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Legitimacy in 21st-Century Polylateralism

The Case of Global Health Funds

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Abstract

This study presents an empirically based analysis of legitimacy aspects of polylateral governance across three global health funds: Gavi, the Vaccine Alliance; Global Fund to Fight Against AIDS, Tuberculosis and Malaria; and the Global Financing Facility for

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Women, Children and Adolescents. Adopting a normative approach to legitimacy, we ask how these global health funds fare against key legitimacy principles in global governance, as expressed in the 2011 Busan Partnership Agreement and the earlier Paris Declaration on Aid Effectiveness (2005). The findings show that, while global health funds exhibit high levels of alignment with the set standards of technocratic legitimacy, they fail to meet the principles of democratic legitimacy and fairness. This shortfall is largely due to the structure and operations of the funds' boards that accord significant sway to financiers and partners from the Global North.

Keywords

global health fund – legitimacy – global governance – polylateralism – Gavi – Global Financing Facility – Global Fund

1 Introduction

The desire for legitimacy is common to political actors across all levels of governance. It enables their effective exercise of authority and bolsters their position within the broader dynamics in their given field. International organizations and states often draw legitimacy from their institutionalized democratic mandates and accountability mechanisms towards their constituencies, which justify their policy interventions and involvement in global governance. Simultaneously, many bodies and structures of global governance face a 'legitimacy crisis.' They are the objects of widespread criticism that, first, imbalanced power dynamics disproportionately benefit Global North actors and, second, that they have a poor track record of tangible policy impacts.[1]

The 2011 Busan High-Level Forum on Aid Effectiveness (hereafter, *Busan*) focused on two pivotal shortfalls of development cooperation; aid was ineffective and international development governance was 'illegitimate.' Both were attributed to an unequal donor-recipient relationship.[2] From *Busan* emerged a new global governance agenda—the Global Partnership for Effective Development Cooperation—promoting multi-stakeholder partnerships of non-state actors (notably civil society, including the private sector) and states across the hemispheres and relating to one another on the basis of equality.

1 E.g., Oguz Gok and Mehmetcik 2022; Sommerer et al. 2022.
2 Eyben and Savage 2013.

Even though global funds were launched long before this new era of development cooperation, in many ways they represent the ideals of aid effectiveness and multi-stakeholder partnerships as articulated in *Busan*. From a governance perspective, global funds have emerged as a new type of multilateral global governance structure. Conceptualized as a form of 'polylateralism' by the former World Trade Organization Director General Pascal Lamy, global funds involve diverse stakeholders—governments, international organizations, multinational companies, civil society organizations (CSOs), philanthropic entities, and experts—mobilizing and channeling development finance to address clearly defined global issues. This type of polylateralism is now associated with results—rather than politics-oriented processes, effectiveness and broad stakeholder engagement[3]—much in line with the ideas aired in *Busan*. Global funds have been set up in many sectors and command a substantial and increasing share of development aid, particularly in global health.[4] Arguably, they 'yield more influence than many of the members of the UN, and are deploying bigger capacities to cooperate and find solutions to many of the unresolved issues of our times.'[5]

Tallberg and Zurn posit that legitimacy has been 'insufficiently recognized, conceptualized, and explained in standard accounts of international cooperation.'[6] This is particularly the case for global funds, with empirical analyses examining legitimacy largely focusing on UN institutions[7] and the European Union.[8] Recent literature has paid particular attention to how 'traditional' multilateral organizations are driven by Western interests, and the role of emerging powers in the context of shifting global power dynamics.[9] While some analyses of novel, polylateral forms of global governance organizations are emerging,[10] the literature has remained largely silent regarding global funds and there remains a dearth of comparative studies of global funds more generally.[11]

This multiple case study presents an empirically based comparative analysis of legitimacy aspects of global governance across three global health funds: Gavi, the Vaccine Alliance (Gavi); Global Fund to Fight Against AIDS, Tuber-

3 See Taggart 2022.
4 Yeates et al. 2023.
5 Lamy 2024, 241.
6 Tallberg and Zürn 2019, 581.
7 E.g., Dellmuth et al. 2022; Oguz Gok and Mehmetcik 2022; Sommerer et al. 2022.
8 E.g., Tallberg 2021.
9 Narlikar 2022; Parlar Dal and Dipama 2022; Stephen and Zürn 2019.
10 E.g., Taggart 2022.
11 Notable exceptions include Yeates et al. 2023; Hawkes, Buse and Kapilashrami 2017; Manuel and Manuel 2018.

culosis and Malaria (GFATM); and the Global Financing Facility for Women, Children and Adolescents (GFF). The overarching aim of the analysis is to examine how well global health funds fare against key legitimacy principles, as expressed in *Busan* and the earlier Paris Declaration on Aid Effectiveness (2005) (hereafter, *Paris*).[12] These two frameworks have long served as development cooperation guidelines and continue to frame discussions, as evidenced at the 2023 Busan Global Partnership Forum.

The next section discusses the conceptualization of legitimacy in global governance in the current literature and presents the analytical framework adopted in this study. The following section outlines the research methods. The findings section presents research data with regard to three aspects of democratic legitimacy: country ownership, accountability, and inclusiveness. Technocratic legitimacy will also be addressed, with its emphasis on expertise-driven policymaking and focus on results. The discussion and conclusions section highlights our key research findings, namely that all three global health funds fall short of the standards of democratic legitimacy defined by *Paris* and *Busan*, and discusses their broader implications for global governance in health and other sectors.

2 Theoretical and Policy Perspectives on Legitimacy in Global Governance

Legitimacy is understood by Suchman as 'generalized conceptions or assumptions that the actions of an entity are desirable, proper or appropriate within some socially-constructed system of norms, values, beliefs and definitions.'[13] The theoretical literature around the concept of legitimacy in the context of global governance has put forth diverse sources of legitimacy from which policy actors draw. Scholte and Tallberg's typology (Table 1)[14] purports that global governance institutions gain legitimacy through the *democratic, technocratic* and *fairness* aspects in their governance models and policy outcomes—via what they term as the 'procedure' and 'performance' axes of legitimacy.

