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Locating Health Diplomacy through African Negotiations on Performance-based Funding in Global Health

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Abstract
This article examines how national health actors in South Africa, Tanzania and Zambia perceive the participatory quality of negotiation processes associated with the performance-based funding mechanisms of the Global Fund to Fight AIDS, Tuberculosis and Malaria and the World Bank. Through analysis of qualitative fieldwork consisting of 101 interviews within the case countries as well as in Geneva and Washington DC, the research results show that African actors within national governments generally set and negotiate performance targets of performance-based funding schemes. Nevertheless, the results also show that the quality of those negotiations with external funders were inconsistent, suggesting the existence of asymmetrical power and influence in relation to the quality of those negotiations. This raises questions about the level of power and influence being exerted by external funders and how much leverage African political actors have available to them within global health diplomacy. It also provides evidence that certain key aspects of these negotiated processes are closed off from negotiation for African actors, therefore undermining African participation in significant ways.

Introduction

The term *global health diplomacy* (GHD) has become increasingly entrenched within the global health governance lexicon (Kickbusch & Kokeny, 2013). An increasing number of official GHD strategies are being established within developed countries such as Japan (Abe, 2013), France, Norway (OMD, 2007) and the United States (Jaffe, 2013); and in developing countries such as Indonesia (Seiff, 2013), South Africa, Senegal and Thailand (OMD, 2007); as well as in regional organizations such as the Eastern, Central and Southern Africa Health Community (ECSA-HC, 2014). Although GHD has recently received a level of ideational popularity, the concept of health diplomacy itself remains underdeveloped.

The definition of GHD remains varied with understandings ranging from "an emerging field that addresses the dual goals of improving global health and better international relations" (Adams, 2008), to "processes by which governments, multilateral and civil society actors attempt to position health in foreign policy negotiations and to create new forms of global health governance" (Labonte & Gagnon, 2010), and to "multi-level negotiation processes that shape and manage the global health policy environment for health" (Kickbusch et al., 2007; WHO, 2014). A more encompassing definition suggests that GHD is "the policy-shaping processes through which states, intergovernmental organizations, and non-state actors negotiate responses to health challenges or utilize health concepts or mechanisms in policy-shaping and negotiation strategies to achieve foreign policy goals and the utilization of foreign policy to achieve health goals" (GHD.NET, 2009). Although 'negotiation processes' are highlighted as key to GHD, there remains limited research attempting to link directly descriptive accounts of diplomatic exchanges to better theoretical and conceptual explanations about the ways global health policy is negotiated (Blouin et al., 2012; Michaud & Kates, 2013). In this regard, GHD denotes processes of negotiation that take place multilaterally and bilaterally between countries, multisectorally between states, non-state and international organizations, and non-officially between stakeholders and institutional representatives (Katz et al., 2011). What is not always clear, however, is the quality of these negotiations and what it says about global health diplomacy more broadly.

Despite on-going debates about the exact specificity of GHD, it is possible to locate two common properties associated with the concept, which are deemed essential to its core conceptual understanding. Literature surveys show agreement on the need to better map the formal spaces for diplomatic participation (Katz et al., 2011) and the need to pinpoint the practiced processes of negotiation operating between health policymakers (Kickbusch et al., 2013). In other words, whatever GHD is, its conceptualization involves understanding the specified *spaces for diplomatic activity* and the *negotiation practices* that enable diplomatic agreement on health policy. By better understanding these operating conditions, it is then possible to pinpoint key substantive qualities inherent to these diplomacy processes and determine how these qualities

correspond to other explanatory or normative considerations of global health governance more broadly (Berridge, 2005; Kickbusch et al., 2013).

