Hochschule Fulda
University of Applied Sciences

Department of Health Sciences

Increasing funding for Global Mental Health by drawing lessons from the case of HIV/AIDS

Bachelor thesis

Submitted by: Eva Patrizia R. Sander

Matriculation number: 1210772

In the study course:

B.Sc. International Health Sciences

Winter semester 2022/23

Supervisor: Prof. Dr. Dr. Jens Holst

Co-Supervisor: Prof. Dr. Kai Michelsen

Cologne, March 2023

Abstract

Objective: Global Mental Health (GMH) is the field of global health dealing with the spectrum of mental, neurological and substance use disorders (MNS disorders), often with a focus on low- and middle-income countries (LMICs). While MNS disorders constitute a considerable burden of disease, investments in the field lag behind, creating a severe funding gap. In contrast, the Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) epidemic has seen unprecedented commitment, especially in terms of funding. Consequently, this paper examines the research question: “How can the increase in global funding for HIV/AIDS over the past three decades serve as an example to draw lessons for increasing GMH funding in LMICs?”.

Methods: Based on the ‘Theory of Lesson-drawing’ by Rose (1991) two programs, the Joint United Nations Programme on HIV/AIDS (UNAIDS) and The Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund), were analyzed, and a conceptual model created for each program. The conceptual model, in addition to a comprehensive literature review were the base to draw learnings from the fight against the HIV/AIDS epidemic and its funding. Learnings from HIV/AIDS were applied to GMH by giving a prospective evaluation of the transferability and desirability of the analyzed programs and their outcomes.

Results: A concrete next step that should be taken in order to increase funding and implementation of high-quality mental health care in LMICs includes the establishment of a GMH partnership which represents diverse constituencies and expertise. Among other things, emphasis should be put on promoting strong civil-society and community involvement. Additionally, a multi-facetted advocacy and awareness campaign to increase traditional donor contributions, innovative financing mechanisms and domestic resources for GMH should be launched.

Conclusion: Lessons from the increase in global funding for HIV/AIDS and how it was achieved can be drawn in the areas of funding generation, raising political and social commitment and multi-stakeholder collaboration. Yet, the analysis has also shown the potential pitfalls when overall health system strengthening efforts and primary health-care integration are not sufficiently addressed.

Acknowledgments: This paper was produced as a final thesis to acquire the academic degree BSc International Health Sciences at Fulda University of Applied Sciences.
I would like to extend my gratitude to Prof. Dr. Dr. Jens Holst for his support throughout my studies and this thesis supervision, together with Prof. Dr. Kai Michelsen. Moreover, I would like to thank Eric Daniel Sander for his invaluable thoughts and input during the writing process, as well as those who supported me with corrections and proof-reading.

Content

1 Introduction

“I challenge global leaders to build upon these lessons learned from the HIV/AIDS response and apply it positively to the challenge of MNS disorders. We must no longer overlook the deleterious effects that the lack of quality MNS services has upon our communities.” – Agnes Binagwaho, Minister of Health, Rwanda (2008-2016) (Patel et al. 2015: xi).

1.1 Introduction and problem statement

Global Mental Health (GMH) is the interdisciplinary field that aims to reduce inequalities in mental health care in and between countries by scaling up mental health services, particularly in low- and middle-income countries (LMICs) (Patel et al. 2018: 1556; Rajabzadeh et al. 2021: 9). According to Rajabzadeh et al. the term “Global Mental Health” is used in different ways with varying understandings. The most cited understandings found were conceptualized as: “Globalised mental health research”, “Global mental health is implementation”, “Improving the mental health landscape” and lastly “Learning from and supporting LMICs” (Rajabzadeh et al. 2021:6). In all four concepts the role of interdisciplinary involvement and shifting away from Western perspectives, towards a strong inclusion of perspectives from LMICs, were emphasized. Additionally, over time, a shift from a biomedical approach to a more convergent approach of mental health has occurred. This approach recognizes the “complex interplay of psychosocial, environmental, biological, and genetic factors across the life course, but in particular during the sensitive developmental periods of childhood and adolescence” (Patel et al. 2018: 1556) in the prevention and development of mental health issues. GMH combines research from various disciplines, such as anthropology and epidemiology, and other fields of action, such as advocacy, policy and program development and service delivery for mental health (Rajabzadeh 2021: 4). Further, while promoting a global approach, a lot of GMH activities focus on LMICs and improving their mental health infrastructure, care delivery and the situation of persons affected (Rajabzadeh et al. 2021).

GMH deals with a variety of diseases and diagnoses including psychiatric and mental (e.g. depression, bipolar disorder, schizophrenia), neurological (e.g. dementia, Parkinson’s) and substance use disorders. MNS disorders are non-communicable disease (NCDs) with no one clear underlying cause. However, research has shown a strong interdependence between social determinants and their significant role as risk factors in association to onset, severity, and duration of MNS disorders (Patel et al. 2018: 1557). This puts already vulnerable groups, for example due to low socio-economic status, low education level, living in poor environmental conditions or people seeking refuge at high risk for developing MNS disorders. Hereby, especially the sensitive developmental phases of childhood and

adolescence are crucial for mental well-being. Over their life-course approximately one in four people are affected by mental disorders (Lions Head Global Partners (LHGP) 2018: 6). In addition, many MNS disorders are chronic, multimorbid and have comorbidities such as cardiovascular diseases.

As a result, MNS disorders constitute a substantial burden of disease, a trend which has increased by almost 50% from 1990 until 2019 (GBD 2019 Mental Disorder Contributors 2022: 141). Prevalence is estimated to be at roughly 970.1 million cases of mental disorders worldwide. The corresponding number of disability-adjusted life-years (DALYs) due to mental disorders are estimated at 125.3 million, which accounted for 4.9 % of global DALYs in 2019 (GBD 2019 Mental Disorder Contributors 2022: 141). People often suffer from MNS disorders over a long period of time throughout their life-course. This results in 125.3 million years lived with disability (YLDs) due to MNS disorders in 2019, representing 14.9 % of the global YLDs in the respective year (GBD 2019 Mental Disorder Contributors 2022: 142). MNS disorders combined are the seventh leading cause for DALYs. They are prevalent in all age groups with the highest prevalence found in persons between 25 and 34 years, for both genders (GBD 2019 Mental Disorder Contributors 2022: 144). Therefore, a large share of people affected suffer from MNS disorders during their most productive years, leading to loss of human capabilities with severe micro- and macroeconomic effects estimated to reach global economic losses of approximately 16.1 trillion US$ for the timespan between 2010 and 2030 (Bloom et al. 2011: 5; Patel et al. 2018: 1560).

A vast treatment and care gap for MNS disorders persists worldwide. In LMICs, around 90% of patients with severe mental disorders receive no treatment at all. Where treatment and care are available quality is often low, especially for severe mental disorders. (LHGP 2018: 13; Patel et al. 2018: 1558). In addition, people suffering from MNS disorders are at high risk for abuse and violation of their fundamental human rights, for example through unjust incarceration or physical violence (Patel et al. 2018: 1558).

In the past years, the field of GMH is said to have ‘come of age’. It has become a respected discipline in the field of global health (Patel et al. 2018: 1555; Patel et al. 2015; LHGP 2018; Patel et al. 2018; WHO 2021b). The advancement from the Millennium Development Goals (MDGs) to the Sustainable Development Goals (SDGs) in 2015 was an essential step for the inclusion of mental health indicators and the recognition of mental health to be a crucial part for achieving overall health and wellbeing (Patel et al. 2018: 1554). Moreover, meaningful engagement came from the World Health Organization (WHO), through the launch of its Mental Health Gap Action Programme (mhGAP) (WHO 2022) in 2008, the WHO Comprehensive Mental Health Action Plan (2013-2020) (WHO 2013) and WHO Comprehensive Mental Health Action Plan 2013-2030 (WHO 2021a) respectively. This has resulted in important investments, mainly into research for care delivery. Furthermore, since 2007,

development assistance for mental health (DAMH) has doubled in absolute numbers. Yet, despite recent gains in the recognition of the field, challenges persist. Regardless of the increase of funding in absolute numbers, DAMH has never exceeded 1% out of total global development assistance for health (DAH). In 2015, DAMH was as low as 0,4 % of total DAH (LHGP 2018: 6). More so, despite the importance of prevention and attention to child and adolescent mental health, allocations to this matter seem particularly neglected (Patel et al. 2018: 1560). While this important age group is bearing a quarter of the MNS disorder DALYs, allocations were at 12.5% of DAMH, making up no more than 0.1% of the total DAH (Lu et al. 2018: 1). Moreover, domestic spending for mental health exhibits similarly low. Low-income countries (LICs) spend approximately 0.5% of their annual health budgets on mental health (LHGP 2018: 6). Where funding is available for mental health in LMICs, roughly 80% are spend on major institutions and mental hospitals instead of community-based services (LHGP 2018: 35). In 2013, investment per DALY caused by MNS disorders was only 0,85 US$, compared to 144 US$ per DALY caused by HIV/AIDS (Charlson et al. 2017: 5). This is despite an estimated 4 US$ return for every dollar invested (LHGP 2018: 14). From 1995 until 2015, DAMH funding experienced a six-fold increase, from 18 million US$ to 132 million US$, out of a total of 36 billion US$ of DAH. What might seem like a considerable increase is comparably low, when looking at other health areas, HIV/AIDS for example. From 1995 onward, HIV/AIDS funding experienced an 18-fold increase (Charlson et al. 2017: 3f.).

In 2018, the Lions Head Global Partners Group, with contributions from GMH researchers, advocates, and affiliated organizations (LHGP 2018: 57), published a paper, outlining the current funding situation and expected funding needs for different scenarios for varying levels of mental health service coverage (LHGP 2018). Depending on the target spend per person, ranging from 1 US$ to 3 US$ per person per annum (pppa), estimates for the funding needed range between 3.74 billion US$ and 11.22 billion US$ per year (LHGP 2018: 25). This leaves GMH with a substantial funding gap, that in order to avoid the considerable economic losses and leverage on the return of investment ratio, in addition to providing people with their basic human right to access quality health services to attain their best health possible, must be closed as soon as possible through concerted efforts of the global community. In their conclusion, the LHGP authors find that, in order to close the funding gap and to reach the goals and ambitions set out by the SDGs and the Lancet Commission on global mental health and sustainable development (Patel et al. 2018), a combination of increased domestic resource mobilization and the establishment of “one or more ‘new’ financing mechanism(s)” will be needed (LHGP 2018: 6).

1.2 History and funding of the HIV/AIDS response

After the first cases of AIDS were reported in the US in 1981 the HI virus was discovered and determined to be the cause for the syndrome in 1983 (Schmid 2018). The first cases of HIV and AIDS had been reported among homosexual men, or men who have sex with men (MSM), and injecting drug users. Additionally, persons who had received blood products were identified to be affected. However, soon after, women and children who did not exhibit any of the previous characteristics were reported to be infect with HIV as well, suggesting heterosexual as well as mother-to-child transmission of the virus (Hofer 2018). Moreover, increasing numbers of cases of HIV and AIDS were recorded on the African continent, with researchers suggesting that the disease had been spreading on the continent for decades (Ferhervari 2018). This explained the rapidly increasing number of cases, transforming into the global epidemic of HIV/AIDS. By 1996, the WHO and the Joint United Nations Programme on HIV/AIDS (UNAIDS) estimated "that more than 4.6 million people had died from AIDS since the beginning of the epidemic" (Knight 2008: 7), and 20.1 million people worldwide were living with HIV (Knight 2008: 7). According to UNAIDS, in 2021, an estimated total of 40.1 million people had died from HIV/AIDS and approximately 38.4 million people were living with HIV (UNAIDS 2022b). As mentioned previously, since the discovery of HIV and AIDS, the amount of funding allocated to this field has been unprecedented. Funding for HIV/AIDS is spent on research, prevention, and treatment programs, as well as health system strengthening. Common prevention programs include condom use programs, education campaigns, ABC campaigns (abstinence, be faithful, use a condom if A and B fail) and needle exchange programs. After advancements in research pre-exposure prophylaxis (PreP) for high-risk populations became available in addition to anti-retroviral treatment (ART) in the course of the 1990s and early 2000 years (Piot et al. 2015: 179f.). Over the past 30 years, funding for the AIDS response in LMICs has risen from 612 million US$ to approximately 11 billion US$ in 2015 and up to 19 billion US$ today. Furthermore, "[t]hrough coordinated advocacy by a coalition of diverse stakeholders, the challenge of AIDS was met with unprecedented scientific, medical, political, and economic force within two decades of its emergence" (Vigo et al. 2019: 351). Growth in funding, despite the 2008-09 financial crises, was also possible due to increases in domestic funding spent on HIV/AIDS, in addition to the external investments from traditional donors (Piot et al. 2015: 201). In recent years, funding levels have remained relatively flat at this level. Yet, to reach the goals set for HIV/AIDS in the SDGs and the 90-90-90[1] target by UNAIDS to be reached by 2030 a funding gap of roughly 7 billion US$ persists (Bekker et al. 2018: 323; Piot et al. 2015: 201).

[1] 90% of people living with HIV are aware of their status, 90% of people diagnosed with HIV receive ART, at least 90% of those receiving ART are virally suppressed (Kazanjian 2017 :409)

1.3 Objective and development of research question

Although AIDS is a single disease with a definite etiology and GMH constitutes a broad set of MNS disorders with a much less clearly defined cause, both fields of global health action share important characteristics, such as “stigma, human rights abuses, and a sluggish initial global response despite the evidence of transformative interventions” (Vigo et al. 2019: 351). Furthermore, both fields of action operate in low-resource setting, primarily LMICs. For both, HIV/AIDS and MNS disorders, vulnerable groups include the LGBTQ+ community (lesbian, gay, bisexual, transgender, queer and all other gender identities and sexual orientations), people experiencing adverse living conditions (e.g. experiencing homelessness) and persons with low socio-economic status as well as low educational attainment (Patel et al. 2018: 1556f.; 1567).

There is consensus among researchers and advocates for the large need for funding for GMH. However, the question on how to raise and distribute these funds proves to be more difficult and harder to reach consensus on. There is a lot of knowledge and experience in gathering large amounts of funding in the case of HIV/AIDS which could provide beneficial lessons to be learned for GMH. Against this backdrop, this paper aims to look at the different strategies and drivers for this increase in funding made available for the global fight against HIV/AIDS since 1995, as well as other potential influences that impacted the resource allocation to this cause. By taking into consideration criticism directed towards the global fight against HIV/AIDS, this thesis is not limited to ‘positive’ lessons (Dos) to be learned but also ‘Do not’s’ to be considered in this context. Thus, the following research question was formulated: *How can the increase in global funding for HIV/AIDS over the past three decades serve as an example to draw lessons for increasing GMH funding in LMICs?*

This thesis expands the knowledge on the topic through its in-depth analysis of programs established in the response to HIV/AIDS (see chapter 3.1.) and the examination of their results relationship on funding generated. A similar approach of organizational learning from HIV/AIDS as well as maternal and newborn health for successful scale-up of GMH was performed by Vigo et al. (2019). However, the analysis was based on a different selection of programs, with the exception of the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund). The findings will be carefully considered in the discussion of this thesis.

2 Theory of Lesson-Drawing

This thesis uses Richard Roses' (1991) Lesson-Drawing approach to draw lessons from the programs established for the global fight against HIV/AIDS and apply them to commitments for GMH. According to Rose „Lesson-drawing addresses the question: Under what circumstances and to what extent can a programme that is effective in one place transfer to another." (Rose 1991: 3)[2].

2.1 Lesson-drawing and programs

Programs are established as an instrument to achieve policy intentions (Rose 1991: 6) by bringing together the interests of different groups, e.g., public officials, experts, interest groups, and those who benefit from the program (Rose 1991: 7). A program is defined through a statute which declares its "purposes and the conditions under which it operates" (Rose 1991: 6). Additionally, the resources it operates on are defined by a budget which is administered through a public agency and defined personnel. All these characteristics make programs specific and concrete, in contrast to the intentions of politicians who formulate and establish them (Rose 1991: 6).

In accordance with Rose, lesson-drawing does not just evaluate a program active in one place or in the case of HIV/AIDS in one thematic setting. Moreover, it goes further by attempting a prospective judgement on its performance in a new setting, in this case being GMH (Rose 1991: 7, 19). Therefore, the lesson is not just the judgement of the program in place but rather the critical assessment of its transferability to a new setting (Rose 1991: 7). The conclusion of effectiveness in the new setting is what makes lesson-drawing special compared to other social science comparisons (Rose 1991: 8).
The motivation for policy makers to look outside for lessons usually does not stem from the success a foreign program has demonstrated, but rather comes from a place of dissatisfaction with the status quo in their own setting or area of responsibility. Hence, there is need for change (Rose 1991: 5). Therefore, Rose calls dissatisfaction with status quo the "Stimulus to Search for Lessons" (1991: 10).

