemon would prefer others’ cooperation and is dissatisfied with the equilibrium outcome of unilateral action”. In turn, a hegemon must “persuade or coerce others to cooperate” (p.778). In addition, there is an asymmetry of interests as suasion problems “have equilibrium

Similar to the U.S. government, the Gates Foundation is aware of its international influence and is able to utilize its position itself in order to further its interests. As McGoey (2014) describe, “the visibility of the Gates Foundation enables it to leverage its own resources in order to rally partners to the cause it aims to prioritize” (p.112). For example, Gates is often a speaker at G20 meetings, and as McGoey (2014) describe, at the WHO “virtually no major policy decisions ... take place without being casually, unofficially vetted by [Gates Foundation] staff” (p.112).

However, while the U.S. government and the Gates Foundation are able to shape requirements for compliance for other actors in the GFATM, inevitably they do conform to GFATM rules as well. For example, while the Gates Foundation is opposed to investments in health systems strengthening (HSS), this still constitutes a major funding component of the GFATM (Storeng, 2014). As Storeng (2014) describes, the Foundation was adamantly against the incorporation of a health systems component in GAVI’s mandate. As a HSS proponent of the GAVI informed Storeng (2014): “[Bill Gates] is vehemently against health systems... he basically said it is a completed waste of money, that there is no evidence that it works” (p.868). Although the GAVI Board did endorse the incorporation of health systems strengthening in 2005, Storeng (2014) notes that it reflects the “Gates approach” as it continues to “primarily [fund] selective interventions targeted at bottlenecks in disease-specific programs” (p.871). However, since 2005, the GFATM has made HSS investments a significant part of its mandate (McCoy et al., 2012). While these investments focus on improving selective aspects of the system that

outcomes that leave one actor dissatisfied” (Martin, 1993, p.778). In regard to the U.S. government convincing other donors to pledge financing to the GFATM, this does not reflect a suasion game as there are no equilibrium outcomes that leave an actor dissatisfied (Martin, 1993). Despite some donors being less willing to pledge on account of the 2011 corruption crisis and the 2008 – 2009 global recession, there

create better health outcomes for TB, malaria, and HIV/AIDS, HSS investments are still included as an important component of the funding scheme (Ooms et al., 2008).

In terms of the U.S. government, while the GFATM does not protect patent medications as was initially anticipated, it continues to support the GFATM (Bartsch & Kohlmorgen, 2007; Fleet, 2003; Hwenda et al., 2011). Despite the U.S. government being a prominent player in the creation of the GFATM (Kickbusch, 2002), shortly after its creation, the GFATM Board of Directors made it clear that they would not be involved in the protection of patent drugs (Fleet, 2003). Rather, the procurement policy “encourages the recipients of grants to procure medicines at the lowest possible price” (Fleet 2003, p.4). In addition, the pharmaceutical industry does not have a Board seat and its participation is limited to inclusion in the GFATM’s private sector delegation (Bartsch & Kohlmorgen, 2007). Furthermore, as Bartsch and Kohlmorgen describe, its “desire to contribute... via the provision of (branded) drugs was rejected at various times”, and due to the multisectoral nature of the GFATM, pharmaceutical companies were unable to wield the influence initially sought by major donor states (Bartsch & Kohlmorgen, 2007, p.20). Overall, as Lidén et al. (2013) note, by May 2001, “the Global Fund had already become peripheral to American interests” (p.38).

However, despite this lack of promotion of patent drugs, the U.S. government continues to actively promote, and invest in, the GFATM (Bartsch & Kohlmorgen, 2007). Bartsch and Kohlmorgen (2007) attribute the U.S. government’s continuing commitment to the GFATM to the institutional context of the Fund. As the authors describe, within this context, traditionally weaker actors have developed discursive power, and

really is no asymmetry of interests regarding funding the GFATM. In reality, the issue is merely how much funding to pledge.

“pharmaceutical companies of industrialized countries were forced to political and institutional compromises” (p.21). Indeed, as Birn (2014) describes, with the presence of bilateral and philanthropic donors, which lead to an increased volume and accessibility of medicines, “Big Pharma” was unable to maintain its powerful position in patent protection.

Another reason why the U.S. government continues to comply with the GFATM despite it not financing branded drugs, is the transformation in geopolitics over the past decade (Hwenda et al., 2011). As Hwenda et al. (2011) note, this shift has resulted from the “altering (of) the dynamics of multilateral negotiations and the importance of soft power to influence international health politics” (p.10). While power asymmetries exist, traditional powers have less control in multilateral institutions to determine the policy agenda owing to the “greater cooperation between LMICs [lower middle income countries] and emerging economies like the BRICs [which has] increased their bargaining power in multilateral negotiations” (Hwenda et al., 2010, p.10; Lee & Gómez, 2011). This shift is especially evident in the case of global health, as emerging economies are increasingly becoming engaged in global health diplomacy (Lee & Gómez, 2011). For example, Brazil has emerged as an influential player in global health diplomacy: during the 1990s, despite a backlash from the U.S. Trade Representative and “Big Pharma,” Brazil was an advocate of extending TRIPS flexibilities for medicine and the domestic production of patent protected medicines (Lee & Gómez, 2011, p.3). In addition to currently collaborating with other emerging economies on extending TRIPS flexibilities, Brazil has also been active in exporting “public health policies, technical expertise and capacity building experiences” (Lee & Gómez, 2011, p.5). Overall, the

country has been able to leverage its soft power, which has been reinforced by its economic standing, or its growing hard power (Lee & Gómez, 2011). In turn, by working with other emerging economies and LMICs, Brazil has been critical in circumventing the traditional power of major states and the pharmaceutical industry within global health (Lee & Gómez, 2011).

