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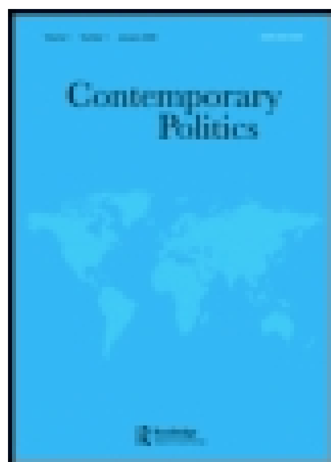

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The European Union and transnational health policy networks: a case study of interaction with the Global Fund

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This article examines the nature of the engagement between the European Union and the Global Fund created to combat HIV/AIDS, tuberculosis and malaria. The authors reveal that in relations between the EU and the Fund, influence is reciprocal although asymmetrical with the EU commanding more leverage. They also contend that the EU considers its engagement with the Global Fund as successful to the extent that the success of this interaction is contingent on the Global Fund's capacity for implementation. They conclude that the relationship between the EU and the Fund will continue for the foreseeable future.

Keywords: Global Fund; the European Union; health; networks; development; HIV/AIDS; malaria; tuberculosis

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Along with *international health knowledge networks*, which link experts, scholars and health practitioners transnationally whose aim at developing and sharing medical and public health knowledge to occasionally inform and influence policy-makers,[1] and *transnational advocacy networks in health* composed of varied actors mobilized to raise awareness on a particular health-related problem; transnational *public–private partnerships* (PPPs) have progressively emerged as a central feature of the global health landscape and as the most visible, institutionalized and influential illustration of transnational policy networks (TPNs) in the health sector.

In the domain of health, the EU has been engaged with several of these transnational actors and developed different relationships with each of them. Today, one of the PPPs in health with which the EU has developed a rather comprehensive relationship remains the Global Fund for the fight against AIDS, malaria and tuberculosis (TB) (Global Fund).

Consequently, in this article, after an overview of the recent evolution of the research agenda on PPPs as well as of the EU's interaction with such partnerships in the sector of health, we propose to focus on the EU's engagement with the Global Fund. In this context, in reference to the lines of inquiry expatiated on in Kingah, Schmidt, and Yong (2015), we aim to answer

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the following questions: What is the type of interaction the EU has developed with the Global Fund? Does the EU influence the Global Fund and if so how? Does the Global Fund influence EU's policy and decision-making processes and if so how? Can the EU's engagement with the Global Fund be considered successful? And finally, is greater engagement with the Global Fund and similar transnational PPPs in the health sector a strategy the EU should pursue or forfeit?

1. Transnational PPPs in health and their interactions with the EU

1.1. *Nature, origins and challenges of transnational PPPs in the health sector*

Transnational PPPs are in general defined as 'a collaborative relationship which transcends national boundaries and brings together at least three parties, among them a corporation (and/or industry association) and a shared health-creating goal on the basis of a mutually agreed division of labour' (Buse & Walt, 2000a, p. 550). It is important to underline that PPPs are not only per se transnational as during this last decade the health sector has witnessed the emergence of numerous domestic PPPs which in some aspects face similar problems with their transnational counterparts. However, for our purposes, we will only focus on transnational PPPs which represent an illustration of TPNs.

According to the 'Initiative on Public–Private Partnerships for Health' developed by the Global Forum for Health Research, there is today in the health sector around 91 transnational PPPs which are very diverse in nature (Open University, 2015). Indeed, some PPPs are global (Global Programme to Eliminate Filariasis) while others are regional (African Malaria Partnership), some focus on a specific disease (Global Alliance to Eliminate Leprosy) while others cover large thematic areas (Alliance for Health Policy and Systems Research) or aim at developing products (International AIDS Vaccine Initiative (IAVI)). Last but not least, some engage a limited number of private and public actors (PPP for Chlorproguanil-dapsone (LAPDAP) against malaria) as others involve numerous stakeholders (Children's Vaccine Initiative). In such a context, several scholars have developed different classifications of PPPs in the health sector in order to better define, study and compare them. Such classifications have been developed in light of the specific health problem the PPP seeks to address (TB, HIV/AIDS, malaria, filariasis, among others), the constituent membership or the organizational forms of such partnership (Mitchell-Weaver & Manning, 1990), but also in reference to the nature of their activities (consultation, concertation and operational functions) (Buse & Walt, 2000b, p. 700), their management (Widdus, Chacko, Holm, & Currat, 2001), or to their goals/purposes (Kickbush & Quick, 1998, p. 69; Buse & Walt, 2000b, p. 700). Although the diversity of the proposed categorizations have not always helped the reader to better appreciate the very nature of these PPPs and while so far there is consequently no common typology of PPPs in the health sector, it is, however, possible to identify in the academic literature four main criteria generally used – independently or crossways – to categorize such partnerships. Indeed, PPPs in the health sector might be classified in view of (1) their scope (local, national, regional and global), (2) the nature of the public and private partners, (3) the level of commitment of the partners to the partnership (governance level, managerial level or operational level as well as financial contributions) and (4) on their purpose (product-based, product development-based and issues/systems-based) (Mitchell, n.d., p. 10; Buse & Walt, 2000b, p. 700).