2.2 Stimulus of dissatisfaction

As long as everyone is satisfied the most efficient strategy for policy makers is to do nothing, since inaction is the most preserves resources. However, disruptions in the routine create dissatisfaction with the status quo and doing nothing is no longer an option for the way forward (Rose 1991: 10). For both cases, HIV/AIDS and GMH, the stimulus of

[2] The theory by Rose is written in British English; however, this thesis is written in American English. To remain stringent the author will use the spelling 'program' as the equivalent term for 'programme' used by Rose.

dissatisfaction is the increasing disease burden both create, and inadequate amounts of resources allocated to the causes. Additionally, for HIV/AIDS another stimulus was the potential security risk which forced policy makers to act (Knight 2008: 106f.). In both cases it was the policy environment which changed and created dissatisfaction, rather than the program producing negative results (Rose 1991: 12), simply because no programs were or are in place yet. Therefore, the change does not originate from a place of learning of better alternatives but from the realization that inaction is unsustainable (Rose 1991: 12). Not least inaction of policy makers is sanctioned in case of dissatisfaction, as it would result in an increasing disease burden and cost of disease. Moreover, dissatisfaction of the status quo paired with inaction of policymakers can also quickly lead to dissatisfaction with the policymakers themselves. Thus, the "cost of inaction" (Rose 1991: 12) is estimated to be higher than the cost of action and potential gain from the investment. Consequently, policy makers search for satisfaction because "'[They] can't afford not to'" (Rose 1991: 13).

In their search for satisfaction policymakers can look across time and space for programs operating in other places and settings or programs proven effective in the past. The proximity in which they search is determined by what is already known to policy makers as what is known will always be favored over what is unknown (Rose 1991: 13). When searching across space, policy makers will search in areas where they feel they have similarities. Hence, local community policymakers are more likely to search for programs in other local communities nearby (Rose 1991: 13). Yet, subjective identification will play a more critical role in where policy makers choose to look than geographic proximity (Rose 1991: 14). Therefore, international policymakers are likely to search for programs on an international level where the baseline issue and starting point were similar, for example the spatial dimension of countries affected, which in case of HIV/AIDS and GMH were foremost LMICs. However, due to the functional interdependence of countries because they are mutually affected, they cannot ignore actions of other countries which influence the problem at hand. This is especially true for issues that in their nature transcend national borders, for example environmental, or as seen most recently with the COVID-19 pandemic, health issues (Rose 1991: 17).

2.3 Steps of lesson-drawing

In his 1991 publication Rose outlines four steps for lesson drawing (see Table 1) (Rose 1991: 19ff.).

Table 1: Four steps of lesson drawing

Step 1	Search for programs addressing similar problems
Step 2	Produce a conceptual model
Step 3	Comparison of different models and the program currently in place
Step 4	Prospective evaluation

(Source: own presentation after Rose 1991: 19ff.)

“The first step in lesson-drawing is to seek information about programmes of public agencies elsewhere that have addressed a similar problem.” (Rose 1991: 19). The focus lies on programs which have potential to be successful when imported, even though this might require some adaptions as the overall goal is to gain transferrable knowledge that is generic and applicable (Rose 1991: 19f.). In this thesis, program selection is explained and justified in Chapter 3.1. In the second step the goal is to produce a conceptual model of the program, with an accurate, yet generic description. The description should be stripped to the basic elements which show how the program works, defining the relationships between cause and effect and identifies the programs outputs. This model, however, has no expressive power about desirability of the program yet (Rose 1991: 20). Accordingly, the production of conceptual models for the programs chosen will be established in the results part of this paper (chapter 4). Thirdly, the model or models produced are compared with the program or action currently in place, which initially caused the dissatisfaction. This comparison aims to look at different factors, such as differences between the programs in dimension or kind, as well as political acceptability and resources needed and available (Rose 1991: 20f.). Finally, the last step of lesson-drawing, described in the discussion (Chapter 5), is the prospective evaluation of the likely success of the program when transferred to the new place or setting (Rose 1991: 22). Consequently, the judgement whether a program will or will not work needs to be justified, taking into consideration the observed characteristics of the effective program in comparison with the conditions in the setting it should be transferred to. Yet, this judgment can never be entirely free of speculation (Rose 1991: 23). Prospective evaluation stands out from conventional evaluation based on retrospective empirical examination, by offering an ex-ante estimate on the success of a program. This offers unique opportunities for policymakers forced to make decisions under time pressure since it can help to give a forewarning in case necessary conditions for success cannot be met in the new setting (Rose 1991: 23f.).

“The ideal programme is both practical and desirable.” (Rose 1991: 24). This is the situation before dissatisfaction arises and should be the goal for the introduction of a new program. Therefore, for the prospective evaluation two different kinds of feasibility of the program should be taken into consideration, namely technical feasibility to assess practicality and political feasibility estimating desirability (Rose 1991: 25). Consequently, four different judgements are possible resulting from the prospective evaluation: a program is deemed neither technically nor politically feasible, meaning that the outcomes are not desirable for politicians and the program is expected to fail when transferred. A program could be judged desirable but not practical or vice versa. Lastly, the most anticipated result is that technical expertise judges a program practical, and politicians are attracted by the desirable results (Rose 1991: 26).

Different results can come from a successful lesson. When adapting a program to a new setting some adaptions are likely needed to accommodate the new circumstances. Simple ‘copying’ is possible when the circumstances are almost the same and the introduction of the program does not require any or only small adaptations. ‘Emulation’ is the process of adopting the desired program, however, by adjusting for the circumstances of the new setting to enhance likelihood of success. ‘Hybridization’ happens when elements of two different programs are combined and introduced in the new setting. This also happens when the lesson drawn is a ‘synthesis’ of elements from three or more programs in effect somewhere else. Lastly, lesson-drawing can serve as an ‘inspiration’ when no program or elements of one are adapted, yet the process has inspired and served as an intellectual stimulus for a new program to be created (Rose 1991: 21f.). Hence, lesson-drawing is not merely ‘copy and paste’-ing but should be considered “a creative act” (Rose 1991: 21).

3 Methodology

3.1 Identification and choice of HIV/AIDS programs

During the preliminary research multiple programs, initiatives and organizations involved in funding the global fight against HIV/AIDS were recognized, including UNAIDS, the World Bank Multi-Country AIDS Program in Africa (Africa MAP), the Global Fund to Fight AIDS, Tuberculosis, and Malaria (the Global Fund) and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR)[3].

Despite being the largest funder for HIV/AIDS within the UN system, contributions by World Banks Africa MAP are comparably low to overall contributions (Oomman n.y.), as is the scope and reach of the program compared to the others listed. Africa MAP was therefore not chosen for the analysis. In contrast, PEPFAR is recognized to be one of the largest donors focused on HIV/AIDS, funding approximately 22 % of the global HIV/AIDS response in 2021 (own calculation after UNAIDS 2022a). PEPFAR was established in 2003 to distribute funding from the US congress, earmarked specifically for HIV and AIDS. However, PEPFAR and the US government face regular criticism for the high level of 'strings attached' to their funding (Knight 2008: 170f.) as they act bilaterally. Since the research question is focused on "global funding" PEPFAR was also excluded from the program analysis.

The establishment of UNAIDS, which is tightly embedded into the Unite Nations organizational structure, was an important prerequisite leading to the founding of the various funding organizations mentioned above. In addition, despite not being a funding organization per se, UNAIDS is critical to the general funding generation for HIV/AIDS. The issue cannot be discussed without considering the wide range of achievements made by UNAIDS. Therefore, UNAIDS was the first organization chosen for an in-depth analysis to draw lessons from.

The Global Fund on the other hand is a multilateral hybrid organization which is focused on providing funding for three focus diseases by combining public and private partnerships (PPPs) (Vigo et al. 2019: 351). It provides the highest levels of contributions for HIV/AIDS among multilateral donors (UNAIDS 2022a). Furthermore, the Global Fund offers a variety of innovative organizational and funding features, offering a spectrum of lessons to be drawn for GMH. Consequently, the Global Fund was chosen for the second program analysis.

[3] listed in order of establishment

3.2 Literature search and appraisal

The analysis and critical discussion of UNAIDS and the Global Fund are based on a comprehensive literature search. For this purpose, the databases MEDLINE (PubMed), CINAHL, EMBASE, Wiley Online Library, Web of Science were searched, with access to databases and publications provided through Fulda University of Applied Sciences. Moreover, databases from the various United Nations Organizations and Agencies were considered. In addition, primary literature and referred sources from adequate publications were obtained through the snowball principle, using Google Scholar. According to the research question and chosen programs keywords for the literature search are: “UNAIDS”, “Global Fund”, “HIV/AIDS fund*” OR “HIV/AIDS financ*”, “development assistance for health”, and “Global Mental Health fund*”. Keyword searches in Title and Abstracts yielded high numbers of results with a high share of publications unrelated to the research question. However, publications focusing on either program or HIV/AIDS usually specifically mentioned them in the title. Therefore, searches were limited to titles and were abstracts excluded from the advanced search. No time limits were applied to the search terms “UNAIDS” and “Global Fund”, since the historical development of the programs is an important factor in their analysis and the judgement on their performance of funding generation over time. For the remaining keywords a time limit of five years was set. Furthermore, articles included were published in English or German language. Detailed search results can be found in the Appendix (see Appendix 1: Keyword Searches).

In addition to the literature search program websites were used for understanding the functions of each program. For disease data on HIV/AIDS and MNS disorders, the author searched for the most recent data available, usually not older than five years. However, due to the COVID-19 pandemic collection and reporting of some data was disrupted. Therefore, in some cases exceptions to the 5-year range may occur.

Following the analysis, lesson-drawing as described by Richard Rose (Rose 1991; Evans 2006) was performed for the two programs. A prospective evaluation of the applicability and replicability of these programs for the case of GMH was done and critically discussed. Finally, conclusions were drawn and an outlook on further research needs given.

4 Results

4.1 The Joint United Nations Programme on HIV/AIDS

UNAIDS coordinates the HIV/AIDS response of all eleven cosponsoring UN organizations[4], sets out global principles and priorities for the response to the HIV/AIDS pandemic and has been especially active in moderating the alignment of donor efforts and national priorities of recipient countries (Lisk et al. 2013: 128)

4.1.1 Background and history of UNAIDS establishment

The HIV/AIDS epidemic and its impact on a social, demographic, economic, cultural, and political level was firstly recognized by the UN General Assembly in 1987. Accordingly, the need for a coordinated response by a multitude of UN agencies was identified. Consequently, in 1988 the Global Programme on AIDS (GPA) was established as part of WHO, to organize the UNs response to the HIV/AIDS epidemic. Despite its success in advocating and exchanging information on HIV/AIDS, GPA lacked the inter-agency coordination which had been recognized to be needed (Knight 2008: 15 ff.). Therefore, in 1993, a joint and cosponsored program was proposed: a coordinating body that brings together the multitude of stakeholders involved, including advocacy groups and people living with HIV/AIDS, while ensuring ownership of the "broad set of UN agencies" (Knight 2008: 20f.). This coordinating body is supposed to serve as a global focal point for the response to HIV/AIDS. In the following months the design of the program and the role and power of its Secretariat were heatedly discussed. While most UN organizations preferred a rather small Secretariat with a focus on information exchange donors generally supported a strong Secretariat. Despite the initial proposal for the new program to act as a funding agency, this was met with strong opposition from some UN agencies (Knight 2008: 21ff.). Finally, in fall of 1993, the UN Secretary-General expressed his support of a program with a strong Secretariat, granting it a "high level of coordinating control over the Cosponsors" (Knight 2008: 22), but without explicit funding powers. The request for endorsement from the Economic and Social Council (ECOSOC) followed for the new joint program, cosponsored by initially six organizations, which had already been represented at GPA (WHO, UNICEF, UNFPA, UNDP, UNESCO, World Bank). The final decision was made on July 26th, 1994. Yet, cosponsoring UN agencies were reluctant to agree to the new program, but the uncoordinated requests for funding

[4] Cosponsoring Organizations: United Nations Development Programme (UNDP), United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), World Health Organization (WHO), United Nations Educational, Scientific and Cultural Organization (UNESCO), World Bank, United Nations Office on Drugs and Crime (UNODC), International Labor Organization (ILO), World Food Programme (WFP), Office of the United Nations Higher Commissioner for Refugees (UNHCR), United Nations Entity for Gender Equality and the Empowerment of Women (UN Women)

from multiple agencies and the lack of coordination had left donors unsatisfied. As a result, they threatened to pull funding altogether if no cosponsored agency would be established (Knight 2008: 22f.). Although the establishment of the new Joint Programme had already been decided by the ECOSOC it took another two years for it to start operating as a result of interagency rivalries between different UN entities. In addition, the form and functions of the new program had to be worked out (Knight 2008: 24). Finally, the new cosponsored Joint United Nations Programme on HIV/AIDS – UNAIDS – started operating in 1996 and was the first of its kind within the UN body.

4.1.2 Objectives, governing structure, and budget

With the endorsement by the ECOSOC the six objectives (see Table 2) of the new program were formulated, defining the areas of work for UNAIDS and serving as its guiding framework.

Table 2: UNAIDS objectives

Objective 1	Provide leadership in the global response to HIV/AIDS
Objective 2	Mediate consensus on global HIV/AIDS policies and programs
Objective 3	Strengthen monitoring capacities and implement appropriate strategies at country-level
Objective 4	Support national governments in developing and implementing comprehensive strategies and effective HIV/AIDS activities
Objective 5	Political and social mobilization for HIV/AIDS response and prevention
Objective 6	Advocating on global and local level for adequate resource mobilization and allocation

(Source: own presentation after Knight 2008: 29)

Programme Coordinating Board (PCB)

UNAIDS is guided by the Programme Coordinating Board, consisting of 22 Member States with a specific distribution of seats[5], with strong representation of traditionally receiving countries. Additionally, five non-governmental organizations (NGOs) serve as non-voting PCB members, as well as the cosponsors (UNAIDS 2020: 16ff.). The PCB is the governing and decision-making body of UNAIDS (Knight 2008: 34; UNAIDS 2020: 16). Its responsibilities include reviewing and approval of UNAIDS policies, plans of action and financial plans. This is to be done in consideration of the Executive Directors' and Committee of Cosponsoring Organizations (CCO) input and recommendations (UNAIDS 2020: 15ff.). For the PCB to work up to its best potential it can establish working groups and subcommittees to work on specific topics (UNAIDS 2020: 20; UNAIDS 2022d). The unique composition of the

[5] Five seats for Africa and Asia each, three seats for Latin America and the Caribbean combined, two seats for Eastern Europe, and the remaining seven seats for 'Western Europe and other States'

PCB makes UNAIDS the only UN body that has active representatives of NGOs on their governing body (Knight 2008: 34). In addition, this kind of governing structure enables active participation of civil society and people infected and most affected (Lisk et al. 2013: 127f.).

Committee of Cosponsoring Organizations (CCO)

In addition to the PCB, the conglomerate of six agencies who had previously been on the GPA Management Committee were formalized into the Joint Programme's Committee of Cosponsoring Organizations (CCO). The initial six cosponsors have since been joined by multiple other UN bodies. As of February 2023, there are eleven cosponsoring UN organizations (UNAIDS 2022f). The CCO is composed of the heads of each cosponsoring organization. All decisions made by the PCB are taken to the cosponsoring organizations respective boards through the CCO, to ensure UNAIDS policies are incorporated into cosponsors activities and result frameworks (UNAIDS 2022c). The CCO responsible for providing input from the cosponsoring agencies to UNAIDS strategies and policies. Furthermore, the CCO reviews the budgetary and workplan proposals by the Executive Director as well as the PCB. Moreover, CCO members review the activities of the cosponsoring organizations and their level of consistency with UNAIDS policy and targets. Additionally, it is the responsibility of the CCO members to give technical advice according to the mandate of their respective organization (UNAIDS 2020: 22).

UNAIDS Secretariat and Executive Director

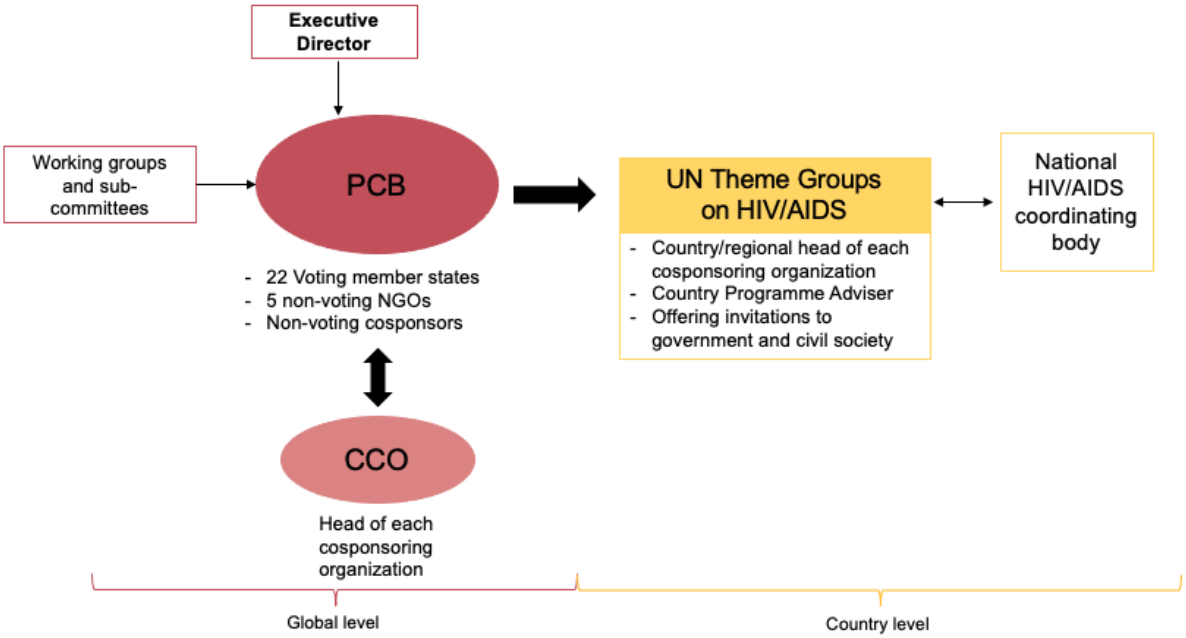
The UNAIDS Secretariat consists of the Executive Director, appointed by the UNs' Secretary-General, together with all administrative and technical staff necessary for the program to run smoothly. The Executive Director is by office the Secretary to both the PCB and CCO (UNAIDS 2020: 23f.).