Therefore, while the GFATM largely conforms with the objectives of the Gates Foundation and the U.S. government, such that they are able to establish the rules for compliance for other actors, there are aspects to the GFATM's approach that these donors do not agree with but that they are willing to comply with. In addition, the explanations provided above as to why these donors choose to comply are still valid as the GFATM is but one of several major funding mechanisms to invest in. For example, the U.S. government could have chosen to invest all of its funding in its bilateral funding mechanism, PEPFAR, at the beginning of the 2000s, where it would have had complete control over the allocation of funds, rather than split its resource allocation for global health.

Furthermore, with the changing geopolitical landscape described above, traditional donors are going to continue to lose relative power in decision-making on global health (Hwenda et al., 2011). In this context, it will be interesting to monitor whether the Gates Foundation and the U.S. government will continue to have a major say in the governance of the GFATM, and whether they will acquiesce in their loss of influence given the emergence of increasingly powerful states, such as Brazil (Hwenda et al., 2011; Lee & Gómez, 2011).

Conclusion

From this chapter it is clear that there are several underlying motivations as to why donor states, philanthropic organizations and corporations comply with the GFATM according to the logic of consequences. Inevitably some of the incentives outlined may be more pertinent than others or may have held more weight in the cost-benefit calculations of donors at different stages in the evolution of the GFATM. In addition, it is evident that the GFATM as an entity does not solely determine the rules for compliance, but that major donors, such as the Gates Foundation and the U.S. government, are important in shaping the rules that other actors comply with in the context of the GFATM. The next Chapter will advance this discussion by extending beyond the logic of consequences, with its assumption that the interests of actors are fixed and rational, to the logic of appropriateness, taking into consideration the assumption that interests are not fixed and that identities and the social environment are mutually constitutive.

CHAPTER 5: COMPLIANCE THROUGH THE LOGIC OF APPROPRIATENESS

In order to gain a comprehensive understanding of the motivations driving donors' compliance with the GFATM, it is also imperative to apply the logic of appropriateness. It is accepted within the literature that the incorporation of both logics is intrinsic to understanding compliance as each sheds light on different aspects of why actors comply (Mitchell, 1996). As March and Olsen (1998) contend, political actors “are constituted both by their interests, by which they evaluate their expected consequences, and by the rules embedded in their identities and political institutions” (p.952). Haas (2000) echoes this argument by noting that states choose to comply based on “socially generated convictions and understandings” (p.62). These collective understandings are based both on a “moral sense of obligation” and the impact on a country's self-interest (Haas, 2000, p.62). Therefore, only by considering these two logics together can a full understanding of compliance be achieved.

Logic of Appropriateness

As outlined in Chapter 2, the logic of appropriateness understands that rather than behave according to individual rational interests, actors behave according to rules “that are socially constructed, publicly known, anticipated and accepted” (March & Olsen, 1998, p.952). This logic also recognizes that an actor's identity formation is mutually constitutive with its external environment (March & Olsen, 1998, p.952). In this regard, the logic of appropriateness is essential in understanding compliance, as unlike the logic of consequences view that preferences are “stable, consistent and exogenous”, the logic of appropriateness understands that they are always “changing, inconsistent, and endogenous” (p.950).

The following sections will outline several possible norms embraced by the GFATM that serve as explanations for why global health donors comply with the GFATM.

Aid Effectiveness

The first set of norms embodied by the GFATM that influence global actors' compliance are country ownership and harmonization. While the GFATM has incorporated these concepts within its strategy since its inception, they were truly embedded within the global health discourse in 2005 with the Paris Declaration on Aid Effectiveness (Ulbert, 2008). As Ulbert (2008) describes, the Paris Declaration is a series of commitments by the international community based on five principles: "ownership, alignment, harmonization, managing for results and mutual accountability" (p.7). In turn, the Declaration outlined twelve indicators to measure the progress of these principles (Ulbert, 2008). As Hyden (2008) notes, the Paris Declaration is understood to be "a significant juncture in the history of development assistance and co-operation," as the international community committed to promoting country ownership and aid harmonization among donors throughout its development initiatives (Kelly & Birdsall, 2010).