Simultaneously to this analytical tool that we will apply to present the Global Fund later on in order to have a better understanding of its very nature, several issues have also emerged from and fuelled the academic debate on transnational PPPs in the health sector. Indeed, one of the basic points of contention about such PPPs is related to the origin and reasons of such arrangements. In other words: Why have public and private actors decided to partner in health? For most

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scholars, the emergence of PPPs was the result of a modification in the private and public relationship, namely a rapprochement of both sectors initiated in the 1980s. Buse and Walt explain this evolution in the health sector by an ideological shift in economic philosophy calling for a health market mechanism that includes private and public actors; the growing disenchantment with the UN and its agencies; and the acknowledgment that public or private sectors cannot work independently to face health issues and that they have developed through their activities a high level of interdependence (Buse & Walt, 2000a, p. 558). Similarly, for Mitchell, the emergence of PPP in the health sector is a direct consequence of a new appreciation of the roles of the private and public sectors in the field; the recognition by both sectors of their interdependence; and a better understanding of the potential gain for the actors involved in such partnership.

This last point leads us to another recurrent question about PPPs in health, namely the main motivations or interests driving each partner to be involved in such initiatives. Interestingly, the academic literature on PPPs in health reveals that beyond the claimed and collective objectives of such partnerships, multiple reasons – hidden or not – can be identified: direct and indirect financial benefits (tax evasion, financial support and investment opportunities), transfer of technical knowledge, brand and image promotion, publicity for philanthropy, legitimacy, authority, influence as well as prestige (Mitchell, n.d., p. 9; Buse & Walt, 2000a, p. 556). Although financial benefits remain important motivations, others exist, and these other incentives continue to be very influential depending on the situation and the actor. Consequently, identifying such dynamics remains an important task for scholars – although sometimes challenging – in order to fully understand PPPs and notably the very nature of the involvement of its partners, which defend different ethos and principles.

Understanding what leads to successful PPP involvement in health has also been frequently debated by scholars (Mitchell, n.d., p. 3; Monaghan, Malek, & Simson, 2001, p. 46). In general, three main conditions are underlined by most authors: (1) legal and regulatory framework, (2) common understanding, that is, delineated and agreed objectives, roles and responsibilities and (3) transparency and equality. To these conditions of success, other elements have been also mentioned such as actively sustaining the partnership, meeting agreed obligations, equality of participation, accountability or consumer participation. While referring to PPPs' 'effectiveness', Buse and Walt recognized that 'it remains difficult to estimate the actual or potential health consequences of GPPPs' and even point out that 'it is not axiomatic that all GPPPs are necessarily good for health' (Buse & Walt, 2000b, p. 706). Many PPPs have been recognized by the academic community as successful for being able, for example, to develop and register new medicines (PPP for new antimalarial, LAPDAP) (Lang & Greenwood, 2003), to highlight the lack of product R&D in neglected disease and attracting new resources to face these issues (Hookworm Vaccine Initiative, Leishmania Vaccine Initiative) (Wheeler & Berkley, 2001), or to improve the access of the poorest to medicines (Albendazole Donation Programme against lymphatic filariasis) (Hopkins & Molineux, 2009).

While transnational PPPs in the health sector have generally been considered significant contributors to global health (Widdus, 2005, p. S2), as providing an 'efficient model' (Croft, 2005, p. S9) of investment and even 'unavoidable and imperative' (Nishtar, 2004, p. 9), being relatively new, they have also generated feelings of uncertainty about their evolution and future. Furthermore, at least two different types of challenges have been identified and intensely discussed, namely ethical and governance challenges.

About ethical challenges of transnational PPPs, scholars point out several aspects such as the danger that PPPs reorient the mission and the priorities of the public health sector and then jeopardize equity in health (Zwi & Asante, 2007, p. 177) and the risk that the public sector considers PPPs as opportunities to renounce to its responsibilities with terrible consequences for the most vulnerable citizens (Pearson, 1999). Others include the loss of independence of the WHO when it

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is engaged in PPPs; the strong influence of the private sector on its international standards (Ferriman, 2000; Woodman, 1999); the threat of instrumentalization of PPP by some partners for their own interests and the menace of several conflicts of interest sometimes at the expense of public health (Nishtar, 2004, p. 5).

Simultaneously, scholars have identified numerous governance challenges that PPPs in health have to face. Among them are the legitimacy of the partners represented in the PPPs and the place given to the recipient country partners, the limited accountability of the PPPs to their donors and beneficiaries, the role and influence of the UN agencies often financially weak and perceived as over-bureaucratic and inefficient, or the real level of financial contribution of the partners, the relative costs and risks of the involvement of each of them and the sustainability of funding (Buse & Harmer, 2007; Croft, 2005; Martin & Alachmi, 2012). All these points have been vividly debated by scholars and health professionals with the main objective of underlining dangers and inefficient behaviours as well as to help most transnational PPPs to become significant contributors to global health.