UN Theme Groups on HIV/AIDS

In addition to the organizational structures on the global level UNAIDS has established 'UN Theme Groups on HIV', to extend its work on the country level (see Figure 1). The Theme Groups comprise the head of each cosponsoring organization of the respective country/region, likewise the organization of the CCO. In addition, the group is joined by the Country Programme Adviser (CPA), employed by UNAIDS (Knight 2008: 50). Furthermore, Theme Groups offer civil society an opportunity for a seat at the table and help manage the relationship between national governments and local civil society organizations (CSOs) through UNAIDS mediation (Knight 2008: 52). These Theme Groups were intended as the link between the UN body and the country's national HIV/AIDS coordinating institution, for example ministries of health. Aligned with UNAIDS objectives the implied task is to formulate national HIV strategies according to local needs (Knight 2008: 50). In addition, the Theme

Groups are an important tool to streamline activities of multiple agencies and organizations in the same country, competing for funding and creating duplicates (Knight 2008: 51).

Figure 1: Governing structure – UNAIDS



(Source: own presentation)

Funding and resources

Unlike its predecessor, UNAIDS itself is not a funding agency but supports the Global AIDS Strategy through its advocacy and technical advisory work. Through this work, the organization played and still plays an incremental role in the mobilization of resources for the response to HIV/AIDS (Lisk et al. 2013: 129f.; Knight 2008: 22). Yet, this means, that UNAIDS itself relies on outside funding, which, in large parts, is channeled through the eleven cosponsoring UN organizations (UNAIDS 2021a: 81). UNAIDS operates on a budget, which decided on in a biennial rhythm, in line with the biennial work plan (Knight 2008: 56 ff.; Lisk et al. 2013: 130). For the years 2022-2026, the budgets and work plans are embedded into the strategic directions set out by the 2022-2026 Unified Budget, Results and Accountability Framework (UBRAF) (UNAIDS 2021a: 5).

UNAIDS funds are separated into core and non-core funds. Core funds are used to fund the Secretariat itself with all its functions, as well as the HIV/AIDS related work of the eleven cosponsoring organizations. In contrast, non-core funds are mostly earmarked for specific purposes and support additional initiatives and programs beyond the work of the Secretariat. Therefore, they cannot be used as flexible as core funds and are seen as supplementary (UNAIDS 2023a).

The majority of UNAIDS funds, both core and non-core funds, are mobilized on the global level (UNAIDS 2017: 8). Donations are made either on an ad hoc basis or are based on

multi-year commitments, which ensure more predictable funding for UNAIDS. These contributions are supplemented by donations from bi- and multilateral aid agencies and development partners, as well as foundations and the private sector. (UNAIDS 2023a). Additionally, UNAIDS regional and country offices raise money locally, through a mix of domestic funding, private sector donations and international donors (UNAIDS 2017: 8). Moreover, a large share of funds mobilized by UNAIDS Cosponsors mainly flows as non-core funds into the various UNAIDS Strategy areas (UNAIDS 2023d), e.g. testing and treatment, prevention or mother to child transmission (UNAIDS 2023e).

In 2021, UNAIDS held its first Structured Funding Dialogue with donors, with the goal to strongly position UNAIDS and its work in the Global AIDS Strategy, create momentum for its priorities and invigorate more predictable and flexible funding for the future (UNAIDS 2021b: 2). During this event, it was highlighted that in recent years, UNAIDS funding had been relatively stable (UNAIDS 2021b: 7). However, funding gaps remained and are to be expected to increase in the upcoming years if the donor community does not step up. For the 2022-23 funding period, a 35 million US$ funding gap is expected just for core funds. In addition to the general funding gap, the mixture of funding available has changed drastically. While core, non-earmarked funds amounted to 174 million US$ in the 2016-17 funding period, they have lowered down to just 44 million US$ in 2020-21. This leaves UNAIDS without its much-needed flexibility to direct funds to key issues (UNAIDS 2021b: 8).

4.1.3 Development and achievements by UNAIDS

Despite substantial reluctance of UN agencies to collaborate and to ‘being coordinated’ by UNAIDS, the organization managed to gain momentum over the first five years of its operation. An essential factor promoting UNAIDS’ role as an important resource was the focus on collecting and publishing reliable and comprehensive data on the extend and impact of the epidemic (Knight 2008: 59ff.).

In January 2000, the UN Security Council discussed HIV/AIDS as a major security concern and a hindrance to development efforts. This was a premiere for the Security Council, to consider a health issue as a threat to global security. These considerations were the result of close collaboration between the United States Ambassador to the UN and Security Council member, Richard Holbrooke, with UNAIDS. During the Security Council meeting light was shed on various effects of the epidemic, from its overwhelming impact on health systems to socioeconomic crises and its threat to political stability (Knight 2008: 106f.). This was especially important, as many African leaders had been resistant to acknowledge the severity of the situation, despite being most affected by its consequences (Knight 2008: 1007). Later that year, the United Nations Millennium Declaration was adopted by the 2000 Millennium Summit, declaring the UNs eight Millennium Development Goals (MDGs), set to

be achieved by 2015 (UN 2015). Particularly important for UNAIDS work was Goal 6: “Combat HIV/AIDS, malaria and other diseases” (UNAIDS 2020: 143), with sub-targets focusing on halting and reversing the spread of HIV/AIDS by 2015 and increasing access to ARTs (UNAIDS 2020: 143). “With three of the eight MDGs specifically focused on health, the MDG agenda catalyzed a remarkable increase in official development assistance for health” (Bekker et al. 2018: 318).

Following the debate in the Security Council, the UN General Assembly had passed a resolution to hold a UN General Assembly Special Session on AIDS (UNGASS) the following year (Knight 2008: 110). In 2001, the world’s leaders came together for three days to discuss HIV/AIDS and demonstrate commitment at the highest level. The goal of UNGASS was a Declaration of Commitment on HIV/AIDS, which came with considerable challenges. Topics such as the balance between prevention and treatment, as well as more sensitive issue such as cultural and religious barriers rendered substantial discussion (Knight 2008: 132ff.). However, UNGASS offered a stage for UNAIDS to show its capabilities in coordinating and bringing together different agencies and stakeholders and brokering joint commitment (Knight 2008: 134f.). By the beginning of the new millennium, through major contribution by UNAIDS, the attitude towards HIV/AIDS had changed majorly. Starting out as a denied and talked-down epidemic it now became a broadly recognized issue, needing attention from the entirety of global organizations and leaders (Knight 2008: 105).

In 2002 and 2003, the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) started operating. As a result, a vast increase of funding for the fight against HIV/AIDS was pledged and disbursed. According to the first U.S. Global AIDS Coordinator Randall Tobias “the existence of UNAIDS ha[s~~d~~] been very critical to the development of PEPFAR” (Knight 2008: 170), which in turn would generate additional 10 billion US$ for the next five years (Knight 2008: 169). Besides, to make the Global Fund and PEPFAR work, the already established country networks of UNAIDS were imperative (Knight 2008: 170; Brugha et al. 2004: 97).

In 2004, UNAIDS leveraged on its well-established partnership with MTV and together they launched the Global Media AIDS Initiative (GMAI), in collaboration with 20 major media corporations to help raise awareness through a variety of educational and entertainment productions focusing on HIV/AIDS. One year later already 130 media companies worldwide were involved (Knight 2008: 182f.). Other milestones in the work of UNAIDS and the fight against HIV/AIDS during the first years of the 21st century included the launch of various Partnerships, e.g. the International Partnership against AIDS in Africa (IPAA) (Knight 2008: 118) and the Pan Caribbean Partnership against HIV/AIDS (PANCAP) (Knight 2008: 130f.). Furthermore, the World Bank recognized the magnitude of the epidemic and launched its own Multi-Country HIV/AIDS Programme for Africa (MAP) to channel funding (Knight 2008:

117f.). In addition, achievements in lowering ART prizes and increasing treatment rates were made (Knight 2008: 121ff.).

By 2006, more than 100 countries had established national HIV/AIDS strategies and national HIV/AIDS coordinating bodies that put monitoring and evaluation systems in place (Lisk et al. 2013: 128). Having such strategies and coordinating bodies helped to accumulate additional domestic and donor funding and monitor progress and targets. Furthermore, the UN General Assembly held another High-Level Meeting in HIV/AIDS in June 2006, to recognize the achievements made but also reiterate the continued need for action and their commitment to fighting HIV/AIDS (United Nations 2006).

In 2008, UNAIDS' first Executive Director, Peter Piot stepped down after eleven years in this position. UNAIDS' achievements until 2008 were widely recognized to be a closely tied to his persona, and result of his strong leadership and advocacy work. However, this raised questions on how to differentiate the program from his person, in addition to criticism regarding UNAIDS passive attitude towards ideology driven policies and programs (Das/ Samarasekera 2008: 2100f.). Discussions arose whether UNAIDS could function with a new Executive Director and who he or she could be, or, if UNAIDS was outdated and should be shut down all together. Ultimately, there was consensus that the work of UNAIDS is still needed, although reforms would be necessary in some areas, for example regarding the scrutiny of UNAIDS estimates and in invigorating coordination within and outside of UANIDS (Das/ Samarasekera 2008: 2102). Michel Sidibé followed into Peter Piots footsteps and became the new Executive Director, staying this position from 2009-2019 (UNAIDS 2023b).

In June of 2011, HIV/AIDS was once more recognized for its detrimental effects on human and country development and the need for sustained action reiterated by the 2011 UN Security Council Resolution (UN 2011a) and the 2011 Political Declaration on HIV and AIDS (UN 2011b). In this General Assembly Resolution Member States re-pledged their commitment to sustaining progress in the fight against HIV/AIDS. Further Political Declarations followed, focusing on ending the AIDS epidemic by 2030, in 2016 (UNAIDS 2016) and again in 2021, with the "Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030" (UNAIDS 2021c).

The target to end the AIDS epidemic as a public health threat by 2030 had been set as part of the SDGs, which were introduced in 2015, following the MDGs (Bekker et al. 2018: 320). Especially 'Goal 3 – Good Health and Well-being', target 3.3 focuses on fighting communicable diseases and ending the AIDS, TB and malaria epidemics by 2030. It has since become an important focal point for global health action (Joint SDG Fund n.y.). Additionally, in 2013, in contemplation of the 2015 MDG deadline, UNAIDS set the 90-90-90 target to be reached by 2020 (Bekker et al. 2018: 320).

After allegations of harassment became loud in 2018, findings by an Independent Expert Panel were damning. The panel attested UNAIDS “a work culture of fear, lack of trust and retaliation” (Horton 2018: 2536), with employees almost used to bullying, sexual harassment and abuse of power (Horton 2018: 2536, Wise 2018). Furthermore, the panel made Executive Director Michele Sidibé responsible, by enabling a culture of autocratic and patriarchal leadership, far off from UNAIDS’ commitment to good governance and non-discrimination (Horton 2018: 2536). “UNAIDS secretariat was in crisis, and the evidence of a broken organisational culture was overwhelming“ (Wise 2018). The publication of the findings opened the door back up for critics to question the continued need for UNAIDS’ existence (Headley et al. 2019: 381f.). Yet, similar to the situation ten years earlier, critics were met by a number of voices demonstrating the continued need for UNAIDS as an organization. However, it was clear that a change in leadership was necessary to follow through with much needed reforms and a cultural change within UNAIDS (Headley et al. 2019: 382). Following the leadership crisis and reputational loss for UNAIDS, Sidibé stepped down and was superseded by todays UNAIDS Executive Director Winnie Byanyima, who has put an emphasis on the situation of women and girls in her work at UNAIDS (UNAIDS 2019).

Since 2020, reaching UNAIDS and SDG targets has been heavily impacted by the COVID-19 pandemic (Jiang et al. 2022).

4.2 The Global Fund to Fight AIDS, Tuberculosis and Malaria

The Global Fund to Fight AIDS, Tuberculosis and Malaria was introduced in 2002 as PPP (Hanefeld 2014: 54) with the goal “to attract, manage, and disburse additional resources worldwide to control the[~~se~~] three” priority diseases (Brugha et al. 2004: 95). Hereby, the focus lies on the generation of additional resources and not just channeling the already available funding from donors (Brugha 2005: 623).

4.2.1 Background and establishment

The first discussion about a funding mechanism to fight the epidemics of HIV/AIDS, tuberculosis (TB) and malaria was at the first Group of eight (G8) meeting in 2000, and later reiterated in a follow-up meeting the same year (Knight 2008: 116f.). The rationale for establishing the Global Fund had also been discussed at UNGASS, in form of a special fund for HIV/AIDS through which countries could make sustainable contributions to reach the goals of the MDGs, with an annual budget between seven to ten billion dollars (Maciocco/Stefanini 2007: 482). In 2001, discussions by donors and UN organizations continued (Knight 2008: 157). Civil society hoped for a balanced private-public distribution, with recipients and donors having a seat at the table, next to the UN, CSOs, and NGOs. This was

also supported by UNAIDS, who fought for implementing countries to have an equal voice in the Global Fund (Knight 2008: 158). The decision for the establishment of the Global Fund was endorsed by the G8 in July 2001. The actual establishment was managed by a Transitional Working Group, and only six months later, in January 2002, the Global Fund started its work (The Global Fund 2023f).

4.2.2 Objective, governing structure, and budget

The Global Fund was explicitly designed to be a funding mechanism without the mandate to act as an implementing or technical agency (Poore 2004: 52). Upon its introduction, the Global Fund was perceived as highly innovative. Firstly, this was due to its ambitious goal to tackle the three most important and devastating diseases for the health and development of LMICs. Secondly, the short time in which it was decided on and set up was a novum, and lastly, its pledge to far-reaching transparency was very attractive to donors. Furthermore, the Global Fund marketed a quick disbursement mechanism (Brugha 2005: 623) in contrast to the usual time-consuming bi- and multilateral donor negotiations (Brugha et al. 2004: 98f.).

Board

The Global Fund itself only operates in its main offices in Geneva, Switzerland, and does not have any country-offices itself (Zühr et al. 2014: 7). It is governed by the Board, which consists of 20 voting members equally representing donor countries, implementing countries, the private sector, private foundations, NGOs, and communities affected by the diseases. Additionally, eight non-voting members, including the Chair and Vice-Chair of the Board, representatives of the supporting organizations (UNAIDS, WHO, World Bank) as well as other public donors, are part of the board (The Global Fund 2023b). Each of the members represent their constituency in all board functions. These include strategy development, governance oversight and performance assessment, resource commitment to receivers, risk management as well as engagement with partners focusing on advocacy and resource mobilization (The Global Fund 2023b). The board delegates some of its work to three standing Committees: the Audit and Finance Committee, the Ethics and Governance Committee, and the Strategy Committee. Committee members are also representatives of their constituencies. Seat distribution is done with respect to the balance of donors and implementers (The Global Fund 2023c).

Secretariat and other operational structures

There are additional structures reporting to the board, which are significant for the Global Fund. The **Secretariat,** located in Geneva, represents approximately 700 staff members who carry out the Funds daily operations. These include among others grant and risk

management, finance and accounting, coordination of the grant application process, engagement with donors, private sector, and advocacy groups, as well as legal affairs (The Global Fund 2023m). “The Secretariat is headed by the Executive Director of the Global Fund” (Zühr et al. 2014: 7), who is appointed by the board.

The **Technical Review Pane**l receives all proposals and requests for funding and evaluates each, before making a recommendation to the board, which then makes the final decision on funding approval (The Global Fund 2023n). Experts serving on the Technical Review Panel do not represent any constituency but themselves and their professional opinion (The Global Fund 2023o).

The **Office of the Inspector General** holds a special role within the Global Funds system, as it is independent from the Secretariat. The Inspector General is granted special access to all books and records concerning Global Fund funding as well as all implementation and program sites. “Through audits, investigations and consultancy work, the Office of the Inspector General promotes good practice, reduces risk and reports on abuse.” (The Global Fund 2023h). The Office of the Inspector General is an eminent part of the Global Funds pledge to thorough transparency and accountability to its donors and recipients.