12 The 2005 Paris Declaration on Aid Effectiveness was adopted by ninety countries and twenty-seven development institutions, and later consolidated by the 2008 Accra Agenda for Action. These development cooperation principles were updated and extended by the 2011 Busan Partnership which was endorsed by 161 stakeholders (see Table 2 for a comparison of these frameworks).

13 Suchman 1995, 75.

14 Scholte and Tallberg 2018b.

TABLE 1 Institutional sources of legitimacy as described by Scholte and Tallberg (2018b)

	Democratic	**Technocratic**	**Fair**
Procedure	Participation	Efficiency	Impartiality
	Accountability	Expertise	Proportionality
Performance	Democracy promotion in wider society	Problem solving	Human dignity
		Collective gains	Distributive justice

Analyses of legitimacy have typically pursued either a normative or sociological approach. In the first case, a theorist identifies relevant legitimacy criteria and compares arrangements to the set legitimacy standards. Sociological approaches, in turn, are purely interested in the legitimacy perceptions or beliefs of the empirical population.[15] While much of the recent literature on legitimacy in global governance has analyzed 'legitimacy beliefs' and 'perceptions' through the sociological approach, this study adopts a normative approach with a focus on procedural legitimacy (i.e., governance processes), drawing on legitimacy principles established in *Paris* and *Busan* (Table 2). Many of these principles are equally present in the 2023 Lusaka Agenda, including alignment with country priorities, coordination and harmonization of efforts, and mutual accountability.

Our study utilizes an analytical framework that draws on Scholte and Tallberg's typology (Table 1) and the *Paris* and *Busan* principles to focus on clear analytical categories of *procedural legitimacy* reflecting the two levels of governance in which global health funds typically operate. These categories include 'governance structures' (fund boards) and 'operational principles' (ways of working at the country level). Given that a systematic evaluation of the impacts of different global health fund operations falls outside the scope of this study, performance legitimacy is not included in the analysis.

Regarding democratic legitimacy, 'country ownership' stands out as the overarching standard for legitimate development cooperation in *Busan*, while equally reflecting the importance of the fairness of a system by prompting a 'just' process by which recipient countries have a voice in deciding policy strategies directly affecting them. 'Mutual accountability', highlighted in *Paris* and *Busan* to include accountability towards affected populations, constitutes a second aspect of democratic legitimacy, while the third principle of *inclusive*

15 Dellmuth et al. 2022.

TABLE 2 Paris Declaration/Accra Agenda for Action and Busan Partnership principles

2005 Paris Declaration principles / 2008 Accra Agenda for Action	**2011 Busan Partnership principles**
Ownership: Developing countries set their own strategies for poverty reduction, improve their institutions and tackle corruption **Alignment**: Donor countries align behind these objectives and use local systems	**Ownership** of development priorities by developing countries: Countries should define the development model that they want to implement.
Results: Developing countries and donors shift focus to development results and results get measured. **Harmonization**: Donor countries coordinate, simplify procedures and share information to avoid duplication.	Focus on **results**: Having a sustainable impact should be the driving force behind investments and efforts in development policy making.
Mutual accountability: Donors and partners are accountable for development results.	Transparency and shared responsibility: Development cooperation must be transparent and **accountable** to all citizens.
Inclusive partnerships: All partners—including donors in the OECD Development Assistance Committee and developing countries, as well as other donors, foundations and civil society—participate fully. **(Accra Agenda for Action)**	**Partnerships** for development: Development depends on the participation of all actors, and recognizes the diversity and complementarity of their functions.

partnerships requires that everyone with a stake is involved. Simultaneously, the virtue of partnerships is associated with diversity and complementarity of functions, stressing their instrumental value in driving *effectiveness*—reflecting the technocratic legitimacy aspect. *Focus on results* is patently a reflection of technocratic legitimacy, complemented by the principle of *harmonization* which equally pursues effectiveness through optimal coordination and synergies between different development interventions.

3 Methodology

This is a qualitative case study comparing the legitimacy aspects of three global health funds from a normative perspective. Gavi, the GFATM and GFF represent a 'new' form of global governance by 'polylateralism' *par excellence*. They are amongst the most prominent, powerful and wealthiest of all global funds. Although all were established in response to pressing global health challenges, they are nevertheless diverse in the timing of their establishment, their mis-

TABLE 3 Analytical framework to operationalize procedural legitimacy in relation to global health funds

	Democratic & fairness aspects			Technocratic aspects
	Country ownership	**Mutual accountability**	**Inclusive partnerships**	**Results/ effectiveness**
Governance structures (boards)	Global South government representation and participation on global boards (including voting rights).	Dispute resolution mechanisms, systems for questioning and reversing decisions. Openness and transparency.	Representation and participation of non-state actors on global boards (including voting rights).	Driven by expertise and evidence.
Operational principles	Countries decide their own priority needs and responses. Alignment with domestic policy strategies.	Accountability (including that towards affected populations).	Broad-based stakeholder engagement.	Focus on data, results, learning and innovation. Harmonization and coordination.

sion, and the resources at their command (Table 4). The multiple case study approach facilitates the examination of the defined legitimacy aspects across these funds, which have slightly different governance mechanisms and operational approaches, increasing the robustness and generalizability of the findings.[16]

The data collection involved a structured scoping review of literature on global health funds. This included peer-reviewed academic publications and relevant grey literature, such as official statistics, websites and policy documents of global health funds, and reports by development organizations. EBSCOhost and Google Scholar were utilized to search for academic literature, using inclusion and exclusion criteria to ensure high quality and relevance of search returns, as well as the widest range of evidence and perspectives.

