HEALTH

Fresh start for global disease fund

But shake-up raises doubts over the future of a major malaria-control programme.

BY DECLAN BUTLER

THE GLOBAL FUND

The Global Fund's AMFm project put cheap and effective malaria drugs on the shelves of rural shops.

It has been a rough couple of years for the Global Fund to Fight AIDS, Tuberculosis and Malaria, the world's largest funder of international health programmes. Since its creation in 2002, the organization, based in Geneva, Switzerland, has channelled US$24.7 billion to delivering disease-control measures such as drugs, diagnostics and bed nets, saving millions of lives. But the global financial crisis has hit the fund hard, and its troubles mounted in 2011 when allegations of corruption among its grant recipients tarnished its reputation and alarmed donors.

Last week, the Global Fund tried to move on, announcing a new leader and unveiling major changes to its funding programme. The changes come, however, at a time of flatlining donations to the fund, probably heralding an era of curtailed ambitions and risking the fund's unique role in scaling up control measures against the three killer diseases in response to specific countries' needs.

At its most recent fund-raising meeting, in October 2010, the fund had hoped to expand its efforts by raising $20 billion for 2011–13, but donors pledged just $11.7 billion, barely enough to maintain its existing programmes. Then followed the fraud allegations, which largely rehashed audits already made public by the fund itself. A retrospective audit published in July this year suggests that the allegations may have been overblown. It found that, in a sample of grants worth $3.8 billion that were awarded from 2005 to 2012 in 27 countries, just 0.5% of grant funding was lost to outright fraud. Experts say that figure is not exceptional for funding programmes in poor nations that often struggle with corruption.

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By November 2011, the organization's funding difficulties led it to cancel all new awards until 2014. On top of that, a management crisis ensued, with executive director Michel Kazatchkine resigning in January this year. Kazatchkine's departure followed the board's appointment in November 2011 of a temporary general manager alongside him to reform the agency.

Last week's appointment of Mark Dybul as executive director could signal a fresh start, and has been broadly welcomed. A physician and immunologist who co-directs the Global Health Law Program at the O'Neill Institute for National and Global Health Law at Georgetown University, Washington DC, Dybul helped to create the US President's Emergency Program for AIDS Relief, and led the much-lauded body from 2006 to 2009. "He did a really thoughtful, responsible and accountable job," says Barry Bloom of the Harvard School of Public Health in Boston, Massachusetts.

In response to a September 2011 report from a high-level review panel, the fund's board also adopted a new grant-funding model that departs from its revolutionary demand-driven model. Unlike typical aid organizations, which craft and spend a given budget, the fund has until now operated by soliciting and peer-reviewing requests for aid from countries, and then seeking donor financing for all the top-rated proposals.

Under the new model, funding will still be demand-driven to some extent, although constrained by the probable continued flatlining of the budget. Countries applying for funds will now be subjected to a means test that imposes funding caps depending on their wealth and their burdens of AIDS, malaria and tuberculosis. Some funds will still be made available outside this scheme for proposals that are judged to be of exceptional interest.

Another concern of global-health experts is that the new funding model risks neglecting poor populations living in middle-income countries.

The board also threw into question the future of the Affordable Medicines Facility — Malaria (AMFm), a multimillion-dollar programme aimed at providing subsidized artemisinin-based combination therapies for malaria to private-sector local stores and pharmacies. These are often the only point of supply for medicines for many in the rural developing world, particularly in Africa (see *Nature* **490,** 13–14; 2012).

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The board decided that the stand-alone AMFm programme will now be integrated into the Global Fund's existing grants system, but did not ring-fence any new money for it. Because existing funds for the AMFm run out at the end of 2013, many experts assert that this move effectively kills the programme.

Kate Macintyre, executive director of Aidspan, a non-governmental organization based in Nairobi that acts as a watchdog of the Global Fund, says she is "optimistic" that the turmoil has come to an end, and that the fund is back on track. "A lot of the fund's problems look like they are behind it," she says. She adds that a key test for the fund's future will be the eagerness of donors to contribute at replenishment meetings in May and September 2013, which will cover its work from 2014 to 2016.

The fund is also working harder to win support from the corporate and philanthropic sectors. Jennifer Cohn, a medical coordinator at Médecins Sans Frontières, which provides medical humanitarian aid, hopes that a tax on financial transactions planned by ten European countries might also be tapped to provide the Global Fund with another source of support. The most urgent need for the fund, she says, is to start "getting money out the door" again. ■ SEE EDITORIAL P.495

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