The purpose of this article is to investigate how national health actors in South Africa, Tanzania and Zambia negotiate the performance-based funding (PBF) mechanisms associated with the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and the World Bank. As will be outlined below, by negotiation we mean the "process of exchange between two or more interested parties for the purpose of reaching an agreement that can satisfy various interests of mutual concern" (Fisher et al., 1997). By using PBF as a lens to examine how actors engage in global health policy, and by focusing on specific country contexts, it is possible to better isolate key negotiation processes available to African actors as an aspect of global health diplomacy. PBF is important as a thematic case study because it has emerged as an increasingly omnipotent policy phenomenon in the governance of health (Ireland et al., 2011), which resonates with GHD definitions that emphasize health negotiations and the need to better understand the spaces and practices involved (PBF involves multilevel negotiations among policymakers at local, national, regional and global levels). Investigating the dynamics involved in PBF negotiations makes it possible to discern unique properties specific to the *quality* of negotiated agreement as, for example, in terms of equitable diplomatic positioning as perceived by the negotiating agents themselves.

In global health, PBF refers to the idea of transferring resources from funders (money, material goods) on condition that particular actions are taken and that recipients achieve specific, predefined performance targets (Eldridge & Palmer, 2009). With reference to the Paris Declaration on Aid Effectiveness (PDAE, 2005),[1] funding agencies such as the World Bank and GFATM argue that PBF will promote reform in a way that is 'nationally owned' and accountable (Witter et al., 2012), because performance indicators are designed by, and negotiated with, national coordinating bodies that have set these targets for themselves. Nevertheless, there is no systematic research examining the quality of these negotiations and how final agreements represent African interests in overall health diplomacy. As will be presented below, due to the nature of World Bank and GFATM PBF mechanisms, most negotiations take place bilaterally between the funder and the national government/principal recipients. This often does not involve regional actors and tends to exclude and/or undervalue many local stakeholders (although this varies from case to case and is determined by how stakeholders are included in national decision-making processes) (Barnes et al., 2015). Because most negotiations about the final make-up of PBF agreements are bilateral (although various NGOs can act as brokers), this article focuses on processes of negotiating PBF mechanisms between external funders and

[1] The Paris Declaration (2005) is a practical, "action guiding roadmap" to improve the quality and effectiveness of aid for development. It provides a series of measurement and monitoring commitments to help ensure that donors and receipts hold each other to account. The five guiding pillars of the declaration are: country ownership, alignment, harmonization, managing for development results and mutual accountability.

national/principal recipients, leaving aside discussion of internal negotiating mechanisms within state bodies/Country Coordination Mechanisms (CCMs) or how INGOs/NGOs influence these processes.

Through this examination it is possible to conclude that although some phases of the *negotiation* process display conditions of equitable consonance between stakeholders in terms of recognized health priorities and the importance of cooperative health initiatives, the negotiations themselves often operate within frameworks that limit African negotiations in profound ways. As a result, if the substantive quality of global health diplomacy is to be judged on the perceived quality of mutually consistent negotiations and outcomes (Drager et al., 2000; Raiffa, 2007), then the evidence suggests that current practice of PBF modalities is often in tension with more idealized GHD understandings of mutually consistent negotiation. It is possible, therefore, to locate asymmetrical influence and power that negatively affect diplomatic relations as they concern global health financing.

Methodology

The empirical material underpinning this article is from fieldwork conducted as part of a broader research program of the Regional Network for Equity in Health in east and southern Africa (EQUINET) supported by the International Research Development Centre (Canada) on global health diplomacy in east and southern Africa. The research took place between October 2012 and June 2013, in which 101 people participated in hour-long semi-structured interviews in Geneva, South Africa, Tanzania, Washington DC, and Zambia (Barnes et al., 2014 & 2015). South Africa, Tanzania and Zambia were selected as cases because they exhibit essential variables for comparison, including: 1) recent or ongoing PBF projects associated with the World Bank and GFATM; 2) ongoing PBF negotiations with the World Bank and GFATM; and 3) had diplomatic missions in Geneva engaged in negotiations on global health policy. There were two main differences deemed useful for cross-country comparison: 1) the percentage of overall health budget for each of the case studies was significantly different in terms of national reliance on external funding, allowing comparison in terms of how budgetary dependence allowed for better or worse negotiating position; and 2) each case country had stated different forms of 'success' in ongoing negotiations with the World Bank and Global Fund. In all cases, the self-definition of success in terms of negotiated outcome suggested mixed perceptions of quality that provided illuminating insights on African diplomacy in terms of PBF programs and the policy aims of GHD more broadly.