The desktop research was supplemented by fifteen semi-structured interviews in total, with eight current or former senior officials of global health funds and seven academic and policy experts. For fund officials, interviewee recruitment was done by seniority and area of responsibility, accounting for different governance aspects of global health funds. Policy experts were selected based

16 Yui 2018.

TABLE 4 Summary of institutional governance features of GAVI, GFATM and GFF[a]

Name & year est.	Political-institutional origins	Legal status	Mission	Size	Countries supported
Gavi 1999	Initially named the Global Alliance for Vaccines and Immunizations, it merged the previous 'Gavi Fund', a US non-profit organisation, and 'the Gavi Alliance', a partnership without legal personality.	Since 2009, GAVI has international institution status in Switzerland and public charity status in the USA.	Increasing equitable and sustainable use of vaccines against 20 infectious diseases; health systems strengthening.	7.5 USD Billion	In 2024, 54 countries are eligible to apply for new vaccine support from Gavi. (Eligibility criteria: GNI per capita ≤ USD 1,810).
GFATM 2002	GFATM emerged in the MDG era (2000–2015) to address reducing child mortality (MDG4), improving maternal health (MDG5), and combating HIV/AIDS, malaria and other communicable diseases (MDG 6).	Created as an independent Swiss-based foundation.	Fight HIV/AIDS, TB, Malaria, challenge injustice viz these diseases; strengthen health systems.	14.0 USD Billion	126 countries supported during the 2023–2025 allocation period. (Eligibility determined by income classification and disease burden).
GFF 2015	The GFF was launched as a key financing platform of the UN Secretary-General's Every Woman Every Child movement launched in 2010 (today known as the Global Strategy for Women's, Children's and Adolescents' Health, 2016–2030).	A financing facility with a complementary multi-donor trust fund—the GFF Trust Fund, hosted at the World Bank (USA).	Accelerate progress on RMNCAH-N by mobilising and aligning domestic resources, WB concessional financing, external financing, and private-sector resources.	0.99 USD Billion	36 low and lower-middle income countries (allocation eligibility and amount determined by need, population, and income).

a RMNCAH-N: reproductive, maternal, newborn, child and adolescent health and nutrition.

on their longstanding experience in global governance and familiarity with global funds through earlier roles, collaborations, or in other capacities (e.g., research). A snowballing technique (identifying relevant informants through recommendations by senior officials) was utilized alongside direct recruitment via email. Conducted online between June 2022 and February 2023, these interviews aimed to elicit how the funds work in practice and issues arising. We followed up with some interviewees for further information in September 2024.

TABLE 5 Global health fund definitions of country ownership

Global health fund	Policy document	Definition of country ownership
GFATM	2023–2028 Strategy	"*Countries determine how to use these funds and take responsibility for fighting the three diseases through responses that are country led and tailored to their unique context*" (+ the concept is 'inclusive' and pertains also civil society, affected communities and other stakeholders).
Gavi	2021–2025 Strategy	"*Deliberate approach to balance short-term health systems support and long-term health systems strengthening and to bolster country leadership to sustainably deliver and finance immunisation*"; "*community ownership and trust should be at the center of interventions*"
GFF	Website (2025) 2021–2025 Strategy	"*Countries own the GFF process, with a wide set of stakeholders coming together under government leadership to identify the results they want to achieve and ultimately to provide the financing to achieve them*" (+ bolstering country leadership is the first strategic objective of the GFF strategy, which expounds also on growing efforts to integrate affected communities and civil society organizations)

4 Findings

4.1 *Country Ownership*

Country ownership constitutes the primary axis of legitimacy for development cooperation as defined by *Busan* and *Paris*, which compels donors to 'respect partner country leadership and help strengthen their capacity to exercise it.'[17] The three global health funds examined have largely subscribed to this principle, as illustrated in Table 5. In the following sub-sections, we look at, first, *how* country ownership is pursued within the fund boards and, second, their operational approaches at the country level.

4.1.1 Country Ownership and Government Representation on Funds' Boards

Unlike traditional multilateral organizations where constituents are government representatives and public sector organizations (and, in the case of the International Labour Organization, social partners), global health funds gather state and non-state actors. Also differing from the World Health Organization (WHO) which benefits from broad country representation under its chief

17 OECD 2005, 3.

decision-making body—the World Health Assembly hosting 194 WHO Member States—participants in global health fund boards are much fewer and with differing voting rights (for GFATM and GFF).

The GFF's governing body, the Investors Group, includes a broad array of donor and recipient governments, CSOs, the private sector, UN agencies, the World Bank, and representatives from Gavi and the Global Fund (Figure 1 (left)). In 2019, the GFF revised its governance structure to better balance donor and recipient countries through co-chairing by one donor country and one recipient country representative.[18] However, while GFF presents itself largely as a new type of country-led financing facility (GFF rep 1), only countries domestically financing the GFF priority areas through the GFF model can exercise a vote in the Investors Group. Although some low-income countries (e.g., Burkina Faso, Côte d'Ivoire) have joined the Group and contribute to funding the GFF trust, other prospective recipient countries are allocated a mere advisory role (Gavi rep 1). This significantly limits the voice of other southern countries in GFF governance and decision-making processes. Moreover, the dominant role of the World Bank in the GFF remains a key manifestation of continuing power imbalances.[19]

Gavi's governance structure and process diverges from that of GFF (and GFATM) (Figure 1 (middle and right)) in that all board members participate fully as equals and decisions are made on a consensus-basis. Interviewees highlighted that country-led processes are a 'big principle of Gavi' (Gavi rep 1), although recipient countries constitute only one quarter of Gavi's board and are confined to representing views from 'their' region.