To respond to these challenges, some scholars have proposed to create a set of global principles and norms to assist such partnerships (Nishtar, 2004, p. 9), to develop operational strategies for UN agencies to enter into PPPs (Buse & Waxman, 2001, p. 751) or to implement actions to assist PPPs to adopt better habits in the health sector (Buse and Harmer, 2007, p. 270). The WHO has since the 1990s developed institutional safeguards (guidelines) – although not completed yet – to counterbalance potential risks (Richter, 2004, p. 1).

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1.2. *EU's engagement with transnational PPPs in health*

As a significant global and regional health actor (Rollet & Chang, 2013), the EU has so far been engaged in multiple ways with many transnational PPPs in the health sector. As an illustration, the EU, represented by the European Commission, is a donor (€68 million from 2003 to 2011) to the Global Alliance for Vaccination and Immunization (GAVI Alliance), which aims to increase access to immunizations in poor countries and recently pledged to increase its support to this PPP to €175 million for 2014–2020 (GAVI, 2015).

Besides, within the context of its Framework Programme for Research and Technological Development (FPs, Horizon 2020), the EU is also the main donor to numerous international consortia working on health, which represent transnational PPPs as they involve public and private sectors from different countries. Thus, from 2003 to 2009, the EU financed (€15 million) an international research consortium – MUVAPRED – composed of 30 partners coming from the public sector (UK Health Protection agency, Italian National Council for Research) as well as a private one (Novartis, Inotech AG) and focusing on the development of mucosal vaccines against AIDS and TB.

The EU is furthermore an operational partner to some PPPs in health. It is notably the case of its engagement with IAVI, a transnational PPP founded in 1996, which aims to ensure the development of safe, effective, accessible, preventive HIV vaccines for use throughout the world. Indeed, within the framework of the joint partnership signed between the EU, represented by the EC and IAVI in 2001, the EC AIDS Vaccine Task Team is cooperating closely with IAVI on regulatory issues and incentives to develop and ensure access to AIDS vaccines in developing countries as well as on the acceleration of R&D programmes for AIDS vaccines and the establishment of effective public/private support to clinical trial platforms (IAVI, 2001).

The EU plays a double role as partner as well as the main funding institution of a regional PPP in the life sciences (€3.2 billion – presented as the world's biggest in this domain). This mainly includes the Innovative Medicines Initiative (IMI), which is a joint undertaking created in 2008 between the EU and the European pharmaceutical industry association (EFPIA) to improve health

by accelerating the development of innovative medicines and patient access to them, particularly in the most vulnerable areas.

Finally, it is important to underline in the context of such engagement that transnational PPPs have also sought to influence – with varying degrees of success – health policy-making at the EU level. An example is the case of IAVI, which presented their position at the consultation on the Green Paper on a common strategic framework for EU research and innovation funding in 2011 with the main objective of providing technical input to the development of the EC's AIDS vaccine strategy (IAVI, 2011). Regardless that the EU's engagement with transnational PPPs in health became a trend which evolved rapidly and that such partnership has been discussed during recent meetings (IMI, 2013), to our knowledge, scholars have not yet focused and developed conceptualized analysis concerning such engagement. This is gap that we would like to address in this contribution by concentrating notably on the EU's engagement with the Global Fund and answering the questions raised in Kingah et al. (2015).

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2. Interactions between the EU and the Global Fund

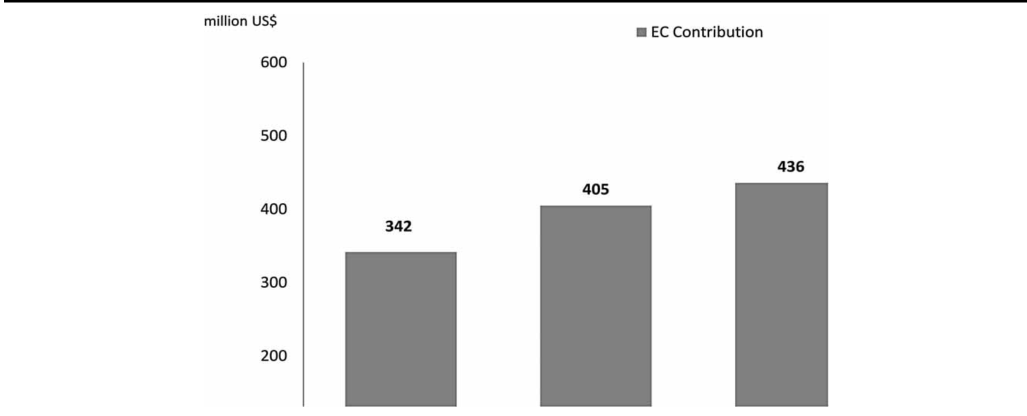
2.1. *The EU as an early and sustainable supporter of the Global Fund*

Established in 2002, the Global Fund is a PPP between governments, civil society, the private sector and affected communities which provide significant additional financial resources for global and national responses against these diseases. These resources are provided according to an operational model based on country ownership and performance-based funding, which means that countries use Global Fund financing to implement programmes based on their own needs and are then responsible for the results and impact achieved. The Global Fund indeed invests nearly US$4 billion to support programmes in more than 150 countries which, as of mid-2014, have helped to put 6.6 million people on antiretroviral therapy for AIDS, to test and treat 11.9 million people for TB, to distribute 410 million insecticide-treated nets to protect families against malaria, to provide 2.5 million women with preventive treatment to protect their babies from infection during and after pregnancy and to treat 140,000 patients infected with multidrug-resistant tuberculosis (Global Fund, 2014a). In this context, the Global Fund today represents the world's largest financing agency supporting HIV/AIDS, TB and malaria programmes in developing countries as it accounts for a quarter of international spending on AIDS and much more (65%) for TB and malaria (Global Fund, 2013a).