Country Coordinating Mechanism (CCM)

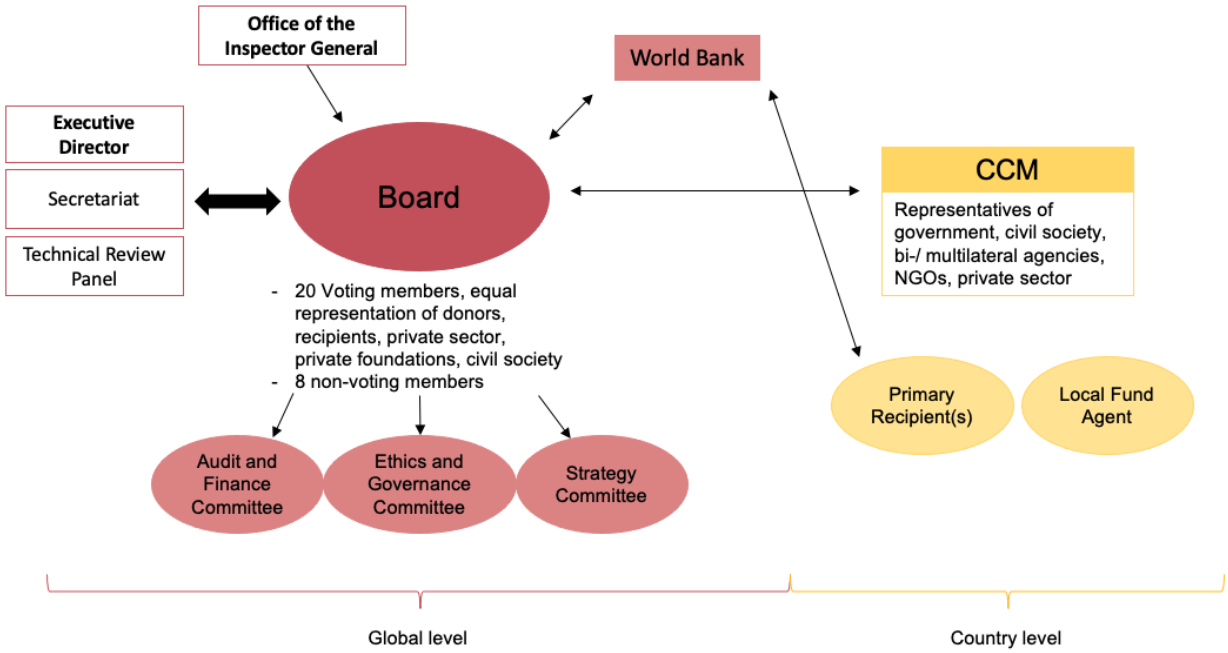
As mentioned before, the Global Fund is unique in its structure as is has no own country offices and therefore relies on support from in-country partners (Zühr et al. 2014: 8), such as UNAIDS or WHO (Knight 2008: 159). Implementing countries have to establish a Country Coordinating Mechanism (CCM) in order to develop and submit a grant proposal to the Global Fund. CCMs should include representatives from the government, NGOs, bi- and/or multilateral organizations, academia, the private sector, civil society and people most affected or living with the priority diseases. According to the Global Fund, civil society should make up around 40% of representatives of the CCM, although this number is far from being met so far (Sands 2019: 101). In their proposal, CCMs must demonstrate its basis on national strategies and on “an inclusive multi-stakeholder process” (Zühr et al. 2014: 10). After a grant proposal is approved by the Global Fund the CCM is then responsible for overseeing the implementation and success of the activities.

In addition, one or more **principal recipients (PRs)** must be appointed by the CCM. The PR is the country organization which receives the funds, “implements and monitors programmes, and is accountable for how funds are used” (Brugha et al. 2004: 95). This can, for example, be the ministry of health or CSOs. After grant approval, the Global Fund signs a grant agreement with every PR listed in the proposal individually, which are then authorized to pass on parts of their funds to other implementing organizations (sub-recipients) (Zühr et al. 2014: 8). Furthermore, to oversee and verify the implementation and progress, and to further ensure in-country financial accountability, the Global Fund contracts an

independent organization to act as **Local Fund Agent** (Brugha et al. 2004: 95). This is usually an accounting firm, which is also tasked with verifying the progress reports submitted by PRs (Zühr et al. 2014: 9).

Organizational structures on the global level and country level are connected and work together as can be seen in Figure 2.

Figure 2: Governing Structure – The Global Fund



(Source: own presentation)

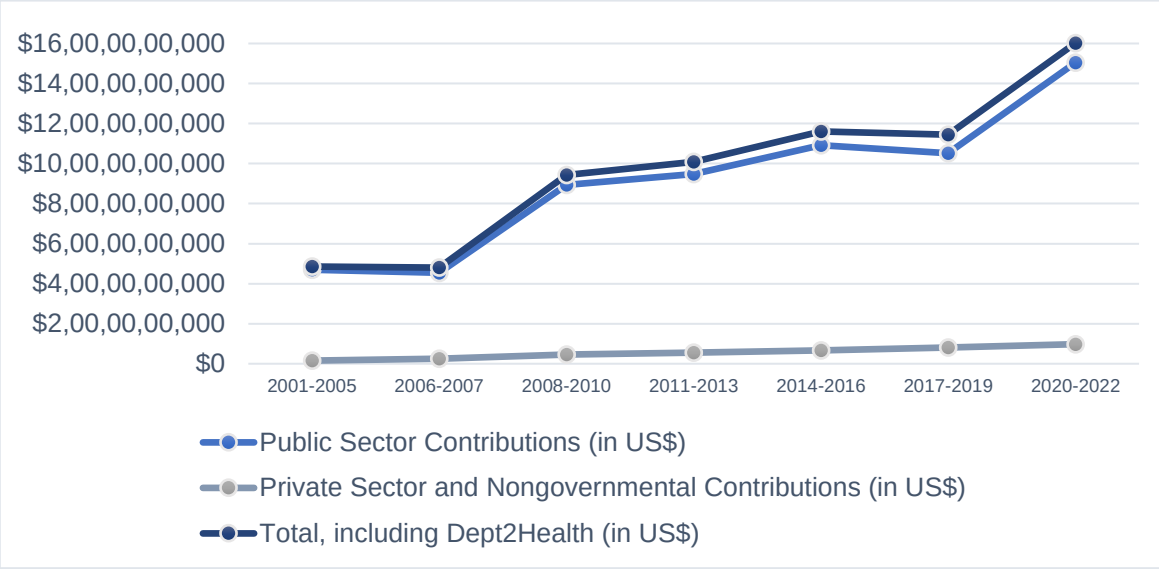
Funding and resources

The World Bank has another important role in the Global Funds system, as it serves as the Funds trustee (Knight 2008: 158). Therefore, funding pledged by donors is collected and disbursed to recipients through World Bank (see Figure 2) (The Global Fund 2022a: 30). Funding for the Global Fund is mobilized through a multitude of donor pledges, private partnerships, and innovative financing mechanisms. The Global Funds most important tool to generate funding are 'Replenishments', which were introduced in 2005 to establish more predictable funding. Replenishments are three-year funding cycles which are preceded by a fundraising period, during which donor governments, private foundations, and the private sector pledge donations in an effort to reach the Global Funds predicted needs (The Global Fund 2023l). However, actual contributions often lack behind the amount of funding pledged during the fundraising period (The Global Fund 2022a: 28f.; The Global Fund 2023e). In the seventh Replenishment 2022, covering the resource needs for the 2024-26 implementation period, the Global Fund estimated a global funding need of 130 billion US$ for all three priority diseases worldwide. To reach this number, the Global Fund asked its donors for at least 18 billion US$ in its latest Investment Case (The Global Fund 2022b), to stay on track

with its current activities and make up for the losses resulting from the COVID-19 pandemic (The Global Fund 2022b: 12).

The majority of Global Fund resources come from public sources, “with 94% of […] funding coming from donor governments” (The Global Fund 2023k), as can be seen in Figure 3.

Figure 3: Budget development, including funding for TB and Malaria – The Global Fund



(Source: own presentation after The Global Fund 2023i)

However, until January 2022, private contributions made up more than 3.5 billion US$ out of overall Global Fund budgets (The Global Fund 2023j). This funding was mobilized by foundations and other nongovernmental groups, as well as faith-based organizations (The Global Fund 2023k). In addition to direct pledges, the Global Fund promotes a variety of innovative financing mechanisms. For instance, some countries offer ‘Dept2Health swaps’ (The Global Fund 2023g). In this scenario, creditor countries cancel dept owed by a beneficiary country in exchange for it to transfer a negotiated share of the original dept to the Global Fund. This funding is then earmarked and reinvested into health programs in the beneficiary country through a Global Fund grant (Cassimon et al. 2008: 1188). Another innovative financing mechanisms, (RED), was introduced in 2006. (RED) is a retail marketing initiative that collaborates with popular brands such as Apple, Nike, Jeep, or Starbucks. Together with (RED) they develop (RED) products as part of their own product-lines. With the purchase of a (RED) product consumers trigger a corporate donation to the Global Fund, earmarked for investments towards HIV/AIDS (The Global Fund 2023a). This form of collaboration is a good example for the Global Funds’ strong position in brokering PPPs. However, the private sector is not only important in leveraging financial resources, but also for implementation and delivery processes. Many private partners are active on the ground, sometimes by serving on CCMs or as PRs or sub-grant recipients, for example providing supply-chain support. Furthermore, private sector partners have a lot of in-kind resources

to offer, such as valuable technical expertise and technologies, supporting data management and digitalization (for example Mastercard and Coca Cola) (The Global Fund 2023d).

Funding from the Global Fund is disbursed through different schemes, for example results-based financing, where funding disbursement is tied to achieving pre-agreed results. This is also known as 'cash on delivery' (The Global Fund 2023g). Another disbursement method is outcome-based financing, for example in the form of social impact bonds. This means, that investors provide funding upfront and are repaid once pre-defined outcomes are achieved, for example with the cost-savings accumulated by reducing the cost for governments to deal with a social issue (Australian Housing and Urban Research Institute 2021). In contrast to UNAIDS, the Global Fund has a slim body of staff, operating in Geneva only. By not having their own country-offices the Global Fund was able to keep operation costs relatively low (Zühr et al. 2014: 7), at approximately 326 million US$ in 2021 (The Global Fund 2022a). However, this is not without mentioning that opportunity costs to manage funds and keep reporting up are then outsourced to the implementing countries (Hanefeld 2014: 55).

When talking about funding and resources in the context of the Global Fund another important aspect is how money is distributed among implementing countries. However, since the focus of this thesis lies on the resource generation rather than the distribution, this aspect will not be further highlighted. Yet, this is not without mentioning the importance of these issues in achieving equity and effectiveness in program delivery.

4.2.3 Development and achievements of the Global Fund

The rapid establishment of the Global Fund did not come without its initial challenges. In the early 2000 years, a multitude of donors focusing on HIV/AIDS, namely the Global Fund, the World Bank Multi-Country AIDS Program (MAP), PEPFAR, and the Clinton Initiative were all acting simultaneously in the same countries (Brugha 2005: 625). This put significant pressure on recipient countries governments to interact and negotiate with all donors and keep their expectations satisfied (Brugha et al. 2004: 98f.). Therefore, it was important to clarify the Global Funds' role within this already complex global health initiative structure. Additionally, the requirement for countries to establish a CCM proved challenging, not least because it was unclear how CCMs should be located within already existing country structures, for example national AIDS councils (Brugha 2005: 624), especially with the additional focus on TB and malaria. Moreover, in some countries power imbalances between government, NGOs, civil society and private sector representatives were reported, which limited some parties to voice their opinions. Collaboration in the CCM was further hampered by the unclear role definition and lack of regular participation of representatives (Brugha et al.

2004: 97f.). On the other hand, the Global Fund was welcomed by some recipient countries because it offered previously unknown autonomy to recipient countries in formulating their own country proposals (Brugha et al. 2004: 96) instead of just doing what external donors and advisors saw fit. This promoted country ownership and alignment with national strategies (Hanefeld 2014: 55).

Once grants had been approved, the Global Fund had high expectations on frequent reporting from implementing countries, and the PRs specifically. However, it became evident quickly that PRs were lacking skills and/or capacity to keep up with such close monitoring and reporting requirements. In some cases, different reporting standards and frequencies had already been implemented by other donors, yet they did not match Global Fund requirements, posing a risk of creating duplication of reporting systems (Brugha et al. 2004: 99). Satisfying all the different reporting requirements was especially difficult in sector-wide approaches with pooled resources from multiple donors (Brugha et al. 2004: 96f.). In the case of Global Fund funding, inability to keep up reporting and meet indicator goals slowed down fund disbursement (results-based financing), as it was linked to regular implementation monitoring and PRs showing Value for Money (VfM) (Brugha et al. 2004: 98). This created a dilemma for the Global Fund early on: the Global Fund had advertised transparency and accountability by establishing high monitoring and reporting expectations. This was also necessary to demonstrate good performance and VfM to donors to attract future funding pledges (Brugha et al. 2004: 100).

On the other hand, it proved unsustainable for many implementing countries and slowed down progress. As a result, the Global Fund had to demonstrate its willingness to adapt. After two years, reporting requirements were redesigned with more flexibility to reduce the strain on the countries with highest disease burdens and the weakest health (reporting) systems (Brugha 2005: 624f.). This was also a necessary reform for the Global Fund, as it was and still is competing with many other initiatives for funding. This emphasized the need for the Global Fund to establish, demonstrate and keep up its role as a quick and reliable partner to donors (Brugha 2005: 625). In addition, the Global Fund still needed to make a case for its ability to "actively harmoniz[e~~ing~~] its systems and process with recipient countries" (Brugha 2005: 625). Adding to the challenges regarding reporting, weak and undersourced health systems in recipient countries also exhibited limited capacities to absorb huge amounts of money in a short time, as the Global Fund was ready to offer and disburse (Brugha et al. 2004: 99). This exacerbated criticism from some donors and scholars on the Global Funds vertical program approach by focusing on three diseases only, thereby disregarding the need for general health system strengthening through a sector-wide approach (Brugha et al. 2004: 96f.; Maciocco/Stefanini 2007: 485). As a result, in 2005, the Global Fund allowed proposals focusing on health system strengthening, to mitigate those

difficulties and support absorption abilities of grant recipients (Maciocco/Stefanini 2007: 485).

Despite initial difficulties, by mid-2006 efforts by the Global Fund had contributed substantially to the MDG targets for health (Komatsu et al. 2007: 805).

In 2010, partially because of the financial crisis, donor pledges fell short in reaching the projected needs of the 2011-2013 replenishment round. The estimated need of at least 13 billion USD to sustain the existing grants in addition to funding new proposals fell short, with only 11.7 billion USD being pledged (The Lancet 2010: 1274). Additionally, in 2011, allegations that Global Fund money was being mismanaged became loud and irregularities had been discovered in internal audits. As a result, the Global Fund further suffered loss of trust from donors. Despite only small amounts of money being misused by a small number of countries, some donors blocked their funding to the Global Fund as a result (Hanefeld 2014: 55). Subsequently, the board took the decision to suspend the already announced funding round because of lack of funds and in order to focus work on reforming the Global Fund. In 2012, the board approved the New Funding Model (NFM), which enabled significant changes to the funding system. This included adjustments in the funding period to improve funding predictability (Zühr et al. 2014: 1), and the introduction of country dialogues to increase interaction between the Secretariat and CCMs to support proposal preparation and improve proposal quality (Zühr et al. 2014: 10). Furthermore, the NFM formulated an explicit funding allocation methodology, accounting for disease burden and the ability to pay of affected countries, which had not been consistently measured before (Fan et al. 2014: 2240).

Until 2016, the Global Fund spent more than 17 billion US$ for HIV/AIDS programs in over 100 countries (Bekker et al. 2018: 323). For the funding period between 2017-19, the Global Fund managed to get back on track in terms of fulfilled replenishments, when of the 13 billion US$ the Fund asked for, about 99,3% were pledged. This was partially due to upped commitments from major donors such as the USA, Japan and Germany. But even more remarkable were record numbers of commitments from African countries (Usher 2016: 1265). As of 2020 there was a 50% decline in the combined mortality of AIDS, TB and Malaria in countries where the Global Fund had funded programs. About half of the 38 million people living with HIV were on ART sponsored by the Global Fund (Olufadewa et al. 2021: 284). By 2022, the Global Fund saved 44 million lives (The Lancet 2022: 787). In its latest replenishment in September 2022 the Global Fund asked for at least 18 billion US$, remaining focused on the Goals of SDG3, fighting against the three priority diseases and strengthening health systems, which had rendered even more fragile in the eye of the COVID-19 pandemic. Therefore, 6 billion US$ are planned to go to pandemic preparedness and health system strengthening specifically (The Lancet 2022: 787).