The degree of international support that the Paris Declaration received is related to Shelton's (2000) argument that the context during the creation of the norm is a factor that influences compliance. As Shelton notes, "the greater the consensus in the international community for the norms and the more compliance, the greater the likelihood that any single state will comply" (2000, p.14). With over 100 developed and developing countries signing onto the Paris Declaration, there was considerable

consensus within the international community in support of the norms of country ownership and aid harmonization, and thus greater likelihood that states would comply with them (OECD, 2005). Indeed, since the Paris Declaration was issued, global health actors' strategies and policy reports have increasingly referenced this Declaration and the need to promote its core principles (Ulbert, 2008). For example, in the independent evaluation of the U.S. government's Implementation of the Paris Declaration, the report outlines that in terms of the U.S. government's leadership, awareness and commitment, it is clearly supportive of the Paris Declaration's principles given the "frequent references to the PD [Paris Declaration] principles in emerging USG policy directives and other documents relevant to DOS [Department of State] and USAID" (p.ix). In particular, an examination of PEPFAR's public statements reveals an evolution of the U.S. government's bilateral initiative's operations in accordance with the Paris principles (PEPFAR, 2009). While PEPFAR has acknowledged the need for capacity building within its official statements since its inception, its 2009 strategy acknowledges that it has to do more in terms of "country capacity and sustainable responses", and recognizes that the implementation of its programs "did not fully complement existing [national] structures or plans" (PEPFAR, 2009). In order to resolve this, the strategy states that it is working towards "more fully incorporating high-level principles of the Paris Declaration... [including] donor support of partner country leadership and shared responsibility in order to bolster the sustainability of its efforts" (PEPFAR, 2009).

Since the Paris Declaration, the GFATM has also been actively incorporating the Paris principles into its strategies in order to maintain the support of its donor base. For example, the 2007 Strategy document acknowledges that there are "new expectations for

the manner in which funders work with recipient countries”, and asserts that the structure and mandate of the GFATM reflects the principles of the Paris Declaration (GFATM, 2007, p.30). In addition, within its Partnership Strategy, which was approved in 2009 and was designed to “reflect and define the intentions and expectations of the partners”, it clearly outlines its willingness to incorporate the Paris principles within its mandate (GFATM, 2009). For example, under the Strategic Objective of Harmonization and Alignment, the Strategy states:

“As part of a collective effort on aid effectiveness in the follow-up to the Paris Declaration and the Accra Agenda for Action, the Global Fund is following through [on] its commitment by taking part in monitoring the Paris Declaration on Aid Effectiveness (coordinated by the OECD).”

In turn, donors are supportive of the Fund’s inclusion of the Declaration’s principles and consequently are supportive of its programs. As Salaam-Blyther & Kendall (2012) note, experts in the U.S. maintain that “the Fund’s grant process allows for greater country ownership of programs, [and] more flexibility in tailoring programs to specific country priorities” (p.17). As a result, these experts argue that the GFATM’s funding process will ensure that these programs are “more sustainable in the future and less dependent on U.S. assistance” (p.17).

Bearing these considerations in mind, the GFATM’s clear incorporation of the Paris Declaration principles into its framework and strategies can be seen as a significant reason why global actors would comply with the principles and practices of the Fund.

Neoliberal Underpinning of the GFATM

Another normative dimension that helps to explain global actors’ compliance with the GFATM is its neoliberal underpinning, reinforcing the biomedical or clinical

paradigm (Maclean & Maclean, 2009; Eyben & Napier-Moore, 2010). As mentioned in Chapter 4, owing to their nature and their inclusion of private actors, PPPs such as the GFATM, emphasize “evidence-based medication” (Eyben & Napier-Moore, 2010, p.295; Biehl & Petryna, 2013). As Biehl and Petryna (2013) describe, evidence-based medication “[is] the default language for both public- and private-sector actors concerned with identifying problems and measuring outcomes” (p.8). In turn, this promotes a “standardized approach to clinical research and practice” where for-profit institutions are the “purveyors of science” and utilize “systematic economic assessment techniques” (Biehl & Petryna, 2013, p.8). With this market-focused instrumentalist approach, PPPs, such as the GFATM, have become increasingly focused on efficiency and effectiveness, and embody a business model geared towards “scientific and economic issues” (Eyben & Napier-Moore, 2010; Maclean & Maclean, 2009; Biehl & Petryna, 2013, p.8). This neoliberal approach is evident within the 2012 – 2016 GFATM Strategy: while it does make clear that funds are provided on “the basis of quality national strategies”, it has reconfigured its performance-based model to reflect “greater investment in data modeling, baseline and progress surveys and extensive operational research to ensure rapid scale-up of highest impact interventions” (p.14).

This neoliberal normative underpinning acts as an incentive for donors to comply with the GFATM. As per the explanation presented in Chapter 4 concerning why the Bill and Melinda Gates Foundation would comply, this technological and results-oriented approach is attractive for donors as it reinforces practices that suit their material interests and can achieve measurable impact with their investments (McGoey, 2014). As the Gates Foundation has continually promoted a technological and results-oriented approach

to financing global health, this neoliberal underpinning resonates well with its approach to development. As Bill Gates stated at the announcement of the Foundation's commitment of 750 million dollars to the GFATM at the 2012 World Economic Forum in Davos, Switzerland: "[t]he Global Fund is one of the most effective ways we invest our money every year" (Gates Foundation, n.d.).

Moral Underpinning of Health

The moral perspective that health is a global public good can also explain why public donors comply with the GFATM (Schaferhoff et al., 2009; Tan et al., 2003). A global public good can be defined as a good "whose consumption is non-rival and/or nonexclusive" (Schaferhoff et al., 2009, p.454). Global public goods are at the very heart of a PPP: as Schaferhoff et al. (2009) describe, PPPs are "institutionalized transboundary interactions between public and private actors, which aim at the provision of collective goods" (p.455). As such, the GFATM as a PPP is seeking to preserve the public good of communicable disease control (Smith & McKellar, 2007; Tan et al., 2003).