Similarly, the GFATM board includes only five seats for recipient countries—representing regional constituencies—amongst the twenty voting members. Given that the GFATM board decisions are made by voting, the imbalance in recipient country representation within the existing structure limits country ownership. One distinctive feature in GFATM board operations is a bloc system between donor and recipient countries, designed to avoid either of these blocs overriding the other by requiring full consensus on contentious decisions. The bloc configuration does not prioritize the views and priorities of recipient countries but provides donors, including private foundations and pharmaceutical companies, with significant powers to effectively veto recipient country positions.[20]

18 See https://www.globalfinancingfacility.org/global-financing-facility-welcomes-new-co-chairs-investors-group.

19 Seidelmann et al. 2020.

20 Gartner, 2022.

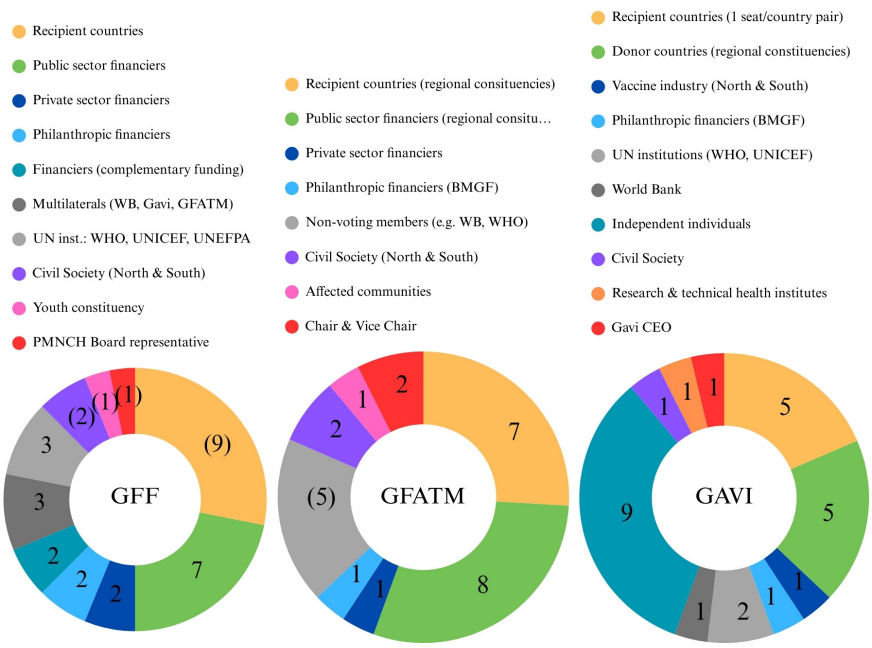

FIGURE 1 Global health fund board composition
Note: Numbers in brackets refer to non-voting members.

Moreover, referring to Gavi and GFATM, interviewees stressed that effective recipient country engagement is often impeded by a lack of resources. As one interviewee commented in relation to Gavi:

> (…) for the governance mechanism to truly work in a representational way, it needs to have processes behind it that support that representation, and that requires some funding (…) often, especially when ministers of health on the Gavi board represented regions, they often only talked about their own country and not the region as a whole.
>
> Gavi rep 2

Acknowledging this challenge, Gavi now provides support to government members on the board in a bid to strengthen the capacity of countries with limited resources to represent their constituencies effectively.

Furthermore, Browne, amongst others, posits that global health funds are 'a priori strongly influenced by their financiers' at the expense of recipient countries (local health experts, CSOs or the public).[21] The uniquely influen-

21 Browne 2017; see also Mitchell and Sparke 2016.

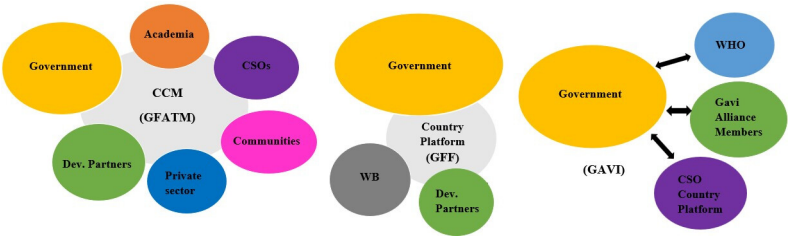

FIGURE 2 Illustration of country-level engagement by global health funds

tial power of the Bill and Melinda Gates Foundation (BMGF) is particularly notable. Since donating an initial commitment worth USD750 million that effectively launched Gavi, BMGF has held a permanent seat on its board, drives leading strategic decisions at the Global Fund, and chaired single-handedly the GFF investor's group until 2019. The sway of BMGF under Gavi and GFATM reflects its own strategic priorities.[22] Despite the multi-stakeholder constitution of global health funds, their institutional configurations render them akin to providing charity in the sense that northern donors are 'still calling the shots,' as emphasized by interviewees (Global Fund rep 1; Policy expert 1).[23]

4.1.2 Pursuing Country Ownership at Country-Level

There is significant diversity in approaches to country-level engagement across the three global health funds (Figure 2). The GFF's country platforms gather state and non-state stakeholders typically convened under the Ministry of Health or Ministry of Finance. Liaison officers support stakeholder engagement at the country level, complementing World Bank country teams working with recipient countries to design an 'investment case.'[24] Interviewed GFF representatives stressed that their model genuinely pursues country ownership through substantive, long-term engagement, in contrast to many bilateral donors who 'pay lip service' to the idea of country ownership whilst running their own programs (GFF rep 1). Given that *Busan* emphasizes the 'use of country systems as the default approach for development co-operation in support of activities managed by the public sector,' GFF's efforts in working through country platforms appear largely aligned.