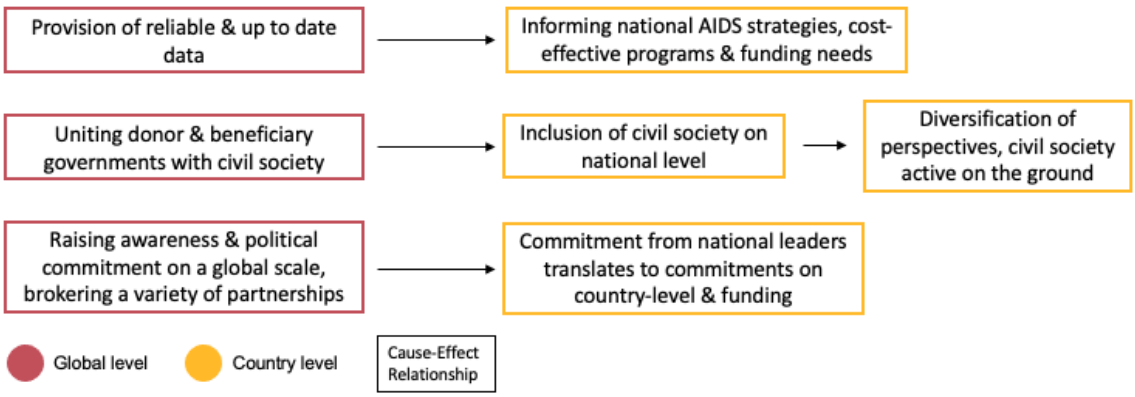
4.3 Learnings

In this section general learnings that can be drawn from the key components of the conceptual model of each program in addition to the establishment, history, and achievements of UNAIDS and the Global Fund will be presented. Furthermore, learnings are depicted on the basis of the comprehensive literature search for both programs and the general fight against the HIV/AIDS epidemic. They will later serve as the basis for the prospective evaluation.

4.3.1 Conceptual model and learnings from UNAIDS

The conceptual model for UNAIDS (see Figure 4) depicts its most basic elements and identifies the programs output for the fight against and funding for HIV/AIDS, by defining their cause-effect relationships. Additionally, the conceptual model differentiates on the activities and outcomes on the global and country-level. The conceptual model is based on the information in chapter 4.1.

Figure 4: Conceptual Model – UNAIDS



(Source: own presentation)

One of the six objectives of UNAIDS, which was prominent in establishing the programs role as an important resource was the focus on collecting and publishing reliable and comprehensive data on the extend and impact of the epidemic (Knight 2008: 59ff.). The introduction of a broad set of indicators and data publications by UNAIDS delivered a much-needed basis for the work and response to the HIV/AIDS epidemic. Having one place to look for up-to-date and reliable data on the development of the epidemic and the indicators set was crucial for monitoring the epidemic. Additionally, it provides a basis to hold leaders and governments accountable and to inform further required action, as well as program and funding needs (Piot et al. 2015: 182; Sridhar 2012: 22; Knight 2008: 181).

UNAIDS demonstrated a vital role in bringing stakeholders together on global and country level, in the PCB and the UN Theme Groups on HIV/AIDS. By engaging various UN organization, civil society and activist groups as well as government officials the multitude of

stakeholders were forced to recognize different perspectives. Furthermore, UNAIDS innovatively engaged with stakeholders such as major corporations and the pharmaceutical industry (Knight 2008: 57ff.; 65ff.). Through its original organizational structure, UNAIDS ensured an integrated response from various perspectives by drawing on the mandates of multiple UN agencies and coordinating their response (Lisk et al. 2013: 127). Furthermore, including perspectives of governments and civil society alike helped to inform local needs and national AIDS strategies. In turn, this promoted country-ownership for AIDS activities and strategies. The idea that "nobody's too rich not to need support or too poor not to offer support" (Knight 2008: 84) further promoted horizontal collaboration within spatial proximity through UNAIDS "technical resource networks". These networks were another good example for country-ownership and the limited need for external actors to step in, as was traditionally the case.

On the contrary, UNAIDS, in line with other UN agencies, is criticized for having become an expensive bureaucracy machine with little actual control and real power over the cosponsor's participation and execution of PCB decisions (Sridhar 2012: 22, Graham 2017: 59). Moreover, UNAIDS faced similar challenges as many other development efforts, which was operating within a fragmented donor landscape. With various reporting requirements from different donors and donor delegations visiting program sites frequently, they were overpowering receiving governments and their capacities. While implementation and absorption capacities in receiving countries were already limited, they were further strained visiting delegations and donor negotiations, instead of working on national HIV/AIDS strategies and their implementation (Knight 2008: 183 ff.). Another issue was the lack of accountability of donors to their beneficiaries and alignment of programs with the country's needs (Knight 2008: 186, 188s). UNAIDS' mandate includes the coordination of donor activities to reduce duplication and transaction costs, not just on the global level, but also in support of national efforts. Yet, despite honest efforts from UNAIDS and various Declarations on Aid Effectiveness and Harmonization signed by HICs and LMICs alike during the first years of the 21st century, effective coordination of funds and programs in implementing countries is still insufficient and program duplication persists (Knight 2008: 185ff.; Piot et al. 2015: 182).

Further, the literature points out that the level of intrinsic motivation and incentives for those being coordinated is very important to make coordination possible and mitigate struggles for status, autonomy and political turf as were seen during the establishment and first years of UNAIDS (Graham 2017: 58f). Therefore, navigating inter-agency rivalries and defining roles and responsibilities between cosponsors and other stakeholders are crucial in the early stages of the program establishment. Nonetheless, the PCBs organizational structure was breaking new ground and still is unique in the UN system, especially in the sense that

for the first time civil society and people most affected were given a seat at the table and a voice on the highest level. This further broadened the perspective on the topic, as well as it demonstrated the importance of inclusion of civil society on all levels, for example in the composition of national AIDS councils and formulation of national AIDS strategies.

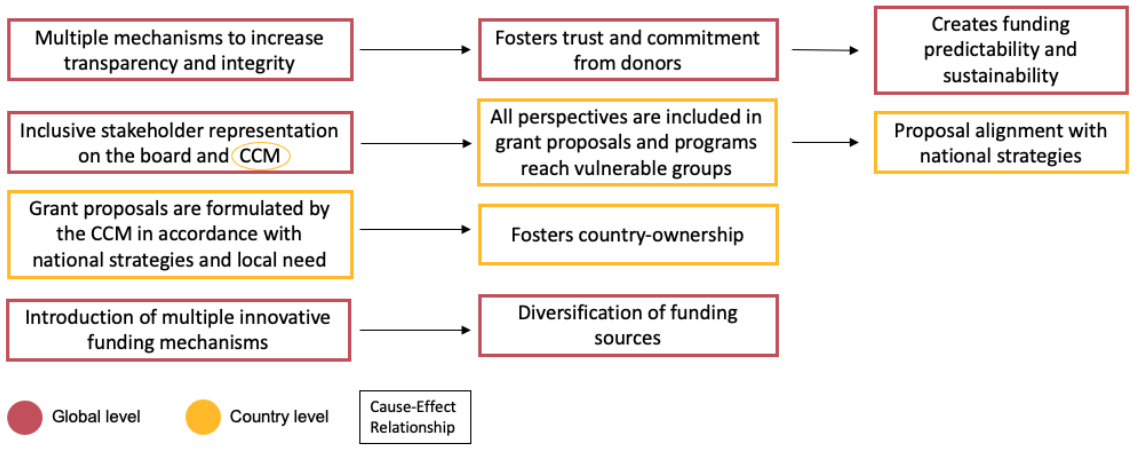
Another strength of UNAIDS and its position within the UN is its ability to broker versatile partnerships in many different domains, for example between countries (e.g. IPAA, PANCAP), with different industries (e.g. the pharmaceutical industry, the media), different funding organizations (The Global Fund, PEPFAR) and civil society. This characteristic helped to spark innovation and tackle the variety of issues accompanying HIV/AIDS from many different angles and with fresh ideas (Knight 2008: 81f.). Furthermore, UNAIDS collaborated with the UN Security Council members and brokered the discussion of HIV/AIDS in the council's session. Framing the pandemic as a security threat catalyzed immense momentum for the fight against HIV/AIDS and pushed it to the top of the agenda for many, particularly African leaders (Knight 2008: 106f.). Additionally, it helped generate funding challenged through security strategies (Shadyab et al. 2017: 80f.) However, framing the disease as a security threat can easily be misinterpreted and translated into infected persons to be perceived as a threat, which heightened stigma and discrimination.

Despite not being a funding organization itself, UNAIDS contributed enormously to the increase in funding (Knight 2008: 169; 181) by lobbying for the cause with key decision-makers and placing HIV/AIDS on top of the global agenda (Sridhar 2012: 22). Its advocacy was not just successful in promoting HIV/AIDS as a priority disease, but also a priority social and political topic, requiring action from all angles and the multitude of cosponsoring UN organizations (Sridhar 2012: 22). Among other things, UNAIDS advocacy work amplified the urgency of the situation and helped to create the stimulus for the creation of funding organizations such as the Global Fund and PEPFAR.

4.3.2 Conceptual model and learnings from the Global Fund

Equal to the UNAIDS conceptual model the Global Funds most basic elements and program outputs on the global and country-level, with regard to their cause-effect relationship, are depicted in Figure 5 based on the information from chapter 4.2.

Figure 5: Conceptual Model - The Global Fund



(Source: own presentation)

The level of transparency about funding and grant progress in the Global Fund is unique and highlighted by researchers. This characteristic is invaluable not just in terms of creating accountability but also in offering a basis for scrutiny and critical assessment for researchers and policymakers (Lu et al. 2006 :487).

Like UNAIDS, the Global Fund brings governments, civil society, the private sector, affected communities, and technical and development partners to the table at both local and global levels. This governance approach increases trust and ensures the inclusion and effective implementation of diverse perspectives (The Global Fund 2022b: 11). Furthermore, by forming CCMs and having them formulate the grant proposals in line with local needs and national strategies, and based on the diverse perspectives of constituencies represented, country-ownership is strengthened.

Yet, despite efforts to design the board democratically, some still criticize that implementing nations are marginalized, and representatives of donor nations and their preferences predominate the decision-making process (Adeboye 2018: 339). Therefore, scholars have pointed out, that “in this era of decolonizing health” further action should be taken to counter “neocolonial imbalance[s] in country representation” on the board, where currently only two out of 20 voting members represent the African region (The Lancet 2022: 787). Among the most affected groups by HIV/AIDS are sex workers, MSM, injecting drug users and adolescent girls. These groups are also highly marginalized and likely to experience

stigma and discrimination. Executive Director, Peter Sands, himself highlights the need to have strong representation of those groups in form of civil society representatives on the board, but especially in CCMs, to support program design in ways it can practically and genuinely reach those most affected (Sands 2019: 101f.). Another way the role of civil society is strengthened in HIV/AIDS programs is their introduction as PRs and service-providers. This further promotes that the groups most vulnerable can be reached through Global Fund funding.

The fight against HIV/AIDS, with the Global Fund on the forefront, pioneered different innovative financing strategies, such as the (RED) retail shopping campaign and dept2health swaps. These were an important addition to traditional donor schemes that also informed funding generation for other major health topics. In addition, they offer inspiration to develop new innovative financing schemes in the future (Hecht et al. 2009: 1601f.). However, there are also critical views on dept2health swaps, as their impact is easily overestimated by simply disregarding the lack of beneficiaries' fiscal space to invest large amounts of money into HIV/AIDS programs at once (Cassimon et al. 2008: 1189ff.).

The Global Fund took a vertical approach, by focusing on three priority diseases. However, despite the vast improvements there remains criticism that the focus on specific diseases often forgets "the fundamental indicators of health" (Maciocco/Stefanini 2007: 485), for example infant and maternal mortality. Adding to this, social determinants of health, such as socio-economic status or discrimination are not adequately addressed through vertical programs, although some exceptions might exist. To reach the high goals set, especially for the fight against HIV/AIDS, narrow-focused programs appear insufficient. Adding on to the criticism, shifting priorities to the Global Fund evidently led to the neglect of other health priorities, such as maternal and child health, for example through the Global Fund's competitive recruitment, often paying higher wages than other health programs had to offer. Subsequently, while HIV/AIDS targets were getting closer to being met, other health indicators were declining where the Global Fund was active (Maciocco/Stefanini 2007: 484f.). This was also the case within the realm of HIV/AIDS, as many experts in the field have point out that after the introduction of the Global Fund, "prevention fell through the cracks" (Knight 2008: 126), with focus shifting heavily to treatment (Knight 2008: 126).

4.3.3 General learnings from HIV/AIDS funding

The HIV/AIDS epidemic constituted a new challenge to the world, forcing the need to transform the usual approach of development aid, for health specifically. One way how this was done was the unprecedented inclusivity of boards and decision-making bodies on global and country-level. Uniting government representatives with non-government representation (NGOs, civil society, private sector), as well as UN organizations and agencies with a variety of focuses and mandates in the governing and decision making-bodies was innovative in the HIV/AIDS response and an incremental factor to its successes (Piot et al. 2015: 181f.). In addition, it fostered accountability, country-ownership and good relationships with civil-society and the private sector (Sridhar 2012: 22).
In both, and virtually all organizations handling such large amounts of money, there is a high need for strong leadership and compliance to mitigate and combat misuse of funds and corruption. Moreover, both, UNAIDS and the Global Fund, have undergone different crises and significant restructuring since their establishment. Here as well, literature often highlights the need for strong leadership, which is also visible through the extensive body of literature dealing with questions of failed leadership and unclear leadership continuance in UNAIDS and the Global Fund (Zühr et al. 2014: 12; Horton 2018; Wise 2018; Headley et al. 2019).

The need for strong country-ownership was frequently highlighted by UNAIDS and the Global Fund. However, since the Global Fund has no country offices itself, their work relies heavily on in-country structures, such as UNAIDS Country Theme Groups, which in some cases had already established national strategies that Global Fund grant proposals could be based on. Consequently, some form of country structures with strong representation of civil society and NGOs is critical to transport global advocacy to the ground. One striking difference between UNAIDS and the Global Fund is the amount of money needed to run each organization, which is partly due to the Global Funds lean organization structure relying on others on country level. Generally, operational costs have to be kept to a minimum to ensure that resources are directed to where they are needed most instead of seeping away in the United Nations and global health initiatives bureaucracy.
Furthermore, one has to keep in mind, that UNAIDS and the Global Fund, in line with virtually all other Global Health Initiatives, compete for the same donor funds (Sridhar 2012: 22) which makes them highly donor dependent. This in turn translates to donor-dependency of recipient countries. However, especially with view on stagnant or even declining donor contributions a revived effort from recipient countries to free domestic funding for HIV/AIDS and health in general, for example by aiming for the Abuja target spent of 15% for health, could ease both the high reliance on donors and general decrease in funding (Hecht et al. 2009:

1603; Yu et al. 2008: 7). This would also support the move from ‘upward accountability’, from recipients being accountable to donors, misguiding agenda setting and dismissing local priorities, which is a general problem in development aid. With a rise in domestic funding, there is a shift to ‘downward accountability’, from national governments to their citizens and beneficiaries on the ground, with more power of national governments to shape their programs according to their need. Despite domestic funding increases in many countries, this development is unevenly distributed. While some countries that were previously donor-dependent are now able to fully fund their own programs (e.g. Botswana and South Africa), others remain heavily donor-dependent and therefore suffer from their upward accountability (Oberth et al. 2016: 2f.).

The HIV/AIDS response is broadly based on human rights frameworks and the right to health. This helped to progress legislation in many countries and dismantle discriminatory judicial rulings (Piot et al. 2015: 182). Furthermore, it serves as precedent and has opened the door for other global health issues to achieve successes by challenging policies and courts on the human rights basis.

As mentioned for the Global Fund, HIV/AIDS activism and funding generation took an exceptionalist and vertical approach, focusing ‘just’ on HIV/AIDS. However, the need for health system strengthening to build up capacities and establish functioning health systems with well-trained staff, infrastructure, management and documentation was widely overlooked, especially in the beginning (Cassimon et al. 2008: 1193f.; Bekker et al. 2018: 323). As a result, early HIV/AIDS prevention and treatment programs were weakened by the lack of health system capacities to deliver (Hanefeld 2014: 55). Additionally, the focus on a biomedical approach to HIV/AIDS left other structural issues inadequately addressed. This includes a vast need for efforts in the realm of gender-based violence, stigma reduction and changes in inappropriate legislature and policy environments (Piot et al. 2015: 183). Shifting funding to HIV/AIDS left other health issues, for example reproductive health, with less resource, leading to a decline of services provided in some areas (Yu et al. 2008: 3f.). Moreover, as mentioned before, funding for prevention fell short behind funding for treatment. Resultingly, the number of people in need of treatment has risen, driving up the need for even more funding (Piot et al. 2015: 183).