As it relates to donors' financing efforts to counter the spread of contagious diseases, Tan et al. (2003) describe how, in addition to security concerns and "domestic disease control concerns",⁸³ governments pledge resources due to this notion of "global public goods" and that "infectious disease control... [is] a common good with benefits for all of humanity" (Tan et al. 2003, p.2). In his analysis of compliance with soft law, Shelton (2000) echoes this notion in that compliance is a result not only of "the possibility of sanctions", but also "from [the] recognition of the need to ensure

⁸³ As Tan et al. (2003) describe, "domestic disease control concerns" refers to the notion that "it makes far more sense both economically and in terms of public health to 'turn off the tap' of disease burden by

sustainability of the common good” (p.14). This reasoning has been particularly evident in light of the scale-up in financing and attention for infectious diseases (Lidén, 2013; Tan et al., 2003). As Tan et al. (2003) note, “for many, the gross health inequalities between the industrialized and developing world have become intolerable on purely ethical and moral grounds” (p.2).

In terms of the GFATM, Lidén (2013) describes that donors pledge resources owing to its “demand-driven funding model” that reflects the moral underpinning of investing in health (p.39). As Lidén (2013) explains, it is much more difficult for a public donor to deny funding to the GFATM’s targeted programs that are certified by health experts, ready to be financed, and presented as a definite way to save thousands of lives, rather than an organization that requires a lump sum of money with no measurable impact. In turn, this model creates a “moral and feasible case” for financing (Lidén, 2013, p.39). Lidén (2013) adds that while technocrats in donor governments will dismiss this reasoning, NGOs and the Global Fund Secretariat will apply additional pressure by demonstrating that an absence of investment will lead to lives lost.

From donors’ public statements, there are several indications that this normative dimension, and the GFATM’s “fundable demand” model, plays a role in why donors choose to invest in the GFATM (Lidén, 2013, p.39). For example, in a 2010 U.S. Department of State Official Blog, former U.S. Global AIDS Coordinator Eric Goosby justifies the U.S. government’s pledge of U.S. 4 billion dollars for the 2011 – 2013 Third Replenishment. As Goosby begins the blog with the statement that the U.S. government “strongly support[s] the Global Fund’s collaborative, country-driven, performance-based

controlling tuberculosis at the global level than to ‘mop’ the global tide of infectious disease through the screening and management of individual patients” (p.2).

approach” (Goosby, 2010). He goes on to explain why the U.S. government made such a historic pledge: “[w]hy are we taking this step? It will save and improve lives of those devastated by these three diseases. It will increase life expectancies in affected countries” (Goosby, 2010). Evidently through this declaration of the U.S. government’s support of the GFATM’s performance-based model and acknowledgment that financing GFATM initiatives saves lives, it is evident that the GFATM’s “fundable demand” model is successful in attracting donor resources (Lidén, 2013, p.39).

Corporate Social Responsibility: Chevron Corporation

Finally, CSR is a central normative dimension in accounting for why corporations would, and would be expected to, comply with the GFATM. While CSR was included in the previous chapter as a reason under the Logic of Consequences, it is also applicable to the Logic of Appropriateness as CSR itself is a normative dimension that has impacted the behaviour and interests of corporations.

As Lee (2010) describes, good business strategy has become aligned with the incorporation of CSR policies into a company’s mandate (Lee, 2010; Lindgreen & Swaen, 2010). This acceptance is the result of a conceptual transformation of CSR, as it has become increasingly rationalized and institutionalized (Lee, 2010). As Lee (2010) describes, since the 1980s, it has become “associated with broader organizational goals such as reputation and stakeholder management” (p.3). This transformation is coupled with the way in which corporations’ performance has been assessed, as it has shifted “from single-minded financial performance to a broader one that includes both financial and social dimensions” (p.63). As a result, by investing in CSR, businesses can achieve several benefits. As Lindgreen and Swaen (2010) argue, these benefits include creating

“a competitive advantage by integrating non-economic factors, differentiating themselves from competitors and building a better image and reputation... and creating consumer goodwill and positive employee attitudes and behaviour” (p.3). As such, CSR not only sets a corporation apart from its competitors and bolsters its reputation, it also has internal benefits to its structure and profitability. In its public statements and policies, the Chevron Corporation has made it clear that investing in CSR improves business performance. According to the corporate responsibility section on Chevron’s website: “Chevron contributes to the economic and social well-being of people in the countries where we operate because we have learned ... that our business success is deeply linked to society’s progress” (Chevron, 2015).

These statements of good will are reflected in a review of its Annual Reports from 1995 – 2014. Whereas in 1995 there was only one mention of “community outreach” as a bullet point under the subheading “Protecting People and the Environment” (Chevron Corporation, 1995, p.6), the 2004 Annual Report includes a picture of a child from a developing country on the front cover with the title “A New Equation”, and an ensuing explanation for the title page: “we are investing in local communities where we do business to enhance capacity for education, health care and economic growth” (Chevron Corporation, 2004). In the 2014 Annual Report, in the opening Letter to Stockholders from the Chairman of the Board and Chief Executive Officer John S. Watson, it acknowledges that in order to “maintain our strong social performance” the corporation needs to ensure it operates in healthy communities and therefore it needs to “continue strategic social investments” (Chevron Corporation, 2014). While Chevron has reported that it has been investing in local communities prior to 2004 (Chevron Corporation,

1998), this clear display of investing in local communities in the 2004 and 2014 Annual Reports in comparison to the 1995 Annual Report is indicative of CSR becoming an increasingly important aspect of Chevron's business strategy.