In reference to the Treaty establishing the European Community, and in particular Article 179 as well as the Community Programme for Action on Communicable diseases in the context of poverty reduction (2001–2006), the EU has been very supportive to the Global fund since its inception (European Parliament – Council, 2001). Indeed, after welcoming the proposal of the UN Secretary General to establish a Global Fund to fight HIV/AIDS, TB and malaria in a joint declaration with the Council (31 May 2001), the European Commission announced at the G8 Geneva Summit of July 2001, with support of the Community and the Member states, its intention to pledge €120 million to the Global Fund.[2] This contribution then represented around 11% of the total donor pledges, which then reached around US $947 million. Since then, in parallel with the EU Member States' financial support to the Global Fund, the European Commission has sustainably and increasingly supported the Global Fund from the common EU budget and from the European Development Fund (EDF) (Table 1).

In terms of comparison, since 2002, the EC has contributed more than €1.2 billion (US$1.6 billion) to the Fund, making the Commission the sixth-largest donor to the Global Fund, after the USA, France, the UK, Germany and Japan with 5.9% of the total contribution (Table 2). Interestingly, if we consider the entirety of the EU's contribution to the Global Fund by aggregating the

Table 1. Evolution of the European Commission's contribution to the Global Fund (2005–2016).



Note: Based on the multiyear financial cycle of the Global Fund replenishment mechanism established in October 2003.
Source: http://www.theglobalfund.org/en/partners/governments/

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EC's contribution with the EU Member states' ones, as of September 2014, it represents 52% of the total contributions to the Global Fund making the EU the largest donor to the Fund.

With the confirmation of the new European Commission led by Jean-Claude Junker and its strong focus on rendering the EU more competitive economically, questions about the future of EU's support to global health, including to the Global Fund, have inevitably been raised notably by civil society organizations (Global Health Advocates, 2014a). While it is difficult here to predict the evolution of the EU's support to Global Fund, it might be said that so far there is no clear indication that the EU's pledge to Global Fund for the years 2016–2018 will decline from the one made formerly by the Barroso Commission which reached over US$500 million for 2014–2016 period (European Commission, 2013). Furthermore, if we look at another public–private health partnership such as GAVI, the latter recently received a pledge of 200 million euros from the new Junker Commission for the years 2016–2020. Representing a significant increase compared to the former Barroso Commission's commitment (175 million euros). Such an announcement could also be considered as a positive trend for the Global Fund as it clearly confirms the pursuit of the EU's involvement and leadership in global health (Global Health

Table 2. Contributions of the major donors to the Global Fund (as of September 2014).

	Donors	Contributions	Percentage of the total contribution (US$27,522,584,400) (%)
(1)	EU (EC + 28 MS)	US$14,311,743,888	52
1	USA	US$9,135,465,791	33.2
2	France	US$3,717,173,396	13.5
3	UK	US$2,079,126,552	7.5
4	Germany	US$2,044,655,818	7.4
5	Japan	US$1,867,195,584	6.8
6	European Commission	US$1,635,211,681	5.9
7	Canada	US$1,377,963,075	5
8	Italy	US$1,008,260,873	3.7
9	Sweden	US$840,073,940	3.1
10	Netherlands	US$829,438,657	3

Source: http://www.theglobalfund.org/en/partners/governments/.

Advocates, 2015). Efforts to mobilize resources for the Global Fund's 5th Replenishment have started in 2015. The launch of the replenishment campaign has been planned for the second half of 2015 and the replenishment pledging conference during which we will learn to what level the EU will contribute to Global Fund for the years 2016–2018 is scheduled for mid-2016.

2.2. *A significant role within the Global Fund*

From the inception of the Global Fund, the EC played a significant role notably in terms of the Global Fund's governance. Indeed, the EC contributed to the preparatory work for the setting up of the Fund, in particular to the work of the Transitional Working Group[3] for the finalization of preparatory arrangements to bring the fund into operation. Such involvement offered to the EC the opportunity to shape the rules related to management, governance, fiduciary aspects, accountability and legal arrangements for the functioning of the fund to receive contributions.

When the Fund was launched, the role played by the EC within it was strengthened through its presence on the Board of the Fund. The EC was then directly involved in the exercise of the main functions of the Global Funds' Board namely governance oversight, strategy development, performance assessment and risk management. Thus, the participation as member of the EC in the Board's Finance and Operational Performance Committee (FOPC)[4] which oversees the financial management of Global Fund resources and ensures optimal performance in the operations and corporate management of the Secretariat, is vital because it allows the EC to have a say in the decision related to financial key performance indicators or policy framework to guide development of operational policies as well as on the advice made by the FOPC to the Board concerning multiyear budget and cash-flow projections or the annual operating expenses budget.