On the other hand, the outpour of resources towards HIV/AIDS was also beneficial for other health areas and helped to indirectly strengthen health systems in some places, as a result of infrastructure improvements (e.g. laboratory systems, telecommunication, buildings, water, electricity). Successes in the HIV/AIDS response highly relied on scientific progress in the development of PreP and ART, and the ongoing search for vaccines (Piot et al. 2015: 182). The introduction of ART opened hospital beds back up, since before its introduction

people with HIV/AIDS occupied between 50-80% of hospital beds and service resources in many sub-Saharan countries (Yu et al. 2008: 2ff.). Therefore, despite broad criticism on the vertical, disease-specific approach, successful gains were made in many areas, including funding, multi-stakeholder collaboration, emphasizing civil-society inclusion, scientific innovations as well as political commitment and awareness (Bekker et al. 2018: 323). Furthermore, a 2015 Lancet Commission on defeating AIDS, chaired by former UNAIDS Executive Director Peter Piot, attested that for HIV/AIDS the combination of prevention and treatment, in line with social and political commitment as well as structural interventions, has proven powerful, despite not being 'a magic solution to all problem' (Piot et al. 2015: 179).

The aforementioned Lancet Commission, on the other hand, criticizes that the need for a quick response to the rising numbers of people infected with HIV in the 1990s led to ineffective use of resources. What was understandable in the beginning, given lack of information and data, has however, continued far into today. Despite a strong focus on coordination and harmonization by UNAIDS, there are distinct shortcomings in this field, resulting in duplication and parallel structures regarding funding, monitoring and reporting and lack of harmonization with national strategies (Piot et al. 2015: 182f.). Inadequate management of funds and other resources, lacking cost and duplication reduction strategies, as well as corruption and misappropriation of funding have been frequently criticized (Piot et al. 2015: 183). Moreover, funding for HIV/AIDS programs was often focused on delivering short-term goals. This was to the disadvantage of long-term and sustainable funding and investment, despite the need for life-long treatment and interventions and the need for structural changes (Piot et al. 2015: 182). Consequently, there is need for the HIV/AIDS fight (prevention, treatment and care) to be integrated into existing health systems and services, to be treated like the chronic disease it now is instead of managing it like the emergency it was at the end of the 20th century (Yu et al. 2008). Therefore, the consequence should be a shift in how funding for HIV/AIDS and health system strengthening is generated and disbursed.

Looking beyond UNAIDS and the Global Fund, ample criticism exists on the level of conditionalities attached to funding. A prime example for this is the case of PEPFAR, ruling that 33% of its resources must be spend on abstinence and fidelity programs. Because of their strained position, most African countries were not able to reject this conditionality-soaked funding. However, this made it quite difficult for funding recipients to tailor programs to their local needs. Instead, it further imposed western donor ideologies, also going beyond PEPFAR, on African countries (Adeboye 2018: 338f.). Despite the Global Fund and UNAIDS both strongly advocating for country-ownership and alignment with national strategies, one

has to recognize that this was still not the case for all donors. Furthermore, criticism has been voiced about the celebration of achievements made, which widely focus on the attitudes and perspectives of international donors and the global health community, but largely dismisses the fact that the situation of those on the ground and most affected remains largely unchanged (Adeboye 2018: 339). In practice this means that despite declining infection rates in some areas, there are still a high number of new infections occurring every day, stigma persists, and children and women are still more vulnerable to the virus. According to Adeboye (2018), this is a result of insufficiently addressing the social circumstances mentioned above, in which the epidemic still exists and persists. To her it appears that, in addition to health investments, “Africans also need a ‘social pill’” (Adeboye 2018: 339). Other researchers agree that the persisting epidemic toady is “driven by marginalisation, stigma, and discrimination, resulting in poor health care, insufficient access to treatment, and substantial power imbalances” (Headley et al. 2019: 382).

Finally, despite the achievements made in the HIV/AIDS fight, efforts have to be kept up to secure sustainable commitment and financing in the future and stay on track for the ambitious goals of the Agenda 2030 and the SDGs. At the moment, funding commitments of traditional donors as well as political commitment in some of the countries most affected are decreasing. Accordingly, there is increasing recognition of the need to integrate the HIV/AIDS response more strongly into broader health system strengthening efforts and primary health care (PHC), in order to sustain the achievements of the past decades and achieve the ambitious goals set for the fight against HIV/AIDS (Bekker et al. 2018: 323).

Important development: funding from external donors is increasingly mirrored by “substantially increasing investments from domestic governments” (Piot et al. 2015: 182)

5 Discussion

5.1 Prospective Evaluation

As seen in the previous chapter, the fight against HIV/AIDS offers a variety of learnings with positive as well as negative outcomes one should consider in the establishment of new programs. In this next chapter we will attempt a prospective evaluation of the programs and outcomes discussed and their desirability, practicality, and transferability to GMH.

The prerequisite for UNAIDS' and later the Global Fund's establishment was the recognition of HIV/AIDS to be the 'disease of the time', with great potential to harm development efforts worldwide. HIV/AIDS was a new phenomenon, with an unknown etiology and no practical guidelines in place yet. Consequently, the need for a multisectoral response with broad stakeholder inclusion was established, as inaction would have hindered development of LMICs substantially, and it justified the surge in programs and funding. While a similar awareness for GMH and its importance for human and country development would be desirable and the GMH field has made major steps towards this in recent years, it is unlikely to reach comparable levels to HIV/AIDS. On the one hand, this is induced by the increasing competition of health affairs with the multitude of other pressing issues, including forced migration, climate change and environmental degradation, social justice, terrorism as well as armed conflict. This development can also be observed in the transition from MDGs to SDGs. While health "occupied three of the eight MDGs, health is specifically addressed in only one of 17 SDGs and ten of 169 SDG targets" (Bekker et al. 2018: 315). On the other hand, GMH also competes with a myriad of health priorities, such as mother and child health, reproductive health and often mentioned health system strengthening efforts, in addition to pandemic preparedness. Additionally, GMH and MNS disorders have been known for quite some time and do not have the 'surprise momentum' like HIV/AIDS had in the 1980s and 90s. Moreover, physical diseases are often perceived as 'more important' than mental diseases, even by those affected. However, experiences of the COVID-19 pandemic have catapulted health to the top of decision-makers' agenda and questions about the mental health impact of the pandemic have fostered momentum and awareness for the cause.

To give a prospective evaluation a good starting point is to reconsider the fundamental tasks of UNAIDS and the Global Fund. While UNAIDS offers technical assistance and serves as knowledge base, but does not act as a funding organization, the opposite is true for the Global Fund, with no merit in implementation or technical assistance. As one main lesson was the need to minimize fragmentation the leading question should be if two separate organizations or programs with divided tasks are necessary, especially because it has

shown to create confusion about their respective role. Additionally, by avoiding duplication and keeping the organizational structure lean operational costs can be avoided and funding channeled to where it can create the greatest impact. Furthermore, one might look around at what tasks are already covered by existing organizations, for example by the WHO. As mentioned in Chapter 1.3 Vigo et al. performed a similar analysis of scale-up potential for GMH by drawing from the Global Fund, WHO's Partnership for Maternal, Newborn and Child Health (PMNCH) and the World Bank's Global Financing Facility (GFF) (2019: 351). They argue against the establishment of another organization focused on advocacy, stewardship and capacity-building, such as UNAIDS, as this would lead to further fragmentation and create unnecessary competition with WHO (Vigo et al. 2019: 352). They too find that reliance on WHO for advocacy and stewardship will likely not render as strong results as were seen from UNAIDS' efforts for HIV/AIDS, especially in fund mobilization. However, WHO should be the primary provider of highly reliable data on MNS disorders and GMH in general, as it is already mandated with monitoring outcomes and capacity-building in the realm of mental health, for example through its mhGAP programs. Moreover, this way, data collection and methodology, as well as epidemiological estimation procedures are under scrutiny of more diverse experts. In turn, this reduces the risk of over- and underestimation, which has been criticized in the case of some UNAIDS estimates (Das/Samarasekera 2017: 2102). In line with the argument of fragmentation, Vigo et al. make the point that the embedment of a new organization into the UN landscape leads to a high dependency on the UN, for example regarding procedures and goals. Although Vigo et al. cite another program (PMNCH) for their case, this argument also applies here, for example in terms of dependency on cosponsors to cooperate (2019: 353). Therefore, in spite of the desirability of many of the outcomes UNAIDS produced, transferability of the organization as a whole does not appear given or practical.

In their findings Vigo et al. agree with this viewpoint as they see the main task of a new program for GMH only in the field of funding, pooling and disbursement. Yet, they endorse WHO to be a strong partner in a GMH focused organization (2019: 353). Consequently, in their assessment of the Global Fund, Vigo et al. rate its characteristics of autonomy from pre-existing bureaucracies as well as inclusive and diverse representation of stakeholders as highly desirable for GMH. However, in terms of transferability of the entire organizational structure, it is deemed rather unfeasible and unsustainable. This is due to expected high costs of establishing and operating such a new and autonomous organization, which poses a high risk of failure (Vigo et al. 2019: 352). Adding to this, the creation of another organization following the Global Fund model would mean creating another vertically focused and disease(group)-specific organization at risk of losing sight of the need for system

strengthening and consideration of other determinants for mental health. This factor might be even more critical for GMH, since treatment for MNS disorders is much more complex than for HIV/AIDS. This is especially true, since mental well-being and mental disorders exist on different levels of the continuum and are less definite as an HIV infection (infected vs. not infected). Moreover, administration of medication for MNS disorders is more multi-faceted and therefore bound to regular modification and monitoring and does not 'fix it' as much as one could argue is the case for HIV/AIDS. Therefore, successes in the HIV/AIDS response resulting from the introduction of PreP and ART are highly desirable but not directly transferable to GMH due to the non-communicable nature of MNS disorders. Consequently, focusing on an integrated, whole system approach including psychosocial interventions is necessary, right from the beginning.

While the establishment of a 'second UNAIDS' and a similar 'Global Fund for GMH' is not practical or sustainable, transferring elements of the UNAIDS and Global Fund structure could be. Uniting government representatives with non-government representation (NGOs, civil society, private sector), as well as UN organizations and agencies with a variety of focuses and mandates in the governing and decision-making bodies was innovative in the HIV/AIDS response and an incremental factor to its successes (Piot et al. 2015: 181f.). It brought attention to HIV/AIDS in different areas of activity and simultaneously leverages on expertise of different stakeholders. This kind of multistakeholder involvement renders results that are highly desirable for GMH and should, although in an adapted form, be transferred to a new program outside the UN system. Adding to this, there is a great need for strong civil society engagement and 'grassroot energy' as was present in the HIV/AIDS movement for the global mental health field (Bekker et al. 2018: 323), to push the issue to the top of the agenda and work against stigma and marginalization. Consequently, some form of country representation, with the same strong representation of civil society and NGOs is important to transport global advocacy to the ground. This is equally important for the case of GMH as it was for HIV/AIDS, as this a promising tool to bridge cultural barriers and stigma by including for example faith-based organizations on country and community level. Adding to the point, having some form of country-level working group is crucial to develop programs that follow local needs and national strategies, and are not imposed by donors from 'outside'.

Criticism that western agendas overpower LMICs and do not take the culture, context and experience of those most affected into consideration exist in close to all fields of development aid and cooperation. GMH is no exception and already being accused of such tendencies (Rajabzadeh et al. 2021: 4). Therefore, actively working against this bias by establishing country-ownership and advocacy for their own needs should be prioritized for a GMH

program. Fortunately, strong community participation is already endorsed by the GMH research and advocacy community, following the credo “nothing about us without us” (Patel et al. 2018: 1557). However, activism of people living with MNS disorders and those most affected might fall short in some places, due to the limitations living with MNS disorders can have. Moreover, in contexts where civil society participation is not as common and CSOs less established additional efforts should be made to strengthen these structures. Therefore, it is important to encourage those affected and give room for their stories. The high level of community participation needs to be represented in program design and policy making on local, national and global level (Rajabzadeh et al. 2021: 7). Hence, transferability of promoting country-ownership and civil society engagement seems practical and promises highly desirable outcomes.

Adding on to this, strong community and civil society involvement is also crucial because the voice of activism is an important medium to express dissatisfaction with the status quo and can be an important driver urging political leaders to act (Piot et al. 2015: 181). Moreover, following the precedent of HIV/AIDS and coming back to the fundamental understanding that health is a human right gives civil societies and activist groups an arena to challenge countries’ responsibility to provide healthcare without restrictive and/or marginalizing limitations of the law. (Maciocco/ Stefanini 2007: 480). This could promote countries to evoke a stronger human rights basis in mental health care and help reduce stigma of persons affected by reducing punishing laws. This is also an important factor, as mental health care still opens a lot of doors for human right violations (Patel et al. 2018: 1558) and has to be carefully considered in program design and funding disbursement.

In many low-income countries quality mental health services have to be built up from the bottom. Consequently, including mental health services in community and primary health care from the beginning would be an accessible and realistic way to reduce system fragmentation further, not just in terms of funding but also in terms of care delivery. In contrast, in middle-income countries, where domestic funding is already available for GMH, it is currently spent on specialized hospitals with a small reach. Here, funds “need to be redirected to strengthen primary care and community services” (Vigo et al. 2019: 352) to be capable to manage physical as well as psycho-social and psychiatric needs. The point of redirection of funds assumes domestic funding is available to some extent. However, an important factor which is not sufficiently addressed through activities of the Global Fund and UNAIDS for HIV/AIDS is heightening the effort of countries to create fiscal space for health and to direct domestic funding to mental health. Despite all funding channeled from donors, this is essential to the effort of reaching any of the treatment packages and 1 US$ to 3 US$ investment pppa scenarios as proposed by the LHGP group (LHGP 2018: 27ff.; 35).

Furthermore, it supports country-ownership and helps diminish donor, and especially western ideologies on LMICs, or recipient communities in general.

One of the key elements supporting the increase of resources contributed to the Global Fund was its pledge to transparency and the systems embedded into the organizational structure to ensure this. Effective corruption and fraud countermeasures have to be in place to make sure the huge sums of money end up where donors intended to put them. Especially in the establishment of a new funding program those in charge should go beyond standard measures of compliance and emphasize this topic, also in terms of leadership choice, to generate credibility and trust from donors.

5.2 Consequences for GMH

In order to increase funding for GMH and to scale up mental health services in LMICs an innovative, diverse and well-resourced funding program is necessary. This new program needs to be a credible partner for donors and investors, ensuring transparency in fund management and VfM. Moreover, this program will face challenges of fragmentation and must be ready to manufacture an integrated response from all relevant stakeholder and constituencies to overcome current inconsistencies. This includes priority setting in regard to populations, countries and disorders, in close collaboration with WHO. The core task of the program must be developing various funding mechanisms and financial instruments to attract, pool and disburse funds for GMH. Moreover, the new program needs to build capacities in the realm of implementation and evaluation, as well as establishing accountability mechanisms. Vigo et al. agree, that “the time is ripe for establishing a multipolar and inclusive partnership to address the challenge of financing a global scale-up of mental health services” (2019: 351). In order to avoid undesirable features such as dependency on dominant partners like the UN or high costs for establishment and operations of the new GMH funding program, they suggest an “autonomous partnership with a secretariat housed […] in an expert organisation” (2019: 352), instead of a multilateral organization. The supporting secretariat could be embedded in an academic institute, but the program itself would be governed by a board representing diverse constituencies. Constituencies must include HIC and LMIC representatives alike, academia and implementers, especially strong representation of CSOs and people with lived experiences, the private sector, as well as affiliated UN organizations and those who hold expertise in relevant issues. These would for example include World Bank as expert on generating and disbursing funds, and potentially as trustee, or UNICEF, as expert on reaching the highly vulnerable group of children and adolescents.

Additionally, in the previous chapter it was established that efforts in collecting epidemiological data and publishing estimates as well as creating awareness and establishing GMH as a high-priority item on the global agenda should stay with WHO. Consequently, WHO must take a strong role in the new GMH partnership, without overpowering other constituencies. Moreover, it is now up to WHO to launch a timely and multi-facetted advocacy and awareness campaign, addressing various audiences, from regular people and those potentially affected to local, national and global decision-makers. WHOs advocacy work must be brought into various forums where the work has touching points with GMH on global and country-level, for example the UN General Assembly, ILO or World Bank, as well as national Ministries of Health, CSOs and the private sector and should be supported by the expertise on GMH accumulated in the diverse board of the GMH partnership.

An additional feature of the GMH partnership program must be a form of country-level forum on GMH, which is connected to the global partnership. The country-level forum should consist of similar constituencies as the global board, in addition to other locally important entities, for example faith-based organizations. In this context, community participation should be given special attention. Tasks of country forums need to be defined in accordance with priorities set by the GMH partnership and might vary depending on the priorities set for different geographical areas or focus on diseases within the MNS disorder spectrum. Moreover, the state of mental health services in each respective country needs to be considered. Where no national strategies for mental health are in place yet, country forums on GMH should start off with creating those, drawing on the expertise of the various constituencies. This offers an important basis for quality care, especially where services have to be built up from the bottom. Further, national strategies attract funding from ‘outside‘, but also serve as grounds for increasing domestic funding. Additionally, writing proposals for GMH grants could be another task, however, this depends on the financial instruments implemented by the GMH partnership. Country forums on GMH should be able to work as autonomously as possible, within the frameworks of the GMH partnership, in order to foster country-ownership and limit the influence of foreign ideologies which have a tendency of disregarding local needs and cultural and ethnic customs. This plays an especially important role in GMH as the perception of MNS disorders is susceptible to religious or other cultural beliefs. While WHO should take the hat in initiating a global awareness campaign it is critical to involve country forums to reach local communities and translate the aspects of the campaign in a culturally sensitive manner.