Nevertheless, that there has been widespread critique regarding the World Bank influence in investment case planning is hardly surprising.[25] Reflecting

22 Clinton and Sridhar 2017.
23 See also Reid-Henry et al. 2022, 2023.
24 Fernandes and Sridhar 2017; Salisbury et al. 2019.
25 George et al. 2021.

the Bank's active role at the country level, one GFF representative shared that some governments needed to be 'pushed' to assume full responsibility for the investment case by increasing their financial contributions to invest more heavily in RMNCAH-N (GFF rep 2). While this persuasion work may be necessary to bolster domestic commitment, the strategy does not reflect the spirit of country ownership according to *Paris* and *Busan*. It shows that global health funds do not simply seek to 'align' with national development strategies but are actively promoting their own agendas within governments and are vying for influence over government policy and decision-making.

The GFATM's country-level approach is based on the Country Coordination Mechanism (CCM). CCMs are multi-stakeholder entities established and managed to meet GFATM's requirements, even when they are closely connected with a statutory body such as the Prime Minister's Office. The CCM develops funding requests, nominates Principal Recipients (which implement programs) and oversees program implementation. Interviewees reported that friction lies primarily between the government and CSOs in CCMs:

> There's not a lot of complaints from governments. I think most of the complaints we get are from civil society, who sometimes find it difficult to get access, because (…) the role of government agencies is very strong. Logically, because also, they're basically building—in most countries—on government programs (…).
>
> GFATM rep 1

Different power constellations operate under CCMs. In an examined instance in India, decision-making processes led by international organizations (UNAIDS, WHO) and the National AIDS Control Organization were 'arbitrary and non-transparent,' often at the expense of local grassroots organizations which tended not to be selected as fund recipients and program implementers.[26] On the other hand, GFATM officials highlighted that sometimes CSO propositions are not aligned with country strategies or the latest knowledge. While further empirical evidence is needed, the CCM mechanism appears to largely reflect and respect government leadership in policy processes at the country level.

Gavi's country-level stakeholder engagement differs from GFF and GFATM in that it relies largely on engagement by governments and collaboration with local/regional WHO representatives.[27] Gavi's evaluations have highlighted the

26 Kapilashrami and McPake 2013.

27 Gavi's stakeholder engagement differs in the context of Health System Strengthening

efficiency and effectiveness advantages of the country-level lean organizational structure, but stakeholders have criticized Gavi for tolerating a lack of clarity of roles and responsibilities, trust and transparency. Indeed, findings from a study in Uganda point to low efficiency due to unclear guidelines around stakeholder responsibilities,[28] while evidence from Benin shows that traditional governance structures, national bodies and key stakeholders such as the WHO are not systematically consulted—resulting in vaccination errors.[29] The challenges emanating from the alliance's complex structure and unclear roles and responsibilities were corroborated by interviewees. However, they pointed to progress on this front, especially since the introduction of the Partner Engagement Framework process in 2016 (Gavi rep 2).

4.2 *Mutual Accountability*

Paris and *Busan* highlight accountability between donors and recipients, as well as towards 'all citizens.' *Busan*, in particular, expounds that 'mutual accountability and accountability to the intended beneficiaries of our co-operation, as well as to our respective citizens, organizations, constituents and shareholders, is critical to delivering results. Transparent practices form the basis for enhanced accountability.'[30] This section examines the extent to which global health funds follow these principles.

4.2.1 Accountability in Global Health Fund Boards

In the context of traditional national and multilateral democratic practice, accountability typically involves transparency processes and structures in order to ensure that decisions can be appealed, petitions and new elections are organized, differing views and transparency issues are handled through public hearings, and that dispute resolution mechanisms are in place.[31] However, in the context of polylateralism, the views and preferences of citizens cannot be made known directly; they are captured only through government and civil society representation.

One way that global health funds have aimed to strengthen their accountability towards Global South citizens is through an increased focus on communities in program evaluations. This is key, given that *Paris* and *Busan* stress

(HSS), where policy planning is carried out at the Planning Departments of Ministries of Health, under the supervision of Health Sector Coordinating Committees.

28 Kamya et al. 2016.

29 Abdoulaye Alfa et al. 2020.

30 OECD 2011, 3.

31 Gleckman, 2018.

accountability in terms of results (as well as citizens). Gavi and GFATM have developed new approaches to capturing community experiences which shape program work and feed into organizational learning.[32] However, this approach requires ongoing engagement by fund staff:

> (…) there is this belief that we just do that to tick a box, because it's, like, an eligibility requirement, it's to look nice. (…) I think we, kind of, failed so far to get the message that we don't engage communities just because we are nice people, but just because if we don't, the responses on the ground are not adequate. So that's very important (…), but we have some work to do there.
>
> GFATM rep 3

Even though not explicitly mentioned in *Paris* and *Busan*, global health funds could also pursue accountability through platforms and processes for public hearings, appeals and other ways for board members, non-represented countries or citizens to challenge board decisions. Interestingly, neither GFF nor Gavi share information on their processes for dealing with complaints, appeals, or transparency matters. Additionally, there are no dispute resolution mechanisms in place beyond those pertaining to internal employee disagreements. The Gavi board's consensus-based decision-making means that at least there are agreed processes for dealing with differing views, though these processes still omit opportunities for non-board parties to challenge board decisions.

GFATM, in turn, adopted in 2011 a Voluntary Dispute Resolution Process on recommendation from the Finance and Audit Committee. While the implementation of the process lagged, the 2014 Office of the Inspector General Stakeholder Engagement Model and the Policy for Disclosure of Reports Issued by the OIG have enabled subjects of audits and investigations to challenge and respond to findings.[33] Nevertheless, this does not constitute a broader accountability mechanism by which citizens of GFATM health aid-receiving countries could raise concerns about board decisions.

4.2.2 Ensuring Accountability in Country-Level Programmatic Work

Paris and *Busan* stress the mutual aspect of accountability, involving not only donor but also recipient country commitment. Interview respondents raised

32 The GFATM 2023–2028 strategy commits 'to maximize the engagement and leadership of affected communities, to ensure that no one is left behind, and that services are designed to respond to the needs of those most at risk' (Global Fund 2023).