To capture individual African actors' understanding of negotiated PBF, a mixed qualitative methodology was employed to ensure that the theoretical, historical and empirical aims of the research were fully met. Secondary sources drew on existing academic literature and policy documents on PBF and participation in global health and international development (Barnes et al., 2014). Primary research was based on policy analysis, semi-structured interviews, participant observation and stakeholder analysis. The interviews followed a thematic guide that included: 1) association with PBF and professional background; 2)

understanding of PBF; 3) knowledge of decision-making and negotiation processes; 4) influence on process; and 5) contextual aspects of strategic planning, input and outcomes of PBF. The sample size of 101 participants was deemed suitable to generate significant results because: 1) stakeholder analysis located the main actors involved in PBF negotiation at the outset and ongoing stakeholder analysis was allowed as processes of snowballing revealed new stakeholders during interviews; 2) there was variation in the elite stakeholders interviewed, with interviews across the different sectors represented (government, civil society, private sector, external funders); 3) the data became saturated (repetition of data across interviewees); and 4) qualitative interviewing and analysis is well suited to capture subjective/intersubjective understandings as they relate to PBF and processes of negotiation. This is because qualitative semi-structured interview techniques allow for greater investigation for why a particular view is held by an interviewee as well as to allow follow-up questions to uncover the underlying rationale for why such a view was held.

During the analysis phase, main concepts and themes were identified through familiarization with the interview material. Familiarization took place during interviews and by thoroughly reading through the transcripts. Thus, there was no clear-cut border between the interview phase and the analysis phase. The floating character of this analysis allowed the researchers to better understand the subject of inquiry, which related to perceptions of participation in PBF and the perceived quality of that participation. Further analysis of the research data progressed in an iterative way using thematic analysis (sorting, labeling, summarizing data using predefined concepts such as understanding, assumptions, rationales and meanings), while also identifying new, emergent themes, detecting patterns and developing explanations to answer research questions. The analysis below represents key categorizations.

Analytical Framework

The original EQUINET Discussion Paper (Barnes et al., 2014) analyzed the data via the thematic analysis described above. In this article, we have extended analysis by employing Zartman and Berman's (1982) *negotiated agreement model* as an analytical framework to catalogue and analyze the empirical material. This framework was selected because of its wider recognition as an instrument that can help locate and classify key negotiation spaces, phases, and internal modes of operation (Lewicki et al., 2009). Zartman and Berman (1982) distinguish three phases of negotiation between interested parties to reach agreement. First, negotiations generally display a *diagnostic phase* where key problems, issues and goals of mutual concern are identified, presented and prepared for deliberation. Second, negotiations also contain a *formula* phase, where a shared, normative and deliberative framework is specified and delineated. Third, all negotiations go through a detailed phase of deliberation, contestation, debate and exchange, where the specific terms of an agreement are enumerated, codified and accepted. In general, but not in all cases, successful diplomatic negotiations will result in agreement regarding three strategic factors: 1) the exact specification of the agents who are bound by the agreement;

2) the exact terms of agreement in relation to who has obligations and the expected delivery of those obligations; and 3) exact enumeration of the agreement's length or time limit. It is in this final *negotiation* phase where requirements/mechanisms regarding policy implementation, monitoring and arbitration of future disputes are stipulated and defined. Moreover, this model was selected because it has historical application in relation to analyzing global health diplomacy specifically and thus has a level of acceptance as an analytical heuristic that can contextualize negotiation processes (Lister and Lee, 2013).