Taking away from the HIV/AIDS story that prevention should not suffer from a focus on treatment, this should also be emphasized in GMH activities, be it advocacy work as well as implementation. It is important to promote prevention, especially through community-

support, to keep the number of patients in need of treatment and consequently the costs of treatment and loss of productivity as low as possible. Moreover, increasing attention should be given to fighting stigma and discrimination. This requires adaptions of national legal frameworks and the revision of discriminatory and punishing legislature for mental disorders and must continue into the most basic levels of care provision. Further, this is a crucial part in ensuring that health care, and mental health care specifically, are provided to everybody, as every person holds the human right to health. Moreover, persons suffering from MNS disorders are highly vulnerable to have their basic human rights violated when seeking treatment, which has to be addressed in programs financed through the global GMH partnership and within each countries' forum.

The Agenda for Sustainable Development, which brought forth the 17 SDGs, has been driving efforts towards universal health coverage (UHC) with increasing momentum created through the understanding of the health to right as a human right (Bekker et al 2018: 315). This offers an important entry point for GMH advocacy, since universal health care must undeniably include mental health care. Including GMH in UHC advocacy is also in line with the need to embed GMH efforts into general health system strengthening, with focus of integration of mental health services into primary health care delivery. Furthermore, especially in low-resource settings special attention should be given to strengthening community-based care.

Another lesson from HIV/AIDS is the need for flexible, non-earmarked funding to ensure that the GMH partnership can tailor funding offers to local needs. Increased donor commitments for GMH are needed, to come anywhere close to closing the funding gap. However, in view of great competition for donor funding among health and other development issues, the general decrease of donor funding for all development areas due to increasing nationalist tendencies of many high-income nations and resultingly unpredictability of funding, as well as efforts to decrease donor-dependency of implementing countries, other funding sources will have to play an increasingly important role. Consequently, more innovative funding mechanisms are needed. The Global Fund championed two examples, the (RED) campaign and Dept2Health swaps, which offer a good baseline and inspiration for the development of new mechanisms. Further ideas include, for example, luxury or 'sin taxes' on harmful products for health, such as tobacco or alcohol, or social impact bonds as mentioned before. With the establishment of funding mechanisms, the focus cannot only be on how funds can be generated and pooled, but one must not lose sight of how those funds are spent and disbursed most effectively. The Global Fund pursued the path of distribution tied to grants, mainly with result-based money disbursement. Yet, new ways of channeling money to beneficiaries in the most effective and equitable way should be considered

concurrently. Lastly, as mentioned previously, increases in domestic funding are dearly needed to scale-up mental health services. Growing national gross domestic products (GDP) of long-time low-income countries are promising. However, within those growing resources fiscal space has to be created for matters of health systems strengthening and GMH, so that the populations can benefit from the increasing prosperity of their countries. It is important to note that no singular approach to funding generation will be sufficient, but a combination of all three, traditional donors, innovative financing mechanisms as well as domestic resource generation is needed to tackle the GMH funding gap.

5.3 Limitations and research demand

The literature search was limited to title searches in order to make the exhaustive body of literature surrounding HIV/AIDS and funding more accessible. Yet, it cannot be ruled out that significant publications to this topic did not show up in the results through this method of choice. Moreover, differences between HIV/AIDS, and even the extension to TB and malaria as a collection of communicable diseases and GMH as part of the NCD disease group are substantial and limit the direct comparison of programs.

While there is a multitude of organizational designs within the international governance landscape from which lessons could be drawn, this analysis only looks at a very limited selection and is by far not exhaustive. The increase in funding is not attributable only to the two programs depicted in the Results section. Considerable amounts of funding were also spent by PEPFAR, the Bill and Melinda Gates foundation in addition to other bilateral and multilateral development agencies, private foundations and global health initiatives. However, the lion share of money was pledged and disbursed after the year 2000, after UNAIDS had put substantial work into bringing HIV/AIDS to the top of the global health agenda, into the security council, as well as the MDGS and SDGs. Without advocacy work and creating political commitment to the cause it is likely that the response from donors would have been delayed by many, crucial years.

This thesis looked at the Global Fund to assess ways how funding for the fight against HIV/AIDS was generated. However, when pledging funding to the Global Fund, donors do not earmark the money for one of the priority diseases. Therefore, one must be careful that funds pledged to the Global Fund cannot automatically be fully attributed to funding against HIV/AIDS, especially where pledges have not been honored yet and the final spending target is not yet determined. It is not clear how bringing together these three diseases in one fund influenced donor decisions in pledging more or less money and there is no evidence whether pledges would have reached similar amounts if the Global Fund had focused on HIV/AIDS only.

The prospective evaluation was performed by one person alone with a background in International Health Sciences. However, the topic of funding generation in general, but especially in a global health and development context involves many more disciplines, e.g. economics, political science and development studies. Therefore, the prospective evaluation on desirability and transferability of the analyzed programs is limited to the perspective of one researcher from one discipline. Yet, this evaluation would profit from more diverse perspectives and judgements.

Further research need exists on how funds are best spent with regard to GMH, by generating the greatest impact for the people most affected through effective disbursement mechanisms. Additionally, research is needed in the realm of culturally appropriate community-based service delivery in low-resource setting. Moreover, mechanisms for successful coordination and harmonization are dearly needed and research should focus on examining various existing structures and their effectiveness, before the establishment of a new program or partnership, to integrate this important aspect from the beginning of its establishment. Moreover, emphasis on how to practically realize GMH integration into overall care delivery is needed and further research should focus on this aspect.

6 Conclusion

While speaking about funding generation, pooling and disbursement for causes such as HIV/AIDS and GMH it is important not to lose sight of the human suffering, disguised behind numbers and technicalities. Moreover, health and well-being should be at the center and cannot get lost in discussions focusing only on productivity increase and economic fitness.

Drawing lessons from the two proposed programs is by far not an exhaustive selection of possible models, as the global architecture of funding initiatives offers many more examples of how funding generation and coordination could be accomplished.

However, it can be concluded that the increase in global funding for HIV/AIDS and how it was achieved offers many valuable lessons in terms of funding generation, raising political and social commitment and multi-stakeholder collaboration.

The analysis of UNAIDS has unmistakably shown the great impact of advocacy and the right framing of an issue. All this has played an important role in the creation of multiple funding mechanisms and sustained commitment by the global community. Another great learning from the fight against HIV/AIDS is the need for inclusion of civil society and those most affected, by any disease, in decision-making bodies on global and country-level, as well as in the creation of national strategies. Adding on, the fight against HIV/AIDS has shown the great importance of strong leadership and transparency, to establish trust from donors but also from those affected.

Yet, despite being a positive example in terms of overall outcomes, lessons to be learned from HIV/AIDS are not exclusively positive. For example, disregarding the need for overall health system strengthening and continuous struggles for coordination have held up progress and effectiveness. Consequently, HIV/AIDS serves as a negative example too, and the lessons learned should focus on how to do it better next time. This also entails the broader consequences for health systems and other health indicators that have to be considered when applying a vertical approach and carefully weighed before taking hasty, unthoughtful action.

Finally, the history of funding HIV/AIDS in the past three decades offers important lessons. These lessons can be drawn and applied for GMH, to inform necessary actions as next steps.

List of tables

List of figures

List of abbreviations

AIDS	-	acquired immunodeficiency syndrome
ARV	-	anti-retroviral treatment
CCO	-	Committee of Cosponsoring Organizations
CSO	-	civil society organization
DAH	-	development aid on health
DALYs	-	Disability-adjusted life-years
G8	-	Group of Eight (Japan, Canada, Italy, France, Germany, United Kingdom, United States of America, Russia)
GBD	-	Global Burden of Disease
GDP	-	gross domestic product
GFF	-	World Bank's Global Financing Facility
GMH	-	Global Mental Health
GPA	-	Global Programme on AIDS (WHO)
HIC	-	high-income country
HIV	-	Human immunodeficiency virus
ILO	-	International Labor Organization
IPAA	-	International Partnership against AIDS in Africa
LGBTQ+	-	lesbian, gay, bisexual, transgender, queer and all other gender identities and sexual orientations
LHGP	-	Lions Head Global Partners
LMICs	-	low- and middle-income countries
MAP Africa	-	Multi-Country HIV/AIDS Programme for Africa
MDGs	-	Millennium Development Goals
mhGAP	-	Mental Health Gap Action Plan
MNS disorders	-	mental, neurological, and substance-use disorders
MSM	-	men who have sex with men
NCD	-	non-communicable disease

NFM	-	New Funding Model (The Global Fund)
ODA	-	Official Development Assistance
PANCAP	-	Pan Caribbean Partnership against HIV/AIDS
PCB	-	Programme Coordinating Board
PEPFAR	-	U.S. President's Emergency Plan for AIDS Relief
PMNCH	-	WHO's Partnership for Maternal, Newborn, and Child Health
PPP	-	public-private partnership
pppa	-	per person per annum
PreP	-	pre-exposure prophylaxis
SDGs	-	Sustainable Development Goals
TB	-	tuberculosis
The Global Fund	-	the Global Fund to fight AIDS, Tuberculosis, and Malaria
UBRAF	-	Unified Budget, Results and Accountability Framework
UHC	-	universal health coverage
UN Women	-	United Nations Entity for Gender Equality and the Empowerment of Women
UNAIDS	-	The Joint United Nations Programme on HIV/AIDS
UNDP	-	United Nations Development Programme
UNESCO	-	United Nations Educational, Scientific and Cultural Organization
UNFPA	-	United Nations Population Fund
UNHCR	-	Office of the United Nations Higher Commissioner for Refugees
UNICEF	-	United Nations Children's Fund
UNODC	-	United Nations Office on Drugs and Crime
VfM	-	Value-for-Money
WFP	-	World Food Programme
WHO	-	World Health Organization
YLDs	-	Years lived with disability

Bibliography

Adeboye, O. (2018): Africa and the international politics of HIV/AIDS. In: Olaniyan, R. A.; Ifidon, E. A. (eds.): Contemporary Issues in Africa's Development: Whither the African Renaissance? Newcastle: Cambridge Scholars Publishing: 320-344.

Australian Housing and Urban Research Institute (2021): What are social impact bonds and how do they work? Melbourne: Australian Housing and Urban Research Institute. Available online at: https://www.ahuri.edu.au/research/brief/what-are-social-impact-bonds-and-how-do-they-work?gclid=CjwKCAiA3KefBhByEiwAi2LDHHAV6AxiWxbmlnbWQ9wp5uTA172_K_y1wGfOpO6DrrwXTQTWqTKJ-BoCtL8QAvD_BwE (retrieved February 13th, 2023).

Bekker, L.-G.; Alleyne, G.; Baral, S.; Cepeda, J.; Daskalakis, D.; Dowdy, D.; Dybul, M.; Eholie, S.; Esom, K.; Garnett, G.; Grimsrud, A.; Hakim, J.; Havlir, D., Isbell, M. T.; Johnson, L.; Kamarulzaman, A.; Kasaie, P.; Kazatchkine, M.; Kilonzo, N.; Klag, M.; Klein, M.; Lewin, S. R.; Luo, C.; Makofane, K.; Martin, N. K.; Mayer, K.; Millett, G.; Ntusi, N.; Pace, L.; Pike, C.; Piot, P.; Pozniak, A.; Quinn, T. C.; Rockstroh, J.; Ratevosian, J.; Ryan, O.; Sippel, S.; Spire, B.; Soucat, A.; Starrs, A.; Strathdee, S. A.; Thomson, N.; Vella, S.; Schechter, M.; Vickerman, P.; Weir, B.; Beyrer, C. (2018): Advancing global health and strengthening the HIV response in the era of the Sustainable Development Goals: the International AIDS Society—Lancet Commission. The Lancet 392 (10144): 312-358.

Bloom, D. E.; Cafiero, E. T.; Jané-Llopis, E.; Abrahams-Gessel, S.; Bloom, L. R.; Fathima, S.; Feigl, A. B.; Gaziano, T.; Mowafi, M.; Pandya, A.; Prettner, K.; Rosenberg, L.; Seligman, B.; Stein, A. Z.; Weinstein, C. (2011): The Global Economic Burden of Noncommunicable Diseases. Geneva: World Economic Forum.

Brugha, R. (2005): The Global Fund at three years – flying a crowded air space. Tropical Medicine and International Health 10 (7): 623-626.

Brugha, R.; Donoghue, M.; Ndubani, P.; Ssengooba, F.; Fernandes, B.; Walt, G. (2004): The Global Fund: managing great expectations. The Lancet 364 (9482): 95-100.

Cassimon, D.; Renard, R.; Verbeke, L. (2008): Assessing dept-to-health swaps: a case study on the Global Fund Dept2Health Conversion Scheme. Tropical Medicine and International Health 13 (9): 1188-1195.

Charlson, F. J.; Dieleman, J.; Singh, L.; Whiteford, H. A. (2017): Donor Financing of Global Health, 1995-2005: An Assessment of Trends, Channels, and Alignment with the Disease Burden. PLOS ONE 12 (2): 1-10.

Das, P.; Samarasekera, U. (2008): What next for UNAIDS? The Lancet 372 (9656): 2099-2102.

GBD Health Financing Collaborator Network (2018): Spending on health and HIV/AIDS: domestic health spending and development assistance in 188 countries, 1995–2015. The Lancet 391 (10132): 1799-1829.

Evans, M. (2006): At the interface between Theory and Practice – Policy Transfer and Lesson-Drawing. Public Administration 84 (2): 479-489.

Fan, V. Y.; Glassman, A.; Silverman, R. L. (2014): How A New Funding Model Will Shift Allocation From The Global Fund To Fight AIDS, Tuberculosis, And Malaria. Health Affairs 33 (12): 2238-2246.

Fehervari, Z. (2018): Origin story. Milestone 7. In: Nature Medicine, Nature, Nature Immunology, Nature Communications, Nature Reviews Microbiology: HIV research. n.p.: Nature Milestones / Springer: 9.

GBD 2019 Mental Disorders Collaborators (2022): Global, regional, and national burden of 12 mental disorders in 204 countries and territories, 1990–2019: a systematic analysis for the Global Burden of Disease Study 2019. The Lancet Psychiatry 9 (2): 137-150.

Graham, E. R. (2017): The Promise and Pitfalls of Assembled Institutions: Lessons from the Global Environment Facility and UNAIDS. Global Policy 8 (1): 52-61.

Hanefeld, J. (2014): The Global Fund to Fight AIDS, Tuberculosis and Malaria: 10 years on. Clinical Medicine 14 (1): 54-57.

Hecht, R.; Bollinger, L.; Stover, J.; McGreevey, W.; Muhib, F.; Madavo, V. E.; Ferranti, D. de (2009): Critical Choices in Financing the response to the Global HIV/AIDS Pandemic. Health Affairs 28 (6): 1591-1605.

Headley, J.; Gustav, R.; Kavanagh, M. M.; Mworeko, L.; Russell, A.; Sharma, A.; Stegling, C. (2019): Leading UNAIDS: a once-in-a-generation challenge? The Lancet 394 (10196): 381-382.

Hofer, U. (2018): Realizing the extent of the AIDS epidemic. Milestone 4. In: Nature Medicine, Nature, Nature Immunology, Nature Communications, Nature Reviews Microbiology: HIV research. n.p.: Nature Milestones / Springer: 6.

Holmes, K. K.; Bertozzi, S.; Bloom, B. R.; Jha, P. (eds.) (2017): Major Infectious Disease. Disease Control Priorities 6. 3rd edn. Washington D.C.: The International Bank for Reconstruction and Development/The World Bank.

Horton, R. (2018): Offline: How to restore the credibility of UNAIDS. The Lancet 392 (10164): 2536.

Jiang, T.; Liu, C.; Zhang, J.; Huang, X.; Xu, J. (2022): Impact of the COVID-19 Pandemic on the UNAIDS Six 95% HIV Control Targets. Frontiers in Medicine 9: 1-4.

Joint SDG Fund (n.y.): Goal 3. Good Health and Well-being. New York: Joint SDG Fund. Online available at: https://jointsdgfund.org/sustainable-development-goals/goal-3-good-health-and-well-being (retrieved March 8th, 2023).

Kazanjian, P. (2017): UNAIDS 90-90-90 Campaign to END the AIDS Epidemic in Historic Perspective. The Milbank Quarterly 95 (2): 408-439.

Knight, L. (2008): UNAIDS: The first 10 Years. Geneva: UNAIDS.

Komatsu, R.; Low-Beer, D.; Schwartländer, B. (2007): Global Fund-supported programmes' contribution to international targets and the Millennium Development Goals: an initial analysis. Bulletin of the World Health Organization 85 (10): 805-811.

LHGP (ed.) (2018). Financing Global Mental Health. London/New York: Lion's Head Global Partners.