In addition, there are normative expectations from the international community that corporations will and/or should become socially responsible, transparent and accountable in the countries where they operate, and will alter their business strategy accordingly (Davies, 2011; Du & Vieira, 2012). As Du and Vieira (2012) describe, within "today's socially conscious environment... institutional norms demand that a company be aware of its impact on various stakeholders and honor the 'social contract' between business and society" (p.3). The expectation that corporations behave responsibly are especially pronounced for major companies that have visible or recognizable brands (Kytte & Ruggie, 2005). Indeed, large multinational corporations can encounter social risk even if what they are being targeted about has nothing directly to do with their product or service. As Kytte and Ruggie (2005) explain, a major corporation will be targeted "for the sheer fact that it *does* have global reach and capacity, and that it is capable of making and implementing decisions at a pace that neither governments nor international agencies can match" (p.8). For example, as noted in the Coca Cola example described in Chapter 4, the corporation was targeted as it has global reach, regardless of the fact that its products do not have anything to do with HIV/AIDS (Kytte & Ruggie, 2005, p.8).

Indeed, the activists' influence over the corporation to provide treatment for its employees and the employees of the African bottlers who package their product (Kytte & Ruggie, 2005) is consistent with the logic of appropriateness' perspective that behaviour

can be influenced “by providing alternative interpretations of the self and situation” (March & Olsen, 1998, p.952). As March and Olsen (1998) explain, “as a cognitive matter, appropriate action is action that is essential to a particular conception of self” (p.952). Therefore, by “providing alternative interpretations of the self”, an actor’s behaviour can be influenced as the notion of what is appropriate has been transformed (March & Olsen, 1998, p.952). As such, through this public display against Coca Cola and shedding light on what is appropriate, which was inevitably at odds with the corporation’s notion of appropriateness and thus potentially harming its reputation, these social activists were able to influence the corporation’s behaviour (Kytte & Ruggie, 2005, p.952; Du & Vieira, 2011).

Conclusion

The incorporation of the logic of appropriateness complements the logic of consequences to provide a complete overview of why donors comply with the GFATM. The added value of the logic of appropriateness is critical: by acknowledging that actors’ preferences are not fixed and that they respond to socially-constructed rules, this examination of the reasons why the U.S. government, the Chevron Corporation, and the Bill and Melinda Gates Foundation comply can be broadened to include CSR, the GFATM’s neoliberal and moral underpinnings, and its promotion of aid effectiveness (March & Olsen, 1998). While these normative dimensions are included as possible explanations of donors’ compliance, the concluding chapter will reflect on the relative weight of these motivations on actors’ cost-benefit calculations.

CHAPTER 6: CONCLUSION

The global health architecture has witnessed a profound change over the past twenty years as GHIs have become critical institutions in improving health outcomes, attracting international donors' funding, and bringing new actors into the global health arena, including civil society and private actors (Bruen & Brugha, 2014; Brugha, 2009; Kapilashrami & Hanefeld, 2014; Lidén, 2013; Spicer et al., 2010). In terms of global health governance, GHIs have had a major impact by displacing traditional donors and becoming prominent centres of influence in determining the global health agenda (Brugha, 2009; Biehl & Petryna, 2013).

The GFATM is a central pillar in global health governance (Shiffman, 2014; Szlezák et al., 2010). Through the incredible amount of resources and influence it has generated, the Fund has been a prominent player in promoting a global health agenda based on “evidenced-based medication” and impact for investment (Eyben & Napier-Moore, 2010, p.295).

Starting from the GFATM's proven track record of attracting and retaining major health donors, this thesis has examined why global health actors participate in this funding mechanism. Situating the GFATM as a PPP, this thesis began from an acceptance of Schaferhoff et al.'s (2009) argument that PPP regulations can act as soft law, and thus compliance theory can also be “used to examine PPPs as transnational governance institutions” (p.461). By incorporating the IL, IR and global health literatures, this thesis sought to understand why a variety of global health actors invest in, and comply with, the GFATM. This is an important research question as there a variety of different channels where the selected actors could choose to invest their global health

allocation towards, including bilateral transfers in the case of the U.S. government, and other GHIs. In addition, as discussed in the Vectors of Influence section in Chapter 4, the GFATM's neutral position towards patent drugs and the inclusion of HSS grants are both aspects that the US government and the Gates Foundation are not supportive of.

However, these donors continue to promote and pledge resources to, and thus comply with, the GFATM. In particular, with the case of patent drugs, while the GFATM was created, with major participation by the US government, under the guise that it would promote patent drugs, the Board voted early on to not do this (Bartsch & Kohlmorgen, 2007; Fleet, 2003; Hwenda et al., 2011). In turn, despite the GFATM not promoting the pharmaceutical industry's interests, the US government maintained its support for the PPP and continues to heavily finance its grants.