Although Zartman and Barman offer a useful model for understanding various phases of negotiation, they do not provide criteria to determine the quality of negotiated agreements and/or the factors required to deliver long-term and continued policy success. As suggested by Berridge (2005), 'good' diplomacy involves the development of relationships and mutual understanding that provide a context for meaningful continuance of negotiations toward the long-term resolution of collective action problems. The negotiation criteria for developing these forms of 'mutually consistent', long-term relationships include enhancing perceptions of trust, creating clear processes for effective communication, generating perceived win-win outcomes and assuring mutual agreement via consensus (Raiffa, 2007; Lister & Lee, 2013, 82). In addition, it is generally accepted that these conditions are significantly undermined by perceptions of force, coercion, asymmetric power, unclear decision-making procedures, a lack of reason-giving and limited or unidirectional arbitration mechanisms and accountability chains (Starkey et al., 2010). For our purposes, if the ultimate aim of GHD is to "result in both better health security and population health outcomes for each of the countries involved as well as improving the relations between states and strengthening the commitment of a wide range of actors" (Kickbusch et al., 2013, 4; Drager, 2001), then the aims of GHD ultimately depend on the perceived quality of the health negotiations involved. As will be argued below in relation to the negotiation of PBF, the findings of this study suggest that current PBF modalities undermine these negotiation ideals and that problems of asymmetrical power and influence continue to significantly affect diplomatic relations as they concern African actors and global health financing.

Results and Discussion

As indicated above, Zartman and Berman (1982) distinguish three phases of negotiation between interested parties active in reaching agreement: a diagnostic phase, a formula phase and a negotiation phase. The case evidence suggests mixed perceptions about the quality of PBF negotiations across the three phases, which provide insights on African diplomacy in terms of negotiated PBF programs and how the quality of these outcomes are often asymmetrically skewed by power and influence.

Diagnostic Phase

All negotiating parties interviewed (Tanzania, Zambia, South Africa, World Bank and GFATM) broadly agreed on the general state of global health and the combined factors that are motivating the need for increased GHD and global

health financing, namely: 1) the disease burden in Africa represents a priority for global health and for global health financing in particular; 2) external financing is required and should be promoted through increased finance partnerships; 3) external funders prefer PBF as the mechanism for delivering global health financing, and; 4) global health targets, including those in the Millennium Development Goals (MDGs), inevitably play an important role in PBF target setting between external funders and recipients.

Although the results above raise intriguing questions about the scale and depth of *norm diffusion* between negotiating parties, for the purposes of this article, it is the apparent acceptance of PBF as a preferred modality of health financing that reveals interesting diagnostic openings and closures for African diplomats within negotiation processes. In particular, in all cases examined, there is clear *diagnostic favouritism* for PBF modalities by funders at national and global levels, and an acceptance that PBF is an effective funding mechanism for health systems, despite inadequate evidence to support this view (Emmert et al., 2012; Eijkenaar et al., 2013; Eldridge and Palmer, 2009; Ireland et al., 2011; Magrath and Nicther, 2012; Montagu and Yamey, 2011; Scheffler, 2010; Witter et al., 2012). Within the interviews, it was possible to locate four rationales seen as underwriting (rightly or wrongly) the current push for PBF in global health (Barnes, et. at. 2015). First, PBF was suggested as a mechanism to better monitor health interventions, thus providing more reliable information for increased evidence-based policy. Second, there was belief that PBF either limited corruption or was a mechanism designed by external funders to help curb corruption through stronger accountability mechanisms. The third rationale was that PBF was a mechanism to increase value for money and limit waste. Fourth, members of GFATM Secretariat stressed their belief that PBF is about being accountable to those most in need by only funding projects that "impacted on peoples well-being in measurable and meaningful ways" (GEN1, Sept. 2013).

However, these views were not always collectively shared by country representatives in Geneva or by respondents within the case countries themselves, who often suggested that accountability was hierarchical at GFATM with priority given to the demands of the funders (GEN2, Sept. 2013; TNZ1, Nov. 2012; ZAM1, Jun. 2013; TNZ2, Oct. 2012; SA2, Sept. 2013; SA1, Sept. 2013). In relation to the World Bank, one national health mission to the UN argued that PBF is an external funder-led initiative to 'conditionalize' funding and that "it might not be in the best interests of African states" because these conditions are "something all applications must conform to regardless of whether it is right for that particular applicant" (GEN2, Sept. 2013; Barnes et al., 2015).