Lisk, F.; Kakkattil, P.; Bullaleh, M. (2013): Increasing the Effectiveness of Multilateral and Bilateral Aid: Lessons from the Global AIDS Response. In: Besada, H.; Kindornay, S. (eds.): Multilateral Development in a Changing Global Order. New York: Palgrave Macmillan: 115-137.

Lu, C.; Li, Z.; Patel, V. (2018): Global child and adolescent mental health: The orphan of development assistance for health. PLOS Medicine 15 (3): 1-12.

Lu, C.; Michaud, C. M.; Khan, K.; Murray, C. J. L. (2006): Absorptive capacity and disbursement by the Global Fund to Fight AIDS, Tuberculosis and Malaria: analysis of grant implementation. The Lancet 368 (9534): 483-488.

Maciocco, G.; Stefanini, A. (2007): From Alma-Ata to the Global Fund: the history of international health policy. Revista Brasileira de Saúde Materno Infantil 7 (4): 479-486.

Nunnenkamp, P.; Öhler, H. (2011): Throwing Foreign Aid at HIV/AIDS in Developing Countries: Missing the Target? World Development 39 (10): 1704-1723.

Oberth, G.; Mumba, O.; Bhayani, L.; Daku, M. (2016): Donor Agendas, Community Priorities and the Democracy of International HIV/AIDS Funding. Cape Town: Centre for Social Science Research. University of Cape Town.

Olufadewa, I. I.; Adesina, M. A.; Oladele, R. I.; Oladoye, M. J.; Eke, N. F.-A. (2021): Global fund: Analyzing 10 Years of bridging health inequalities. International Journal of Health Planning and Management 36 (2): 282-287.

Oomman, N. (n.y.): Overview of the World Bank's Response to the HIV/AIDS Epidemic in Africa, with a Focus on the Multi-Country HIV/AIDS Program (MAP). Washington D. C./London: Center for Global Development. Online available at: https://www.cgdev.org/page/overview-world-bank%E2%80%99s-response-hivaids-epidemic-africa-focus-multi-country-hivaids-program-map (retrieved February 17th, 2023).

Patel, V.; Chisholm, D.; Dua, T.; Laxminarayan, R.; Medina-Mora, M. E. (eds.) (2015): Mental, Neurological, and Substance Use Disorders, Disease Control Priorities 4. 3rd edn. Washington D. C.: International Bank for Reconstruction and Development/ The World Bank.

Patel, V.; Saxena, S.; Lund, C.; Thornicroft, G.; Baingana, F.; Bolton, P.; Chisholm, D.; Collins, P. Y.; Cooper, J. L.; Eaton, J.; Herrman, H.; Herzallah, M. M.; Huang, Y.; Jordans, M. J. D.; Kleinman, A.; Medina-Mora, M. E.; Morgan, E.; Niaz, U.; Omigbo-dun, O.; Prince, M.; Rahman, A.; Saraceno, B.; Sarkar, B. K.; De Silva, M.; Singh, I.; Sunkel, C.; Unützer, J. (2018): The Lancet Commission on global mental health and sustainable development. The Lancet 392 (10157): 1553-1598.

Peiffer, C. A.; Boussalis, C. (2010): Foreign Assistance and the Struggle Against HIV/AIDS in the Developing World. The Journal of Development Studies 46 (3): 556-573.

Piot, P.; Abdool Karim, S. S.; Hecht, R.; Legido-Quigley, H.; Buse, K.; Stover, J.; Resch, S.; Ryckman, T.; Møgedal, S.; Dybul, M.; Goosby, E.; Watts, C.; Kilonzo, N.; McManus, J.; Sidibé, M. (2015): UNAIDS–Lancet Commission. Defeating AIDS-advancing global health. The Lancet 386 (9989): 171-218.

Poore, P. (2004): The Global Fund to fight Aids, Tuberculosis and Malaria (GFATM). Health Policy and Planning 19 (1): 52-53.

Rajabzadeh, V.; Burn, E.; Sajun, S. Z.; Suzuki, M.; Bird, V. J.; Priebe, S. (2021): Understanding global mental health: a conceptual review. BMJ Global Health 6 (3): 1-11.

Rose, R. (1991): What is Lesson-Drawing? Journal of Public Policy 11 (1): 3-30. Online available at: http://www.jstor.org/stable/4007336 (retrieved September 29th, 2022).

Sands, P. (2019): Putting Country Ownership into Practice: The Global Fund and Country Coordinating Mechanisms. Health Systems & Reform 5 (2): 100-103.

Schmid, S. (2018): The discovery of HIV-1. Milestone 2. In: Nature Medicine, Nature, Nature Immunology, Nature Communications, Nature Reviews Microbiology: HIV research. n.p.: Nature Milestones / Springer: 4.

Shadyab, A. H.; Hale, B. R.; Shaffer, R. A. (2017): HIV/AIDS Securitization: Outcomes and Current Challenges. Current HIV Research 15 (2): 78-81.

Sridhar, D. (2013): Coordinating the UN System: Lessons from UNAIDS: A commentary on Mackey. Social Science & Medicine 76 (1): 21-23.

The Global Fund (2001): The Framework Document. Geneva: The Global Fund.

The Global Fund (2022a): Annual Financial Report 2021. Geneva: The Global Fund.

The Global Fund (2022b): Fight For What Counts. Investment Case. Seventh Replenishment 2022. Executive Summary. Geneva: The Global Fund.

The Global Fund (2023a): (RED). Geneva: The Global Fund. Online available at: https://www.theglobalfund.org/en/private-ngo-partners/resource-mobilization/red/ (retrieved January 23rd, 2023).

The Global Fund (2023b): Board. Geneva: The Global Fund. Online available at: https://www.theglobalfund.org/en/board/ (retrieved January 18th, 2023).

The Global Fund (2023c): Committees. Geneva: The Global Fund. Online available at: https://www.theglobalfund.org/en/board/committees/ (retrieved January 18th, 2023).

The Global Fund (2023d): Delivery Innovation. Geneva: The Global Fund. Online available at: https://www.theglobalfund.org/en/private-ngo-partners/delivery-innovation/ (retrieved January 23rd, 2023).

The Global Fund (2023e): Government and Public Donors. Geneva: The Global Fund. Online available at: https://www.theglobalfund.org/en/government/ (retrieved January 23rd, 2023).

The Global Fund (2023f): History of the Global Fund. Geneva: The Global Fund. Online available at: https://www.theglobalfund.org/en/about-the-global-fund/history-of-the-global-fund/ (retrieved January 25th, 2023).

The Global Fund (2023g): Innovative Finance. Geneva: The Global Fund. Online available at: https://www.theglobalfund.org/en/innovative-finance/ (retrieved January 23rd, 2023).

The Global Fund (2023h): Office of the Inspector General. Geneva: The Global Fund. Online available at: https://www.theglobalfund.org/en/oig/ (retrieved January 18th, 2023).

The Global Fund (2023i): Pledges and Contributions. Geneva: The Global Fund. Online available at: https://data-service.theglobalfund.org/downloads (retrieved February 14th, 2023).

The Global Fund (2023j): Private Sector (including Foundations). Geneva: The Global Fund. Online available at: https://www.theglobalfund.org/en/private-ngo-partners/ (retrieved January 23rd, 2023).

The Global Fund (2023k): Private Sector Resource Mobilization. Geneva: The Global Fund. Online available at: https://www.theglobalfund.org/en/private-ngo-partners/resource-mobilization/?page=2 (retrieved January 23rd, 2023).

The Global Fund (2023l): Replenishment. Geneva: The Global Fund. Online available at: https://www.theglobalfund.org/en/replenishment/ (retrieved January 23rd, 2023).

The Global Fund (2023m): Staff & Organization Geneva: The Global Fund. Online available at: https://www.theglobalfund.org/en/staff (retrieved January 18th, 2023).

The Global Fund (2023n): Technical Review Panel. Geneva: The Global Fund. Online available at: https://www.theglobalfund.org/en/technical-review-panel/ (retrieved January 18th, 2023).

The Global Fund (2023o): Technical Review Panel. Members. Geneva: The Global Fund. Online available at: https://www.theglobalfund.org/en/technical-review-panel/members/ (retrieved January 18th, 2023).

The Lancet (ed.) (2010): The Global Fund: a bleak future ahead. The Lancet 376 (9749): 1274.

The Lancet (ed.) (2022): The Global Fund replenishment and future-proofing. The Lancet 400 (10355): 787.

UNAIDS (2016): Press Statement. 2016 United Nations Political Declaration on Ending AIDS sets world on the Fast-Track to end the epidemic by 2030. New York/Geneva: UNAIDS. Online available at: https://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2016/june/20160608_PS_HLM_PoliticalDeclaration (retrieved March 8th, 2023).

UNAIDS (2017): Report on Progress in the Implementation of the UNAIDS Joint Programme Action Plan. Strategic Resource Mobilization Plan 2018-2021. Geneva: UNAIDS. UNAIDS/PCB (41)/17.21 rev1.

UNAIDS (2019): Press Statement. Winnie Byanyima joins UNAIDS as Executive Director. Geneva: UNAIDS. Online available at:

https://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2019/november/20191101_winnie-byanyima (retrieved March 8th, 2023).

UNAIDS (2020): The UNAIDS Governance Handbook. Geneva: UNAIDS.

UNAIDS (2021a): 2022-2026 Unified Budget, Result and Accountability Framework. 2022-2023 Workplan and Budget. Geneva: UNAIDS. UNAIDS/PCB (49)/21.27.

UNAIDS (2021b): Report of the UNAIDS Structured Funding Dialogue. Geneva: UNAIDS. UNAIDS/PCB (49)/CRP3.

UNAIDS (2021c): United Nations General Assembly. Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030. Geneva: UNAIDS.

UNAIDS (2022a): All low- and middle-income countries. Trend in resource availability for HIV by funding source (constant 2019 US$ BN). Geneva: UNAIDS. Online available at: https://hivfinancial.unaids.org/hivfinancialdashboards.html# (retrieved February 17th, 2023).

UNAIDS (2022b): Global HIV & Aids statistics - Fact Sheet 2022. Geneva: UNAIDS. Online available at: https://www.unaids.org/en/resources/fact-sheet (retrieved February 17th, 2023).

UNAIDS (2022c): Governance. Geneva: UNAIDS. Online available at: https://www.unaids.org/en/whoweare/governance (retrieved November 17th, 2022).

UNAIDS (2022d): PCB Subcommittees and Working Groups. Geneva: UNAIDS. Online available at: https://www.unaids.org/en/aboutunaids/unaidsprogrammecoordinatingboard/pcbsubcommittee (retrieved December 14th, 2022).

UNAIDS (2022e): Resources and funding. UNAIDS welcomes strong funding commitments from the United Kingdom and from Ireland. Geneva: UNIADS. Online available at: https://www.unaids.org/en/keywords/resources-and-funding (retrieved February 1st, 2023).

UNIAIDS (2022f): UNAIDS COSPONSORS. Geneva: UNAIDS. Online available at: https://www.unaids.org/en/aboutunaids/unaidscosponsors (retrieved December 12th, 2022).

UNAIDS (2023a): Contributions. Geneva: UNAIDS. Online available at: https://open.unaids.org/contributions (retrieved February 1st, 2023).

UNAIDS (2023b): Michel Sidibé. Former UNAIDS Executive Director (2009-2019). Geneva: UNAIDS. Online available at: https://www.unaids.org/en/aboutunaids/unaidsleadership/bios/michelsidibe (retrieved March 8th, 2023).

UNAIDS (2023c): Resources and funding. UNAIDS welcomes the announcement that Spain will be making a new € 1 million contribution to UNAIDS. Geneva: UNAIDS. Online available at: https://www.unaids.org/en/keywords/resources-and-funding (retrieved February 1st, 2023).

UNAIDS (2023d): Results and Transparency portal. Geneva: UNAIDS. Online available at: https://open.unaids.org/ (retrieved February 2nd, 2023).

UNAIDS (2023e): Strategy Results Areas. Geneva: UNAIDS. Online available at: https://open.unaids.org/strategy-result-areas (retrieved February 2nd, 2023).

UNAIDS (2023f): Top Contributors. Geneva: UNAIDS. Online available at: https://open.unaids.org/top-contributors (retrieved February 26th, 2023).

UN (2006): General Assembly. Resolutions adopted by the General Assembly. 60/262. Political Declaration on HIV/AIDS. Geneva/New York: United Nations.

UN (2011a): Security Council. Resolution 1983 (2011). Adopted by the Security Council at its 6547th meeting, on 7 June 2011. Geneva/New York: United Nations.

UN (2011b): General Assembly. Resolution adopted by the General Assembly. 65/277. Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS. Geneva/New York: United Nations.

UN (2015): We can end Poverty. Millennium Development Goals and Beyond 2015. Background. Geneva/New York: United Nations. Online available at: https://www.un.org/millenniumgoals/bkgd.shtml (retrieved January 19th, 2023).

Usher, A. D. (2016): Global Fund replenishment meeting nears target amount. The Lancet 388 (10051): 1265.

Vigo, D. V.; Patek, V.; Becker, A.; Bloom, D.; Yip, W.; Raviola, G.; Saxena, S.; Kleinman, A. (2019): A partnership for transforming mental health globally. The Lancet Psychiatry 6 (4): 350-356.

WHO (2013): Mental Health Action Plan 2013-2020. Geneva: World Health Organization.

WHO (2021a): Comprehensive Mental Health Action Plan 2013-2030. Geneva: World Health Organization.

WHO (2021b): Mental Health Atlas 2020. Geneva: World Health Organization. Online available at:

WHO (2022): Mental Health Gap Action Programme. Geneva; World Health Organization. Online available at: https://www.who.int/teams/mental-health-and-substance-use/treatment-care/mental-health-gap-action-programme#:~:text=The%20WHO%20Mental%20Health%20Gap,low%2D%20and%20middle%2Dincome (retrieved November 2nd, 2022).

Wise, J. (2018): Independent panel calls for head of UNAIDS to be fired. BMJ 363: article number k5249.

Yu, D.; Souteyrand, Y.; Banda, M. A.; Kaufman, J.; Perriëns, J. H. (2008): Investment in HIV/AIDS programs: Does it help strengthen health systems in developing countries? Globalization and Health 4 (8): 1-10.

Zühr, R.; Schrade, C.; Yamey, G. (2014): Evidence to Policy Initiative. Partnership Profile: The Global Fund. About the Global Fund to Fight AIDS, Tuberculosis and Malaria. San Francisco: The Global Health Group.

List of Appendices

Appendix

Appendix 1: Keyword Searches

Keyword Search in MEDLINE (PubMed)

Search Date	Search term	Filters	Results
04.01.2023	UNAIDS [title]	NOT 90-90-90 [Title]	213
12.01.2023	the global fund [title]	-	185
15.02.2023	HIV/AIDS [title] AND (fund* [title] OR finance* [title])	Publication year: 2018-2023	22
15.02.2023	Development assistance for health [title]	Publication year: 2018-2023	35
15.02.2023	Global Mental Health [title] AND (fund*[Title] OR (financ*[[title])	Publication year: 2018-2023	6

Keyword Search in CINAHL

Search Date	Search term	Filters	Results
04.01.2023	UNAIDS [title]	NOT 90-90-90 [Title]	109
12.01.2023	the global fund [title]	-	247
15.02.2023	HIV/AIDS fund* [title] OR HIV/AIDS financ* [title]	Publication year: 2018-2023	7
15.02.2023	development assistance for health [title]	Publication year: 2018-2023	33
15.02.2023	Global mental health fund* [title] OR global mental health financ* [title]	Publication year: 2018-2023	2

Keyword Search in Embase

Search Date	Search term	Filters	Results
03.01.2023	UNAIDS [title]	NOT 90-90-90 [Title]	208
12.01.2023	the global fund [title]	-	202
15.02.2023	HIV/AIDS [title] AND (fund* [title] OR finance* [title])	Publication year: 2018-2023	27
15.02.2023	development assistance for health [title]	Publication year: 2018-2023	34
15.02.2023	Global Mental Health [title] AND (fund*[Title] OR (financ*[[title])	Publication year: 2018-2023	4

Keyword Search in Wiley Online Library

Search Date	Search term	Filters	Results
04.01.2023	UNAIDS [title]	-	19
12.01.2023	the ‘Global Fund’ [title]	-	17
15.02.2023	HIV/AIDS AND (fund* OR finance*) [title]	Publication year: 2018-2023	3
15.02.2023	development assistance for health [title]	Publication year: 2018-2023	2
15.02.2023	Global Mental Health AND (funding OR financing) [title]	Publication year: 2018-2023	4

Keyword Search in Web of Science Core Collection

Search Date	Search term	Filters	Results
04.01.2023	UNAIDS [title]	NOT 90-90-90 [Title]	162
12.01.2023	the Global Fund [title]	-	428
15.02.2023	HIV/AIDS [title] AND (fund* OR finance*) [title]	Publication year: 2018-2023	24
15.02.2023	development assistance for health [title]	Publication year: 2018-2023	37
15.02.2023	Global Mental Health AND (funding OR financing) [title]	Publication year: 2018-2023	3