33 The Global Fund 2015.

the issue of sometimes-limited government accountability concerning global health fund programs at the country level. This accountability deficit was seen to require constant engagement on behalf of funds and broader stakeholders rallying behind the set objectives. For Gavi, leveraging the power within the broader Alliance group would facilitate holding government and ministerial staff accountable and committed (Gavi rep 2).

Crucially, the strategic involvement of CSOs by global health funds can be interpreted as a mechanism to strengthen accountability for results towards affected populations and recipient country citizens (GFF rep 2; Policy expert 2). For example, the current GFF strategy (rolled out in 2020–2021) has sought to promote the voices and participation of disadvantaged and vulnerable populations in designing and monitoring country-specific investment cases. As part of these efforts, the GFF has recently launched an engagement framework to 'support the critical role CSOs and youth play in driving advocacy and independent accountability.'[34] However, Policy expert (2) highlighted that there is a conflict of interest once CSOs are made program implementers, as often happens under the GFATM's CCM. This point corroborates evidence from Peru showing that the CCM structure compromised CSOs' ability to hold the government accountable to agreements once they were made responsible for program implementation.[35] GFF representative (1) also stressed that CSOs must be kept 'at an arm's length' for them to effectively promote accountability.

4.3 *Inclusive Partnerships*

Multistakeholderism implies broad representation by definition, suggesting that global health funds are widely inclusive—a key *Paris* and *Busan* principle. This section examines how the principle of inclusive partnerships is pursued in practice, both within the funds' boards and through their country-level engagement models.

4.3.1 Inclusiveness and Power in Global Health Fund Boards

Global health funds fare relatively well regarding the overall representation of different stakeholder groups on their boards, even though it could be argued that civil society representation remains limited without separate seats for trade unions and indigenous populations. At the same time, the evidence points to significant power imbalances between dominant and non-dominant actors as expounded earlier in this paper, bringing into question the effective realization of 'inclusive and equal partnerships.'

34 GFF 2020–2021 Annual Report.

35 Amaya et al. 2014.

Some interviewees were skeptical of the involvement of private sector actors in global boards of the funds. The relative power of private sector members on global health fund boards is outside the scope of this study, but the disproportionate representation between private and civil society actors is noteworthy. For example, the Gavi board has only one seat for its entire civil society constituency of over 4,000 organizations from the Global North and the Global South. Also, the Gavi board has no seat for youth (unlike GFF) or affected communities (unlike GFATM), despite its ambition to increase its strategic focus on communities.

Diverging from Gavi, GFATM preserves separate representations for Northern and Southern civil society actors. However, this still amounts to only two seats on the board. Additionally, our interview data shows that CSOs make frequent claims for 'more power' at the board level, through veto rights or other mechanisms (GFATM rep 1), pointing to a shared sentiment of being in a subordinate position to other board members. GFF, in turn, holds one seat for youth representation and two separate seats for Northern and Southern CSOs. However, these are non-voting seats and represent a small minority in the total of thirty-two seats (Figure 2).

It is noteworthy that smaller and less professional organizations, notably from the Global South, are less able to fully participate in fund processes. Some action has been taken to rectify fairness issues regarding civil society participation and having the resources to do so was underscored by some interviewees (e.g., Policy expert 1). GFATM has reacted to such challenges by affording additional time to review documents and giving particular weight to community priorities in the context of grant allocation decisions (GFATM rep 1). Gavi, in turn, allocates human resources to support coordination among members of the civil society constituency in a bid to strengthen Southern voices (Gavi rep 1), and has actively pursued the shift to a Southern-based host of the Gavi CSO constituency:

> (…) I think this has been a big move, actually, on GAVI's part, that there is, like, a host of the Gavi CSO constituency (…) is Amref, which is based out of Nairobi. Earlier, it was a northern-based organisation that was in the role, and one of the reasons why that transition and shift happened with full, kind of, commitment and involvement from the Alliance, is really that I think it's high time that we changed some of the dynamics.
>
> Gavi rep 2

4.3.2 Country-Level Partnerships—Civil Society and Beyond

Global health funds' multi-stakeholder model at the country level, where different public and non-state actors engage in decision-making processes and program implementation, was a key issue raised by interviewees and in the literatures.

The GFF has assisted countries to contract private businesses and CSOs to deliver services, often nation-wide. In this context, it supports governmental capacity-building to manage performance-based financing and contracting of private-sector actors, alongside regulation to ensure service quality within the non-state sector.[36] Simultaneously, the overall country platform structures have, in many instances, remained ineffective and even partially dormant, with limited inclusiveness of CSOs.[37] Interviewees acknowledged these issues and stressed that the GFF has become more inclusive and less driven by the World Bank as it has evolved (GFF rep 1). GFF representatives also shared that the current approach to promoting inclusiveness entails expanding engagement, notably with CSOs working on maternal and child health (selected on a rotating basis) (GFF rep 2).

GFATM's country-level partnership model is unique in that it recommends 40 percent civil society representation in CCMs. Echoing the research,[38] interviewees highlighted the relevance of CCMs for systematically instigating broad-based country-level consultative processes (GFATM rep 2), which are supported with a budget to facilitate stakeholder engagement (Policy expert 3). GFATM representatives reported ongoing initiatives to strengthen inclusiveness and community participation in CCMs. One tangible example, highlighting the strengths of the inclusive approach by the CCM, was the achievement of the 90-90-90 HIV treatment target[39] in Morocco thanks to civil society participation (GFATM rep 2). Nevertheless, empirical evidence from Uganda, DRC and India shows that the CCM structure can create competition for resources and conflict among stakeholders.[40] This issue was readily recognized by interviewees. More professional CSOs familiar with the 'Geneva bureaucracy and language' are more likely to win grants[41] while engagement, especially with

36 Chou et al. 2018.

37 Save the Children 2018b; Seidelmann et al. 2020.

38 Amaya et al. 2014; Armstrong et al. 2019; Htun et al. 2021; Sekalala 2017; Shelley et al. 2020.

39 Ninety percent of all people living with HIV know their HIV status, ninety percent of all people with diagnosed HIV infection receive sustained antiretroviral therapy, and ninety percent of all people receiving antiretroviral therapy will have viral suppression.