Similarly, its involvement in the Strategy, Investment and Impact Committee (SIIC) of the Fund has been vital. The SIIC provides oversight of the strategic direction of the Global Fund and ensures optimal impact and performance of its investments in health. These mean that the EC participated in the initial elaboration of the three- to five-year Global Fund institutional strategy as well the discussion of proposals to modify funding policies (e.g. eligibility policies, prioritization and counterpart financing).

In parallel with its presence on the Board and its committees, the EC is also represented in 17 Country Coordinating Mechanisms (CCM)[5] which are country-level multi-stakeholder partnerships, which first develop and submit grant proposals to the Global Fund based on priority needs at the national level and which after grant approval, oversee progress during the implementation of the Global Fund-supported project. As a member of these CCM, the EC participates in the coordination of the development and submission of national proposals, the oversight of the implementation of the approved grant and the submission of requests for continued funding and the decision concerning the authorization of any reprogramming.

2.3. *Interaction assessed*

Engagement between the EU and the Global Fund is considered successful. To evaluate this partnership, the EC, for example, commissioned an external assessment of an independent consulting company in 2011, which concluded that the EC-Global Fund partnership – as the EC-GAVI cooperation – had been very cost-effective, transparent and with great impact on people's lives. Then, every year, in order to remind the EU member states of the value of such a partnership with the Global Fund, the EC promotes how the EU is contributing to the Fund's outcomes and results. So far, this has been made basically by taking the level of money that was used to reach global results and then dividing the part the EC has put to the Global Fund in order to identify the concrete contribution of the EC (Interview with a member from civil society organization,

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November 2014). Thus, representing 7.4% of the overall contribution to the Global Fund between 2002 and 2009, the EC attributes to its financial support the deliverance of antiretroviral combination therapy to 185.000 people with advanced HIV infection, the supply of TB treatment to 444.000 people with positive TB, the distribution of insecticide-treated nets distributed to 7.696.000 people as well as the provision of treatment to prevent mother to child transmission of HIV to 58,460 HIV-positive pregnant women (European Commission, 2010).

More generally, the EC appreciates the Global Fund's focus and its competences as well as its expertise and its capacity to deliver (Interview with official from the European Commission, November 2014). Such confidence between both partners and such positive appreciation of their relationship has not been affected by the past scandals that emerged in 2011 due to fraud and corruption among some recipient countries. Rather, by handling the problem seriously and efficiently, the Global Fund confirmed its reputation as a transparent and reliable partner to the EC and convinced the latter to release the funds frozen in 2011.

This successful relationship as well as the deep involvement of the EC within the governance of the Global Fund have offered the EC a significant role in terms of decision and policy-making of the fund and by extension in the global fight against HIV/AIDS, TB and malaria. However, in this context, did the EC use such privileged position inside the Global Fund as well as its status of major donor to the Fund to influence the decision and policy-making of this PPP?

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3. EU and Global Fund: a reciprocal but asymmetrical influence

3.1. *A substantial influence of the EU on Global Fund's policy-making*

There is no clear indication of the EU's influence on the Global Fund at the first sight but by comparing official documents from the EU and the Global Fund, as well as conducting interviews with EU officials, NGO representatives and Global Fund stakeholders interesting results were generated. Indeed, one domain where the EU's influence on the Global Fund is discernible is policy-making and especially funding prioritization.

A first illustration of such influence can be found in the manner in which the EU has indirectly influenced the geographic allocation of some funding of the Global Fund. Indeed, since its first pledge of €120 million to the Global Fund in 2001, the EU has used two main instruments to finance such promises namely the Development Cooperation Instrument (DCI) – part of the EU budget (Heading IV) – and the EDF. According to the new EC financial regulations, the money coming from the DCI are not supposed to be spent inside the EU. While the Global Fund has significant activities in some EU Member States, this restriction means that that the Global Fund would have to gradually stop funding those EU Member States and therefore the EU would need to find alternatives in those European countries (Interview with official from the European Commission, November 2014). In other words, the geographic allocation of the Global Fund is indirectly influenced by the consequences of the EC's financial rules which exclude the Fund to work in any EU Member states. As regards the EDF, it also imposes on the Global Fund some geographic restrictions as its contribution to the Fund is reserved for African, Caribbean and Pacific (ACP) countries. Thus, the EU imposes on the Global Fund the demand to use part of its financial support to specific countries and then indirectly influences the funding allocation of the Fund. However, given the fact that compared to the total funding budget of the Global Fund, the contribution from the EDF remains inferior; the EU's influence on the Global Fund's allocation of funding through this channel remains relatively weak.