First, Chapter 3 applied Mitchell's (1996) compliance system to understand what mechanisms the GFATM has established to ensure the compliance and the support of its donors. Framing this process around the 2011 corruption crisis is critical as this time period provides valuable insight into understanding that the compliance system is designed to ensure that donors comply. Following the reports of corruption in the Associated Press and the freezing of funding by several donors, the GFATM was forced to react and reform its organizational structure, mandate, and funding strategy in order to regain the confidence of donors ensure their continued compliance (Usher, 2011). As the GFATM is entirely dependent upon voluntary contributions by donors, it had to restructure its operating mechanisms so that it could regain their confidence (Usher, 2011).

As such, this Chapter highlighted the key dimensions of the compliance system, including the Primary Rule System, the Compliance Information System, the Non-Compliance Response System, and the issues associated with each element prior to the new strategy. It then outlined the several measures the GFATM enacted in the new strategy in order to remedy the issues that were identified. By breaking down the compliance system into components and understanding its design and operation before and after the new strategy, it is evident that the GFATM crafted the strategy in order to meet donors' demands, and to regain their confidence and attract new creditors.

In terms of the application of Mitchell's (1996) model to the GFATM, overall it proved a useful tool in understanding what the GFATM does to ensure the compliance of its donors. As mentioned in Chapter 3, several elements of the GFATM system are designed to ensure the compliance of recipient governments. Rather than focus strictly on the rules in the compliance system tailored towards determining donors' actions, this thesis adopted the perspective that a robust compliance system incorporated into the GFATM would maintain the confidence of traditional donors and attract new creditors to invest in the GFATM. In turn, the thesis was able to examine the weaknesses in the compliance system as it impacted recipients and donors, and how the GFATM worked to remedy these problems.

One issue with applying Mitchell's (1996) conceptualization was in identifying the Non-Compliance Response system, and in particular its sanctioning mechanisms. As the involvement of donors with the GFATM is based on voluntary disbursements of funding and the continued existence of the GFATM is dependent on these disbursements, there are no concrete and tangible sanctioning mechanisms in place for donors. Instead,

as mentioned in Chapter 4 in the hypothesis on interdependent self-interest, major donors such as the U.S. government impose social pressure on other states in order to persuade them to donate, and ultimately to comply with the GFATM mandate (Keohane, 1984).

This thesis also focused on the donors' point of view concerning why they would comply with the GFATM and pledge funding. Adopting March and Olsen's (1998) logic of consequentialism, Chapter 4 identified several explanations as to why the Gates Foundation, the US government, and the Chevron Corporation comply with the GFATM. These included influence at the board level, the HIV-security nexus that rose to prominence in the early 2000s, the protection of patent law and intellectual property rights, and the interdependent self-interested rationale, for the U.S. government specifically, of complying in order to get other donors to pledge funding. For philanthrocapitalist ventures, such as the Gates Foundation, their compliance with the GFATM was hypothesized to reflect a desire to increase their political and economic influence (McGoey, 2014; Morvaridi, 2012), while corporations such as Chevron were hypothesized to do so as epidemics pose a serious threat to profitability and the environments in which they operate (Lisk, 2009).

Chapter 4 also provided a discussion regarding vectors of influence for compliance, and explained that while the Gates Foundation and the U.S government are able to shape the rules for compliance embedded within the GFATM and actively promote these rules, they in turn also comply with the rules of the GFATM in order to achieve their interests. Moreover, they comply with the GFATM despite aspects of its mandate and operations that they disagree with, including HSS and the lack of protection for patented drugs.

In order to provide a holistic understanding of why donors comply, this thesis took an integrativist approach and thus also applied March and Olsen's (1998) logic of appropriateness to donors' compliance (Checkel, 2000). As March and Olsen (1998) contend, political actors "are constituted both by their interests, by which they evaluate their expected consequences, and by the rules embedded in their identities and political institutions" (p.952). Therefore, Chapter 5 presented several hypotheses as to why global health actors comply based on normative reasoning, including complying with the notions of country ownership and aid effectiveness, the GFATM's neoliberal logic, and the moral attraction of improving health outcomes globally.

A main conclusion from this thesis concerns the relative weight of the logic of appropriateness versus the logic of consequences in determining an actor's compliance. As evident from Chapters 4 and 5, both logics offer unique and necessary insights for understanding why the selected global health donors choose to comply with the GFATM (March & Olsen, 1998; Mitchell, 1996). Despite arguments in the literature that question whether the logic of appropriateness actually weighs on an actors' decisions (Finnemore & Sikkink, 1998), Chapter 5 demonstrates that in the case of the GFATM, norms can play a role in altering the interests and behaviour of actors (McCoy et al., 2012, p.7). This is evident, for example, with corporations investing in CSR: while they invest in order to avoid social risk (Ruggie & Kytle, 2005), they also do so because the very notion of good business strategy includes CSR, and because there are expectations from external actors that they should include it in their company's mandate (Davies, 2011; Du & Vieira, 2012). In addition, an examination of the U.S. government's public statements and documents regarding the GFATM over this period reflects its commitment to the

need to mitigate the impact of communicable diseases and improve health outcomes. The U.S. government's commitment of 9.5 billion dollars in pledges by 2013, and their advocacy of other donors increasing their contributions so that Congress could release the U.S.' full amount before the 2013 pledging round, is evidence of the impact that the moral incentive to invest in global health has had on the U.S. government's behaviour (Kaiser Family Foundation, 2013). Of course, the argument can be made that they are choosing to incorporate those norms based on political interest-based considerations, such as mitigating security concerns, as per the HIV-security nexus logic. While the security threat is still present in U.S. government policy documents and statements by U.S. officials however, this is not the foremost reason given by U.S. advocates as to why the U.S. should invest in the GFATM (Barnett & Prins, 2006; McInnes & Rushton, 2010; McInnes, 2006). Rather, moral arguments are most consistent and prominent in U.S. government statements.