40 Kapilashrami and McPake 2013; Shelley et al. 2020.

41 Onokwai and Matthews 2022; Sands 2019; Sekalala 2017.

affected communities such as HIV-positive populations, remains challenging, partially due to their marginalization and criminalization at the country level (GFATM rep 3).

Furthermore, Gavi's support to CSOs at country level in the context of Health Systems Strengthening (involving more substantial stakeholder engagement than other Gavi work) raises several issues. These include 'the substantial delays to HSS grant implementation' which has led to poor results by CSO work, as well as lack of strategic vision, selection of Fund Managers, funding mechanisms, and transparency of CSO Platform support at country level.[42] Yet, positive examples from Pakistan and Ghana, for instance, highlight the critical role of CSO engagement for effective service delivery at the grassroots level.[43] Today, Gavi is increasingly investing in strengthening its stakeholder participation. New Gavi country grants include 10 percent earmarked for CSO funding, and the fund has recently expanded its collaborations, notably to humanitarian organizations (including the International Organization for Migration, Save the Children and the International Rescue Committee), to broaden collaboration with different actors operating in nutrition, water sanitation and education (Gavi rep 1).

4.4 *Results and Effectiveness*

Global health funds have sought to legitimize their role in Global Health Governance primarily through their expert-driven and impact-oriented—or in other words, *technocratic*—approach. Gavi, for example, identifies as 'the sum of its partners' individual strengths, from WHO's scientific expertise and UNICEF's procurement system to the financial know-how of the World Bank and the market knowledge of the vaccine industry.'[44] This section takes a closer look at how global health funds have pursued measurable results and sustainable impact as emphasized by *Paris* and *Busan*.

4.4.1 Expertise and Results-Oriented Approach in Governance Structures

Global health fund boards have incorporated members from diverse industries and sectors to optimize the presence of available expertise. Gavi is overseen by a diverse twenty-eight-member board, with nine independent members expert in auditing, fundraising or investment (amongst other things). Some intervie-

42 ITAD 2018.

43 Thacker et al. 2013.

44 See https://www.gavi.org/our-alliance/operating-model, last visited 25.4.2024.

wees stressed that these experts can balance political dynamics and promote evidence-based approaches:

> That added (…) a very strong point in the governance, (…) their decisions, their opinions, their questioning was equitable. They questioned the governments as much as they questioned the civil society organizations who were on the governance mechanism, as much as they questioned industry. […] They didn't have any skin in the game on who should get more money or who should be in charge.
>
> Policy expert 3

However, not all expertise is necessarily independent or motivated by results. One interviewee highlighted the power of Gavi's technical working groups, consisting of experts (in biotech, vaccine development, amongst other things) in exerting undue influence over board discussions and decisions (Policy expert 3).

As for the GFF, the Investor Group involves non-voting, civil society representatives and Global South countries with crucial contextual knowledge and expertise. Similarly, the GFATM board includes eight non-voting members, including IO representatives (WHO, World Bank) and a public donors' constituency, which act in an advisory role to support the board's decision-making processes. Although the inputs of global health agencies are valuable, it raises the question of whether the WHO, for example, should be in a voting rather than an advisory position. One noteworthy positive aspect of GFATM processes is, however, the Partnership Forum gathering hundreds of partners across the fund structure to deliberate on policies. Organized every four to five years through events in multiple world regions, the Forum contributes towards GFATM strategy development, while the extent of this input remains unclear.

Furthermore, global health funds have complex approaches to evaluation, monitoring, and learning. As the GFF is housed at the World Bank, it follows the Bank's elaborate procedures for project implementation monitoring, effectiveness assessment and impact evaluations. The GFATM's metrics-based monitoring is embedded in the resource-allocation mechanisms from the outset. Performance-based funding and program-specific evaluations constitute key features of its operational model. Also, the GFF has engaged in social impact bonds, which follow such principles.

The funds' documents evidence a commitment to continued improvement of monitoring and evaluation (M&E) methods, with increasing incorporation of social equity impacts. This is important, given that earlier evidence from 2017 shows that 'gender was poorly mainstreamed through the institutional

functioning of the partnerships.'[45] In 2023–2024, GFF adapted its Key Performance Indicators (KPI) to better reflect its primary strategic objectives,[46] while GFATM has undertaken extensive consultations with over 450 experts to strengthen its M&E approaches.[47] Also, Gavi revised its performance indicators along with its 2021–2025 strategy, introducing a new set of social equity indicators.[48] GFATM has also developed a gender equality marker to assess impacts of its work on gender equality and shifted to a more holistic view of effectiveness that accounts for social equity impacts. Finally, GFATM and Gavi have shifted towards greater emphasis on qualitative and community-focused assessment methods.

4.4.2 Focus on Effectiveness in Country-Level Operations

Paris and *Busan's* focus on tangible impacts requires meaningful engagement with country-level stakeholders. Global health funds actively contribute to country-level knowledge dissemination and technical capacity-building, notably within ministries. They provide data, support the development of data collection systems, and offer training, amongst other things. However, this can sometimes lead to parallel systems of metrics, sidelining established international statistics and potentially influencing how and what type of data is collected, and defining development problems on behalf of domestic stakeholders.[49]

Harmonization and coordination of development activities are key to aid effectiveness, especially to indicators of system-wide results. Policy experts we interviewed acknowledged that duplication of efforts, multiple parallel policy processes, amplified bureaucratic and other costs related to fragmented aid landscapes, as well as pressures on recipient countries to constantly adapt and innovate their responses, are all significant issues for aid-receiving countries because they can compromise overall effectiveness within the health sector (Global health expert 4).