Conversely, the EU's influence on the Fund's funding policy has been stronger and more direct. This has been notably the case in 2012. Indeed, in 2011, in order to increase the impact of EU Development policy, the Commission set out a new approach of poverty reduction entitled 'Agenda for change' (European Commission, 2011). This agenda was then approved by the

Council and the Parliament in May 2012 and became the new EU development policy (Council of the European Union, 2012). One of the specificities of this new policy rests on its more targeted and concentrated allocation of funding which reflects the EU's determination to deploy its resources where they are needed most to address poverty. As it was stipulated in the EC's document:

> Grant-based aid should not feature in geographic cooperation with more advanced developing countries already on sustained growth paths and/or able to generate enough own resources. Conversely, many other countries remain heavily reliant on external support to provide basic services to their people. In between, there is a spectrum of situations requiring different policy mixes and cooperation arrangements. A differentiated EU approach to aid allocation and partnerships is therefore key to achieving maximum impact and value for money. (European Commission, 2011)

Using criteria such as country needs (including economic and social trends, as well as vulnerability and fragility), country capacity, country commitments and performance as well as potential impact to determine the level of its assistance; the EU – in line with the Busan Declaration (OECD, 2011) – has made the clear choice of concentrating its aid money to the 48 least-developed countries and to improve the impact of such assistance.

However, such policy shift has had direct consequences for the EU's support to the Global Fund as according to the Agenda for Change its financial support to the Fund should therefore focus on HIV/AIDS, TB and malaria programmes in the poorest countries. In order to find coherence between this new policy and its support to the Global Fund, in 2012, the EU became particularly vocal in pushing for a reform of the Fund's funding strategy and priorities while it was in a process of an ambitious reorganization of its structure and practices. The main objective of the EU was then to make sure that the Global Fund will go in the same direction as the Agenda for Change. Using its status of member of the Global Fund's Board and of its committees – notably the FOPC and the SIIC – as an instrument of influence, the EU succeeded in convincing the Global Fund to adopt a differentiated approach for its funding policy as it is confirmed in what it has been called the Global Fund's New Funding Model (NFM) unveiled in 2012. The sign of such influence is perceptible in the main objective of the Global Fund which obviously echoes the approach adopted by the EU's Agenda for Change. Indeed, as the Global Fund explains, the main goal of this new strategy is therefore:

> […] to invest more strategically, to make the most of its resources and maximize the impact of its grants. The purpose of the Global Fund's new funding model is to invest as effectively as possible and to reach as many people affected by the diseases as possible. The new funding model ensures predictable funding for those countries with a high disease burden and low ability to pay, and it incentivizes better performing interventions. (Global Fund, 2014b)

> Furthermore, EU's influence is also confirmed by the narrow focus of the Global Fund on the poorest countries which also represents a response to OECD funding policies and to the global direction promoted by international institutions such as the World Bank. This shift is particularly evident in the new allocation of the total funding budget. Indeed, in its March 2014 meeting, the Global Fund Board approved the decision that around 82.4% of the funding budget will be dedicated to lower income countries with higher (76.3%) and lower (6.1%) burden of diseases. (Table 3)

Table 3. Distribution of the Global Fund's funding budget (July 2014).

	Composition (income level, disease burden)	Number of countries	Total funding (billions)	Percentage of the total funding (%)
1	Lower income, higher burden	39	11.3	76.3
2	Lower income, lower burden	18	0.9	6.1
3	Higher income, higher burden	11	1.5	10.1
4	Higher income, lower burden	55	1.1	7.4

Source: Global Fund, Frequently Asked Questions on the NFM, July 2014.

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Such influence of the EU's approach on the Global Fund's funding allocation and its consequence namely the NFM of the Global Fund have raised concerns among the recipients and member of the civil society (Amaya, Caceres, Spicer, & Balabanova, 2014). Indeed, serious reservations have been expressed about the NFM as it might place many countries in the lowest-priority eligibility category, which means that those countries will receive less funding and will have limited opportunities through NFM. As a representative from civil society organization explained:

> A report had estimated that the whole EECA (East European Central Asia) will get 50% less of resources than the previous period (Eurasian Harm Reduction Network, 2013). So a huge decrease of funding […] Because Global Fund is one of the major funders of civil societies and projects towards most vulnerable population in these countries, we were worried that the withdrawal of the Fund from those countries might have a huge impact on the most vulnerable but also on the whole fight against TB and HIV. (Interview with member from civil society organization, November 2014)

Finally, in response to increasing pressure from International NGOs in Europe and recipient countries, the Global Fund accepted to provide a transitional period to those countries in order to offer them the time to react to this new situation and numerous exemptions were put in place for the period 2014–2017. However, today, many civil society organizations worry about the post-2017 situation.

By influencing the negotiations on a NFM for the Global Fund with the support of France and Germany also members of the Board as well as of other European donors (the UK, Italy, Sweden, the Netherlands, among others), the EU has deeply influenced a significant aspect of the Fund's activities, not to mention its whole strategy. If such influence rests on specific facilitating factors such as the EC's important position within the Global Fund governance structure or the EU's (EC + EU MS) level of support to the Fund, it confirms that the EU *is* a global health actor which through its partnership with a PPP such as the Global Fund, is significantly influential in terms of global health policies. In other words, engagement with the Global Fund represents for the EU an incomparable instrument of *soft power* to influence global health governance and strategy according to its own interest.