Given the difficulty of discerning why an actor chooses to comply with the GFATM, it is clear that one can never fully understand why a global health actor complies with this funding mechanism (March and Olsen, 1998; Mitchell, 1996). As Haas (2000) notes, it is difficult to gauge why states, and by extension non-state actors, comply with the principles and practices of international institutions. Given the different types of global health donors discussed in the thesis, in addition to changing mandates with a new executive or government of a donor, it is extremely difficult to fully ascertain why a global health donor would comply with the GFATM on an ongoing basis. Furthermore, the different kinds of GFATM donors discussed have differing interests and are responsible to different audiences. For example, the Chevron Corporation is

responsible to stakeholders and consumers, whereas the U.S. government is responsible to voters and pressure groups. Although both have been pressured to act in a moral way within the global community, either through providing development assistance to global health or funding CSR initiatives, they are fundamentally very different kinds of donors.

However, it should be noted that while it may be difficult to develop a complete understanding of why a donor would comply, donor states' reaction to the 2011 corruption scandal is evidence of the fact that in certain circumstances, the logic of consequentialism and self-interested calculations can be an overriding factor. In 2011, Germany, Sweden and Ireland froze their funding after the corruption allegations were revealed by the Associated Press (Heilprin, 2011; Harman, 2014). In response, the GFATM Secretariat stated that its current activities and distribution of drugs would not be affected; however, if the cancellation of funding were to continue, they would have to “delay...the implementation of life-saving activities” (Stefan Emblad, Head of Resource Mobilization at the GFATM, as quoted in Usher, 2011, p.472). Indeed, Germany was warned by the GFATM “that its withheld dollars would lead to the deaths of 43,000 people” (Heilprin, 2011). In the end, Germany did release half of its funds once the interim report was released on June 30, 2011 by the independent international panel (Usher, 2011). However, this funding was conditional on the proviso that it be used exclusively in recipient countries where either the UN Development Program or the Deutsche Gesellschaft für internationale Zusammenarbeit was the implementing agency (Usher, 2011). This suspension of funding reflects the fact that donors were prepared to override the moral imperative of providing life-saving drugs and resources to enforce their fiduciary self-interest.

Another conclusion from this thesis in the context of global governance is that the reasons for donors' compliance with the GFATM are much more multifaceted and complex than simply complying in order to invest development assistance for global health. This thesis sought to understand why global health actors, given their options to invest their money bilaterally or in other organizational structures, chose to pledge resources to the GFATM and comply with its mandate. Applying this question to the logics of appropriateness and consequentialism in Chapters 4 and 5 reveals a diversity of motivations for compliance. For example, the Chevron Corporation has less architectural reasons for compliance in comparison to the U.S. government, which has a clear set of objectives, such as promoting its security interests. In this manner, the thesis has provided a more comprehensive understanding of why the GFATM continues to receive a significant amount of international support and resources.

Finally, a major conclusion from this thesis concerns non-state actors' compliance with an international institution. As mentioned in Chapter 1, with the exception of Börzel (2000), there has been limited research concerning why non-state actors comply with international organizations and initiatives. Therefore, by developing hypotheses concerning the Bill and Melinda Gates Foundation's and the Chevron Corporation's motivations for compliance, the thesis helps to close this gap in the literature. In particular, the examination of CSR and Chevron reveals interesting insights regarding how both the logic of appropriateness and consequentialism impact a private corporation's decision to comply with a global health mechanism like the GFATM. As outlined in Chapter 5, the behaviour, and to some extent the identity, of a corporation has been altered by the international acceptance that a corporation must be socially

responsible within the environment in which it operates (Lee, 2010; Lindgreen & Swaen, 2010). Therefore, similar to a state, there are socially-acceptable rules to which a corporation must adhere to if it is to maintain the attention and support of its stakeholders (Lee, 2010; Lindgreen & Swaen, 2010).

Future Research

A future extension of this project would be to conduct interviews with selected global health actors in order to begin to gain an appreciation for which of the explanations presented in this thesis may bear more weight in an actor's decision to comply. A limitation to this thesis was that, due to an inability to conduct primary field research and the reliance on publicly available reports and statements, it only presented hypotheses as to why global health actors comply with the GFATM. As a result, in certain sections it was difficult to fully determine the connection between a potential reason for compliance and actual compliance with the provisions of the GFATM. For example, while the GFATM was inevitably a product of the early-2000's heightened attention to the HIV-security nexus, it was difficult to fully establish the link between donors' support for the Fund's creation and the perceived security threat of HIV/AIDS. Primary research would shed light on the relative importance of the explanations provided in this thesis, which would allow for a richer understanding of global health donors' compliance with the GFATM.