In this regard, the rationale for PBF in global health policy was not always clear and questions remain as to why it has become the 'only game in town' for health diplomacy. In particular, respondents from the WHO stressed that there was a general lack of debate about PBF and that it was often assumed or accepted that it was the most effective mechanism (GEN6, Sept. 2013). This belief in the effectiveness of PBF was widely held despite an inability by many respondents to cite concrete evidence. At best, respondents were able to point to a small number

of particular cases where PBF had been seen to be effective, such as in Rwanda and Burundi, but the direct evidence for such claims was often admitted to be based more on "everyday conversations and not from any report or evidence" (GEN3, Sept. 2013).

In terms of how the preferred status of PBF affects the *diagnostic quality* of a negotiated agreement, the evidence suggests that the way PBF is structuralized by the World Bank and GFATM closes off other potentially more suitable modalities for delivering funding. In other words, the intellectual *space* available to conceive of alternative models for finance negotiation is restricted within the diagnostic phase due to the dominance of PBF and the pressure to accept it as the only topic for health negotiations. As one WHO representative stated,

> *"I don't think there is a great deal of argument taking place about the risks of these types of funding mechanisms … on the whole donors and consultants are in favour of target-driven financing and they have successfully entrenched this as the primary mode of operation" (GEN4, Sept. 2013).*

Another senior African representative to the WHO further indicated that,

> *"there is not much scope for discussing funding modalities … I mean it does come up, but more in terms of the system needing targeted aid, and more of it. We largely discuss policy in terms of priorities, strategy and practice, not on the details of aid delivery" (GEN5, Sept. 2013).*

A number of interviewees expressed a level of frustration that PBF was not being 'properly' and 'fully debated' at the WHO or with funding institutions themselves because of its 'unquestioned status' (GEN2, Sept. 2013; GEN4, Sept. 2013; GEN6, Sept. 2013). What this suggests, is that within global health diplomacy, the *diagnostic phase* of the PBF negotiation process is essentially fixed, with negotiations mainly taking place about how to get funding or to implement PBF in Africa, and not about the overall appropriateness of PBF as a health reform tool itself.

Formula Phase

The case evidence suggests that there is broad accord between negotiating parties (funders, national/principal recipients) about the normative principles that should ideally underwrite PBF procedures and that these principles should act as foundational aims for negotiated agreement. For example: 1) there is unified recognition that PBF agreements should reflect the *2005 Paris Declaration on Aid Effectiveness* (PDAE, 2005), which stresses national ownership, alignment, harmonization, managing for results and mutual accountability; 2) there is unanimous stakeholder commitment to both the *2008 Accra Agenda for Action* (AAA, 2008) as well as MDG Goal Eight, stressing that health diplomacy should represent the building of 'partnerships for development'; 3) there was stated stakeholder agreement that mutual accountability was required and that the quality of health partnership should in

some way represent an equitable distribution of obligatory benefits and burdens across all parties. As a result, in relation to the ideal aims of negotiation, there is general understanding between stakeholders regarding what PBF negotiations should aim to capture as well as recognition of the MDGs as goals from which the success of health diplomacy should be ultimately judged. This meta-theoretical understanding resonates with the previously outlined criteria deemed necessary for fostering 'mutually consistent' negotiations (Raffia, 2007; Starkey et al., 2010) and the basic diplomatic negotiating conditions required to satisfy the long-term aims of GHD (Berridge, 2005). However, despite a basic meta-theoretical understanding regarding what the procedures and outcomes of PBF should normatively resemble, as will be illustrated below, the current practice of PBF negotiations exhibit inherent asymmetric tensions in its perceived quality, which suggests a sizeable distance between theory and practice.

Negotiation Phase(s)

The research findings revealed three general sublevels for negotiation within the bilateral *negotiation phase* of the PBF diplomacy process. These sublevels related to: 1) negotiations to set performance-based targets; 2) the final terms of negotiated agreements and contracts; and 3) ongoing negotiations associated with the monitoring, evaluation and arbitration of performance satisfaction.