3.2. *Limited and shared influence of the Global Fund on the EU*

The Global Fund's attempts to influence the EU might be first illustrated by its determination to mobilize European parliaments to push governments to contribute to the Fund as well as the European Parliament to pursue its support to the EC funding of the Global Fund. Interestingly, such attempts to influence European Institutions by the Global Fund are always made in cooperation with civil society. Indeed, while the Global Fund does not have lobbyists in Brussels – unlike GAVI – notably because the Fund sustainably receives money from the EU and is now well established enough within the global health community, it partners with European NGOs to advocate on TB, HIV/AIDs and malaria funding towards EU institutions. As a member from civil society recognized, '[t]he Global Fund does not have an army of lobbyists coming to Brussels. They cooperate more with us as civil society and strong advocates to do the advocacy' (Interview with member from civil society organization, November 2014).

Thus, in the margins of the Global Fund's 4th Voluntary Replenishment Process (2014–2016) hosted by the European Commission on 9–10 April 2013 in Brussels, the Global Fund participated in the efforts led by STOP AIDS Alliance to mobilize European Union institutions for a successful replenishment outcome. It has to be recognized that such influence has been so far rather limited as the pledge of €370 million (over US $500 million) made by the EU in December 2013 for the period 2014–2016 falls short of the €450 million target set by civil society to reach a full replenishment of the Global Fund (Global Health Advocates, 2014b).

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But such partnership has also offered to the Global Fund – and the involved NGOs – the opportunity to influence the EU agenda. One of the most recent and concrete illustrations of such influence is certainly the introduction of TB as a priority of the EU agenda of the rotating presidency led by Latvia (January–June 2015). Indeed, the Global Fund in cooperation with WHO Europe and leading NGOs such as Global Health Advocates and STOP TB succeeded in convincing the Latvian prime minister to make TB one of the priorities of the next EU presidency and then to host in 2015 in Riga the first Ministerial conference on TB as a side event of the Eastern Partnership Summit of Heads of State. Although limited and shared with actors of civil society, the Global Fund's influence on the EU exists and is mainly focused so far on convincing the EU to pursue and increase its financial support to the Fund and on putting high on the EU agenda one of the three diseases.

4. Future of the EU engagement with Global Fund

Convinced by the effectiveness of its partnership with Global Fund, the EU has no specific reason to stop its support to this TPN. However, its engagement might evolve in the context of the withdrawal of the Global Fund from middle-income countries according to its NFM and the global promotion of health system strengthening (HSS).

If previous experiences show that countries supported by the Global Fund have made tremendous progress in terms of the fight against HIV/AIDS, TB and malaria at the country level, they also reveal that once these countries stop being funded by the Global Fund, the response against these three diseases experiences a breakdown and the related-mortality and morbidity increases. In this context, the issue of the sustainability of the fight against HIV/AIDS, TB and malaria after the withdrawal of the Global Fund in the middle-income countries targeted by the NFM is today a key concern for the Global Fund as well as the EU which would prefer not to see the progress made possible by its financial support in those countries wasted. As mentioned earlier, albeit the fact that the Global Fund has proposed a transitional period to the countries targeted by the NFM, the possibility that those countries will not be ready to or will not be interested in pursuing the same level of support to the fight against these three diseases, cannot be excluded. If the Global Fund does not have the influence to convince countries to pursue their involvement in the fight against these diseases after its withdrawal, expectations that the EU might play the role of guaranteeing the sustainability of the fight against HIV/AIDS, TB and malaria in those countries will emerge. Indeed, the EU has been called notably by some NGOs to use its financial instruments as well as its political dialogues with these countries as leverage to ensure that the latter will pursue the fight against the three diseases once the Global Fund has withdrawn (Interview with member from civil society organization, November 2014). In order to embrace this approach, USAID could be taken as an example as it imposes on recipient countries some conditions related to their response to HIV/AIDS, TB and malaria to receive funding for development. While such a role for the EU might be a response to the question of sustainability of the fight against the three diseases in the country from where the Global Fund has withdrawn, it would also represent an important evolution of the EU's role in the fight against HIV/AIDS, TB and malaria and in its relation with Global Fund.

The other main trends towards the future of the EU–Global Fund partnership are directly linked to the response that both partners gave to the debate opposing the 'vertical financing' approach aiming at disease-specific results which has guided the main activities of the Global Fund since its inception in the domain of HIV/AIDS, TB and malaria and, the 'horizontal financing' approach aiming at improved health systems which has received growing attention and support this last decade within the international community.

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If significant vertical health programmes are today supported by the EU in several developing countries, in general, the EU's main priority in its external health action is the strengthening of health systems as it is mentioned in the EC's 'Communication on The EU Role in Global Health' (2010) and a staff working document entitled 'Contributing to universal coverage of health services through development policy' (2010). In such a context, supporting Global Fund diseases-specific funding programmes could have become incoherent for the EU's 'horizontal' approach guiding its global health action. In other words, the EU's progressive move to such an approach could have jeopardized its engagement with the Global Fund. However, the recent evolution of the Fund in terms of its strategic approach could avoid such incoherence and guarantee the sustainability of EU's support. Indeed, conscious of such debate and of the criticisms made to the vertical approach in general (Buse & Waxman, 2001), the Global Fund has since 2007 considered financing comprehensive country health programmes, notably HSS initiatives. Since then, the HSS approach proposed by the Global Fund has consisted of 'investing in activities to help health systems overcome constraints to the achievement of improved outcomes for HIV/AIDS, TB and Malaria' (Global Fund, 2013b). In reference to this 'diagonal' approach – aiming for disease-specific results through improved health systems –, according to a recent study, 37% (US$362 million) of Global Fund's Round 8 funds was dedicated to HSS, notably to generic system-level interventions, rather than disease-specific system support and 82% of this funding (US$296 million) was allocated to service delivery, human resources and medicines & technology (Warren, Wyss, Shakarishvili, Atun, & de Savigny, 2013, p. 9). In this perspective, suggestions of transforming the Global Fund to fight AIDS, TB and malaria into a Global Health Fund which would gradually transform its 'diagonal' financing approach to a 'horizontal' financing approach, have been made by several organizations such as Médecins Sans Frontières or Global AIDS Alliance (Ooms, 2008). If such a move happens, it will certainly strengthen the coherence of the EU's development support and diversify the domains of interaction between both partners; however, one of the main challenges for the EU and Global Fund will then be to avoid any reversal of gains made in the three diseases.