Second, an application of Finnemore and Sikkink's (1998) norm "life cycle" to the evolution of the norms associated with the GFATM would be an interesting future study. The authors (1998) explain that the norm "life cycle" involves a three-stage

process: norm emergence, the “norm cascade”,⁸⁴ and norm internalization (p.896).⁸⁵

Given the evolution of the GFATM’s norms since its inception, such as the increasing importance accorded to HSS and aid effectiveness, future research should identify this process of norm transformation as it relates to Finnemore and Sikkink’s (1998) model. This would further extend the preliminary work completed in Chapter 5, which identified some of the normative dimensions that the GFATM has embraced and which can impact whether actors comply with its mandate and pledge funding.

Finally, another area of future study is an examination of the domestic influences on a donor state’s compliance. Haas (2000) explains the various domestic sources that can impact compliance, including political costs and state capacity, technical and political actors, and an active civil society. For example, in the case of the U.S. government, the creation of PEPFAR was heavily influenced by evangelical organizations (Ingram, 2010). Thus, the inclusion of an analysis of domestic sources of influence would provide a more comprehensive understanding as to why the U.S. government, among others, continues to be a major benefactor of the GFATM.

Conclusion

Overall, an examination of global health donors’ compliance with the GFATM sheds light onto this important PPP as a governance mechanism within the global health aid architecture. With the growing importance of non-state and multilateral entities in development and their increasing role in determining the global health agenda, it is

⁸⁴ According to Finnemore and Sikkink (1998), the norm cascade involves the manner by which norms are accepted in the international system.

⁸⁵ According to Finnemore and Sikkink (1998), norm internalization refers to where norms acquire “a taken-for-granted quality and are no longer a matter of broad public debate” (p.902).

important to understand why donors choose to invest in the GFATM in order to gain an appreciation for its influence in global health governance. By applying compliance theory from IR and IL, as well as March and Olsen's logics of consequentialism and appropriateness, this thesis was able to provide a comprehensive account of why actors comply by adopting both constructivist and rationalist explanations, which can be refined and tested through further empirical analysis.

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APPENDIX A: DEFINITIONS: GLOBAL HEALTH PUBLIC-PRIVATE PARTNERSHIPS (GHPs) AND GLOBALIZATION

Global Health Public-Private Partnerships (GHPs)

Buse and Harmer (2007) define global public-private health partnerships (GHPs) as: “an established mechanism of global health governance” (p.260). As Buse and Harmer (2007) explain, GHPs are “relatively institutionalized initiatives, established to address global health problems, in which public and for-private sector organizations have a voice in collective decision-making” (p.260). These GHPs vary in several respects such as “functional aims, the size of their secretariats and budgets, their governing arrangements and their performance”, what is common amongst them is their “innovative approach to joint decision-making among multiple partners from the public and private sectors” (p.260).

Globalization

For the purposes of this paper and the transforming relationship between public and private actors, globalization will be defined as the “qualitative transformation of the international system with lasting implications for the public and private sectors alike, including changes in the nature of the legal processes and structures that shape the relationships and interactions among states” (Witte & Reinicke, 2005, p.75).

APPENDIX B: CURRENT GFATM BOARD MEMBERS BY COUNTRY AND ORGANIZATION

Type of member	Member grouping	Board member and alternate
Donor countries	Australia, Canada, Switzerland	Canada / Australia <i>(alternate)</i>
Donor countries	European Commission - Belgium, Italy, Portugal, Spain	DEVCO/ EUROPEAID
		European Commission <i>(alternate)</i>
		France
	Point Seven	Denmark / Norway <i>(alternate)</i>
		Japan
		United Kingdom
		US
Communities		Positive Initiative / Global Network of People Living with HIV (GNP+) <i>(alternate)</i>
Developed Country NGOs		International AIDS society / Malaria No More UK <i>(alternate)</i>
Developing Country NGOs		Health Options Project Skpoje
		KELIN – Kenya Legal and Ethical Issues Network on HI/AIDS <i>(alternate)</i>
Developing Countries	Eastern and Southern Africa	Rwanda / Swaziland <i>(alternate)</i>
	West and Central Africa	Nigeria / CCM Togo <i>(alternate)</i>
	Eastern Europe and Central Asia	Georgia / Macedonia <i>(alternate)</i>
	Eastern Mediterranean Region	Iran / Tunisia <i>(alternate)</i>
	Latin America and Caribbean	Grenada
	South East Asia	Thailand / Timor-Leste <i>(alternate)</i>
	Western Pacific Region	China
		Vanuatu <i>(alternate)</i>

Type of member	Member grouping	Board member and alternate
Private Foundations		Bill and Melinda Gates Foundation / Kaiser Family Foundation <i>(alternate)</i>
Private sector		Merck & Co. / Mylan <i>(alternate)</i>
Partners (non-voting)		Stop TB Partnership / UNITAID <i>(alternate)</i>
UNAIDS (non-voting)		
WHO (non-voting)		
World Bank (non-voting)		
Swiss Member (non-voting)		

Retrieved from: <http://www.theglobalfund.org/en/board/members/>