Negotiating targets

When asked about the sense of partnership and national ownership with GFATM and the World Bank, several interview respondents revealed that although most targets were 'owned' and negotiated, the actions of both funders steered negotiations in particular ways (albeit by different means as discussed below). GFATM, for example, was regarded as forcing 'conditional compliances' that are not nationally owned. Thus, although most interviewees across all cases felt that national governments can set health targets, there was widespread agreement that there was almost no ability to set 'conditional targets' such as accounting mechanisms, evaluation tools or reporting schemes. In addition, nearly all recipients suggested that GFATM is inflexible in this regard, and there is constant external demand to change existing governance systems to meet exact GFATM procedures (Barnes et al., 2015). As a negative example in South Africa, GFATM required certain procedures for archiving records, yet this went against national privacy protection laws. When asked about what this means in terms of equitable GHD, one top health official suggested, "this makes us question how mutual the partnership is, since the GFATM would not budge on this condition despite the fact that it would violate domestic law" (SA2, Feb. 2013).

Some of those interviewed across all case studies suggested that in developing a contract and setting targets and indicators within PBF schemes, the World Bank had effectively steered many of the types of targets within their PBF programs through dialogue. As one Tanzanian official claimed, "The World Bank had a number of key interventions that they wanted to see implemented and they were very firm in their demands" (GEN5, Sept. 2013; TNZ3, Nov. 2014). In the Zambian case, many interviewees believed that the World Bank pushed Zambia to run a pilot program because they required more test trials to support their

PBF evidence agenda (GEN3, Sept. 2014; ZAM2, Nov. 2014; Barnes et al., 2015). In setting final targets, most interviewees related that the Zambian government was able to push its own agenda, but that "the World Bank certainly had its own ideas" which had to be incorporated into the final PBF agreement and were, to some extent, non-negotiable, since the conditions were attached to the possibility of receiving much needed funding (GEN3, Sept. 2013). As a result, interviewees revealed a high level of frustration at cumbersome or dogmatic conditionalities set by the World Bank and GFATM. According to one country representative in Geneva,

> *"this is not partnership and although PBF is good, it can't be rolled out exactly the same way everywhere and better distinctions of capacity and localized strengths and weaknesses need to be made" (GEN2, Sept. 2013).*

Although there was evidence of recipients having the ability to pursue and secure particular interests during PBF contractual negotiations, the scope for negotiated 'push back' was different in the case of South Africa. In both South Africa and Geneva, interviewees suggested what appears to be a greater ability for South Africa to resist the demands of external funders during initial negotiations about PBF agreements, targets and indicators. The reasoning for this ability to push back was reportedly linked to South Africa having a stronger economy and less reliance on external funds (SA1, Feb. 2013; GEN2, Sept. 2013; Barnes et al., 2015). From this it was implied that the percentage of total health budget reliance on external funders (South Africa 2.1%, Tanzania 40.2% and Zambia 27.8%) influences the scope of effective push back and the ability to resist asymmetrical conditions during PBF negotiations. Nevertheless, South African recipients generally felt that external funders involved in the GFATM process did attempt to steer deliberations toward certain target areas or target outcomes in line with particular donor interests. Several interviewees suggested that GFATM would make strong hints in relation to the type of outputs that would be "more likely to be approved by the Technical Review Panel" and to firmly suggest what sorts of target deliveries would be deemed successful. In its most cynical form, one national health representative went so far as to suggest "that PBF is not a partnership or representative of 'national ownership'" (GEN2, Sept. 2013; SA2, Feb. 2013). As this interviewee suggested, PBF targets and mechanisms might be fairly negotiated in some cases, but that in southern Africa, and indeed elsewhere, funders often dictated the parameters for possible agreement in advance, closed off areas as non-negotiable, and "expect[ed] the applicant to do as they are told" (GEN2, Sept. 2013). Although at this point only speculative, our evidence does raise questions about the relationship between budgetary reliance and negotiated PBF outcomes and to what degree less reliance on external funding increases the possibility for more mutually consistent outcomes.