5. Conclusion and policy implications

From our study on EU–Global Fund engagement, three main conclusions can be drawn. First, in the context of the relationship between the EU and a TPN such as the Global Fund, influence is reciprocal although asymmetrical. Indeed, the EU is a rather influential partner of the Global Fund. Although the geographical location and funding distribution have an effect, this influence is associated with the EU's own financial rules; it is, however, its official position within the Global Fund's structure of governance – as Board Member and Committee member – which offers the EU the opportunities and capacities to deeply influence the Global Fund's policy and decision-making and by extension the support to the fight against HIV/AIDS, TB and malaria. Simultaneously, to a limited extent, the Global Fund with the support of members of the civil society succeeded in influencing the EU, notably in terms of policy priorities.

Second, the EU considers its engagement with the Global Fund as successful. If the success of this interaction certainly rests on the Global Fund's capacity to deliver what it has pledged to the EU, it is also appreciated by the EU in the light of the formidable opportunity it represents for the EU to its pledge to invest 20% of its ODA in health as well as for the Fund's alignment with EU's development strategies and policy (Interview with member from civil society organization, November 2014).

Finally, for all of these reasons as well as the visibility it offers the EU within the global health community, the soft power instrument it provides the EU to influence global health governance as well as the fact that the fight against HIV/AIDS, TB and malaria will remain high on the global

agenda, the relationship between the EU and the Global Fund will undoubtedly continue. However, in light of the recent focus of the EU's global health policy on HSS and the progressive evolution of the Global Fund's approach to the fight against the three diseases – vertical to diagonal approach first, and then potentially to horizontal approach – the nature of the relationship between both actors will certainly evolve in a way that will be mainly determined by the transformation of the Global Fund into a Global Health Fund as well as the nature of the forthcoming Sustainable Development Goals. These concluding remarks have several implications for EU's policy towards Global Fund as well as global health governance in general.

Indeed, if we consider that the Global Fund will continue to play a substantial role in global health governance thanks to its growing focus on health systems strengthening, the EU will certainly have to pursue its support to such unique actor if it desires to continue to be considered a significant global health actor. Simultaneously, given the EU's focus on investing wisely and concrete impact as well as its preference for funding institutions that have proven they are transparent and show results, health organizations seeking to partner with the EU should draw lessons from the successful EU–Global Fund partnership and demonstrate these values.

The EU might also consider the Global Fund as a strong partner of its commitment to universal health coverage (UHC) along with WHO and Luxemburg which have already signed an agreement with the EU to support policy dialogue on national health policies, strategies, and plans and UHC in 19 developing countries (WHO, 2015). It is certainly the right moment to pursue such cooperation between EU and the Global Fund as the current global thinking around health as well as both organizations is moving away from the silo approach to focus more on improving access to health and health systems strengthening. Interestingly, a first move in such direction occurred recently in February 2015 with the involvement of the EU in a Global Fund-led multilateral initiative called 'Equitable Access Initiative' whose main objective is to propose a new policy framework to evaluate national health needs and then be able to efficiently promote and reinforce health access (Global Fund, 2015).

Finally, assessing EU–Global Fund relationship also highlights how third parties such as civil society can prove to be essential in advocating for the EU to engage with a particular health initiative. Therefore, while both entities have historically often worked closely with civil society to advise or to implement health projects, non-governmental actors should be considered when attempting to forge these partnerships. Such involvement would certainly benefit EU–Global fund partnership in terms of experience and expertise sharing as well as of visibility within the global health community.

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Disclosure statement

No potential conflict of interest was reported by the authors.

Notes

1. One example of such network is the Alliance for Health Policy and Systems Research (AHPSR), an international collaboration of more than 350 partners, which develops health policy and systems research (HPSR) in order to improve the health systems of low- and middle-income countries http://www.who.int/alliance-hpsr/en/.
2. This contribution was to be composed of €60 million to be financed from the 2001 budget of the EC and €60 million to be financed from the EDF.
3. Transitional Working Group is composed of designated donors, beneficiary countries, civil society and private sector representatives, UN agencies and the World Bank. The European Commission and some EU Member States were part of this Transitional Working Group.
4. Term of office of each member of the Finance and Operational Performance Committee is two years.
5. It is notably the case in Indonesia and in the Democratic Republic of Congo.

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