At the same time, Gavi and GFATM representatives highlighted that their organizational model is highly conducive to preempting and mitigating duplication of efforts and pushing for harmonized collective efforts, largely on

45 Hawkes, Buse, and Kapilashrami 2017.

46 See https://www.globalfinancingfacility.org/sites/default/files/gff_new/files/documents/GFF-IG16-3_Strategy%20KPIs.pdf, last visited 18.10.2024.

47 See https://www.theglobalfund.org/media/12681/strategy_globalfund2023-2028-kpi_handbook_en.pdf, last visited 18.10.2024.

48 See https://www.gavi.org/programmes-impact/our-impact/measuring-our-performance/2021-2025-indicators, last visited 18.10.2024.

49 See e.g., Mahajan 2019.

account of ongoing engagement with all major partners operating in the same mission space. Moreover, the GFF's *modus operandi* is largely focused on harmonizing investments for RMNCAH-N. GFF interviewees shared that the facility conducts an actor-landscape mapping (including philanthropic investments and projects by international non-governmental organizations) exercise to identify activities and resources flowing into a country, as well as existing financing gaps. It seeks to mitigate fragmentation by connecting with other actors and pooling investments under one single investment case. When bilateral or other donors do not want to conform to the set activities, they are offered options to participate through co-financing or joining specific interventions or components under a project or a program.

5 Discussion and Conclusions

Global health funds are a key global governance mechanism designed to support and accelerate progress in health-related development goals. With some commanding greater health-focused resources than the WHO, so established are these funds that some see them as an alternative governance model to the traditional UN bodies, which are perceived to be 'rigged with political games.'[50] At the same time, recent multi-stakeholder deliberations regarding global health funds and the subsequent 2023 Lusaka Agenda highlight the 'power imbalances in their structures and decision-making processes,'[51] drawing attention to potential legitimacy gaps. This article has asked how well these novel forms of global health governance fare against the *Paris* and *Busan* legitimacy standards and how different governance arrangements condition power relations among actors involved, given that these are an important part of democratic legitimacy. The key finding of this research is that the three global health funds fall short of the standards of democratic legitimacy defined by *Paris* and *Busan*. These funds, especially GFATM and GFF, have sought to endorse *country ownership* notably at the level of country engagement, but significant North-South power inequalities remain. The analysis suggests, in line with arguments elsewhere,[52] that polylateralism as a model of governance allocates political power primarily to financial donors (including private sector and philanthropic partners) and limits the leadership of Global South countries in high-level strategy setting. Gavi's consensual board decisions constitute

50 Gleckman 2018.

51 FGHI 2023.

52 Ralston et al. 2024; Stone 2017.

the more progressive approach among the three global funds examined, but there is a significant issue of proportionality in recipient country representation across the funds.

This is problematic, given that Gavi and GFATM have become dominant global health organizations with important governance roles, which was not their initial purpose (which still is, to further new effective solutions to narrowly-defined health challenges). Global health funds were born out of problem definitions and global policy processes largely driven and conceptualized by Northern actors, and they 'sit' among other global governance institutions in Geneva and Washington DC, a far distance away from the countries they aim to serve. While the standard of 'country ownership' was examined in this study primarily in relation to the board- and country-level operations of global health funds, there is a broader issue of who shapes global health governance institutions, structures and agendas, and how.

Furthermore, it remains unclear to what extent global health fund boards can ever be accountable to the populations they aim to benefit, given that they lack institutionalized dispute resolutions processes and feedback mechanisms accessible to affected populations and the general public. This is inconsistent with *mutual accountability*. Our evidence also shows that CSO engagement in country-level operations is limited to implementation and service delivery and excludes accountability processes. It also indicates that the GFATM's CCMs can drive *inclusiveness* and transparency by virtue of institutionalizing a multistakeholder dialogue in countries, but different power dynamics continue to affect their governance quality and there are significant costs involved in effectively operating such heavy structures. However, further evidence is needed regarding the effectiveness of country-level approaches, especially for Gavi and GFF. At the global level, the presence of civil society actors on the funds' boards increases the funds' inclusiveness credentials, but closer inspection of the boards' composition reveals structural advantages in favor of Northern donors (including the BMGF and other individual financiers), while Southern CSOs have restricted presence (Gavi) and limited voting power (GFF).

At the same time, the examined funds rely on evidence-based and results-oriented approaches across all their operations, and efforts have been made to strengthen community-based evaluations and account for social equity outcomes. As such, they fare reasonably well against the standards of technocratic legitimacy. The deployment of independent advisors in the Gavi board processes is a noteworthy example of good practice. Yet, tension arises between technocratic and democratic legitimacy when technocratic authority, often aligned with Global North knowledge and policy frameworks, diverges from the preferences of local communities.

In conclusion, none of the three global health funds we examined have attained international standards for democratic legitimacy. What are the implications of this conclusion for global governance and development effectiveness more widely? At one level, weakened democratic legitimacy associated with the growing power of global health funds as global health actors and the relative decline of multilateral UN health agencies[53] raises the prospect of, at best, sub-optimal effectiveness of the USD20+ billion of health assistance channeled through GFATM, Gavi and GFF to improve population health in southern countries. We call for a thorough audit of these funds' democratic practices and effectiveness far more comprehensive than this single study has been capable of. At another level, the growing recourse to global funds in sectors ranging from agriculture and rural development, education, climate and, potentially, poverty, hunger and social protection raises very real concerns about the growth of these institutional vehicles in development finance. The experiences of the three global funds in this study should be a red flag for communities of policy and practice around global funds, particularly those motivated by the quality of democracy and governance.

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53 Gleckman 2018, Buse and Walt 2002.

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