Codifying agreement

One particular finding that cut across all case studies was that the World Bank and GFATM often changed or amended targets at the last minute or during the implementation phase (Barnes et al., 2015). These alterations could take the

form of line items being struck from a grant document just before implementation or could take the form of requests to add certain provisions to official documentation as the PBF projects were scaling up. For example, in South Africa, a member of UNAIDS who has worked with many recipients in Africa argued that GFATM often "changed the goal posts and as a result lost the trust of many partners" (SA3, Feb. 2013). In addition, several private sector actors suggested that "the private sector dislikes uncertainty, especially when investment is involved" and the fact that GFATM continued last minute alterations was threatening future public-private partnerships (SA4, Feb. 2013). In Tanzania, officials suggested that having to accept last minute changes was part and parcel of the funding relationship, claiming that

> *"we are the ones that want the money, they always have the upper hand… okay they bring that one there, you read through it, it has all the conditions… we end up saying okay" (TNZ1, Nov. 2012).*

Another Tanzanian described this relationship as "nobody wants to shout at the paymaster" (TNZ2, Oct. 2012), which was mirrored in Zambia, where one ministry official suggested that you do what the funders want "because they are the ones who hold the purse strings" (ZAM1, June 2013).

The stated problem with such alterations was that they were seen as unidirectional, where the external funders could make requests as conditions changed, but that recipients were not able to amend project targets easily as new information became available or as conditions on the ground changed. As a result, many interviewees questioned the quality of and scope for negotiated arbitration in relation to building trust and clear communication processes, claiming, "although we are participating in discussions, the effectiveness of those discussions is often not equally distributed" (SA2, Feb. 2013).

<u>Monitoring, evaluating and arbitrating negotiated agreement</u>

The research revealed a further concern with the monitoring, evaluation and arbitration of PBF, especially as it related to the ability of African actors to negotiate a mutually consistent outcome in the face of changing circumstances. As Spector and Zartman note (2003), effective agreement requires the ability to monitor and arbitrate the conditions of an agreement and to ratify agreements in light of new evidence. Furthermore, the criteria for understanding the quality of negotiation and increased GHD outcomes requires trust building through effective communication channels, multidirectional decision-making processes, reason-giving, perceptions of win-win outcomes and mutual agreement (Raiffa, 2007; Starkey et al., 2010; Berridge, 2005; Lister & Lee, 2013). Yet, PBF processes were far from straightforward in this regard and revealed a clear asymmetry and hierarchy in negotiating position, particularly in Tanzania and Zambia. First, external funders often requested African actors to alter reporting systems, sometimes without sufficient warning or detailed explanation. For example, the *Payment for Performance* (P4P) project in Tanzania was accompanied last minute by a further demand by the World Bank for additional indicators to be incorporated into their Health Management Information System

to meet Bank standards (Barnes et al., 2015). Second, it was commonly related that funder reporting schemes could be changed mid-project with little consideration of the ramp-up time needed. According to different high-level officials in South Africa, "the Fund continues to change the conditional regulations, but not always with sufficient warning" (SA2, Feb. 2013). This ability to change reporting systems without additional negotiation or consultation was not only seen by many African actors as undermining effective program implementation, but also as an unfair ability to dictate non-negotiable terms.

Like monitoring above, the evaluation of performance is a key aspect of PBF agreements and, in theory, there should be entry points for different actors to negotiate outcomes. In practice, however, evaluation was also seen as a point for *closing* down negotiations, given that any sign of non-performance could result in grant/loan termination. Furthermore, given that PBF tends to involve the changing of goalposts after contracts/project agreements have been signed, actors often found it difficult to understand what constitutes adequate performance and, therefore, any delay by extending negotiations was deemed as a disproportionate risk to recipients (Barnes et al., 2015). For example, this sense of uncertainty and risk associated with PBF was reported throughout the Zambian case and at all levels; with health workers suggesting uncertainty about what performance meant and what avenues existed for additional discussions when discrepancies occurred within the evaluation process (Barnes et al., 2015). Lastly, nearly all interviewees held the belief that there was "zero flexibility when it comes to meeting targets" and that additional room for negotiation regarding performance evaluation was often closed off by both the World Bank and GFATM (SA6, Feb. 2013; Barnes et al., 2015). A further lack of GFATM flexibility in the face of external circumstances beyond the control of recipients was also illustrated. As one UNAIDS official remarked,

> *"There is no flexibility in regards to external circumstances. This is particularly problematic in cases of extreme currency fluctuations where funds can be reduced by 20% within a quick period of time leaving principal recipients underfunded, yet responsible to deliver the same targets agreed to prior to the economy tanking" (SA3, Feb. 2013).*

Lastly, another common theme across the three case studies related to a general understanding that current GFATM auditing systems did not allow for additional negotiations and that the structure was unidirectional and thus antithetical to notions of mutually consistent settlement as defined by Raiffa (2007) and Starkey et al., (2010). Respondents held this view because there was often limited reason-giving or feedback process, no ability to see accounting reports and limited ability to discuss the reports with the auditing Local Fund Agent (LFA). As one former LFA auditor himself said,

> *"There was absolutely no dialogue between the recipient and the LFA. The reporting system is not transparent on the LFA side… the LFA is reluctant to provide support during the report write-up phase. Each report takes about*

> *1.5 months to assemble and there is no partnership in this process" (SA5, Feb. 2013).*

More broadly across the three case studies, African actors often stated an uncertainty about how to take arbitration cases forward, the procedures involved or what legal jurisdiction or laws applied (Barnes et al., 2015). This suggests, along with the aforementioned issues, that the *quality* of negotiations within PBF schemes remains wanting, particularly in relation to the more normative understandings of global health diplomacy as a potential mechanism to coordinate mutually consistent and agreed health policies that will "ultimately improve and save lives" by improving long-term diplomatic relations (Marten et al., 2014).

Conclusion

African actors within national governments generally set and negotiate performance targets of PBF schemes, yet the quality of PBF negotiations with external funders remains inconsistent in practice, suggesting the existence of asymmetrical power and influence in relation to the quality of those negotiations. This raises questions about the level of power and influence being exerted by external funders and how much negotiation leverage African political actors have available to them within global health diplomacy. African negotiations are often stymied at various phases of the PBF negotiation process, and evidence suggests that the financial mechanisms offered by external funders steer and limit the quality of these negotiations themselves. This is largely because certain aspects of PBF are often closed off and restricted from negotiation, which is institutionalized at each phase of Zartman and Berman's *negotiated agreement model* (1982). These closures come in the form of PBF ideational dominance that closes out finance alternatives. This comes in the form of non-negotiable grant/loan conditionalities that set limits to the types of health interventions or targets available for negotiation. In addition, it includes non-negotiable reporting, evaluation and arbitration mechanisms that inherently restrict further abilities to negotiate agreement alterations in the face of changing conditions on the ground. African actors could of course seek to challenge these restrictions more overtly, yet this would risk conflict and the subsequent closing down of access to health systems funding. If we are to judge the quality of African health diplomacy in relation to the quality of PBF negotiations within global health policy, then PBF, as it is currently practiced, exhibits asymmetrical power and influence by funders that greatly affect diplomatic relations and the future success of GHD.

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Disclaimer of interest

The authors declare that they have no competing interests.

Interviews

GEN1 (2013). Interview with member of the Global Fund to Fights AIDS, Tuberculosis and Malaria, September, Geneva.

GEN2 (2013). Interview with country representative to the World Health Organization, September, Geneva.

GEN3 (2013). Interview with country representative to the World Health Organization, September, Geneva.

GEN4 (2013). Interview with African Regional Representative, September, Geneva.

GEN6 (2013). Interview with member of UNAIDS, September, Geneva.

SA1 (2013). Interview with member of South Africa National AIDS Council, February, Pretoria, South Africa.

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SA3 (2013). Interview with member of UNAIDS, February, Pretoria, South Africa.

SA4 (2013). Interview with private sector representative and former CCM member, February, Pretoria, South Africa.

SA5 (2013). Interview with former KPMG and Local Fund Agent, February, Pretoria, South Africa.

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