



# **Partners in Crime: National Theft of Global Fund Medicines**

**Africa Fighting Malaria Briefing Paper**

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## Summary

*Millions of dollars of donated antimalarial drugs have been stolen, most often by staff of recipient government medical stores; this strengthens criminal gangs and undermines donor intent. The main culprit donor is the Global Fund to Fight AIDS, TB and Malaria, which worryingly is pushing ahead with further schemes that have the same inherent weaknesses, which may worsen the theft problem. Sweden and Germany have already suspended funding to the Global Fund due to financial irregularities, but it is time for a thorough investigation of drug theft - to ensure that drugs are being used by those intended, rather than encouraging illegal parallel distribution systems, in both recipient nations and nations where products are diverted. It is likely that the entire incentive system needs to change, so that donors only receive future taxpayer funds when they can show that the drugs they buy actually reach intended patients in developing nations, not just reach their governments' medical stores.*

## Background and Introduction

Over the past four years, Africa Fighting Malaria (AFM), a non-profit malaria research group, has sampled malaria drugs from eleven African countries, analyzing them for basic quality. Over time we noticed increasing amounts of the best antimalarial drugs, artemisinin-based combination therapies (ACTs), on sale in the private sector, which had originally been donated to the public sector. They had been stolen and diverted into private markets. We published our analysis in the peer-reviewed literature in September 2010,<sup>2</sup> estimating that over a quarter of the ACTs we bought had been diverted. This research was updated at the end of 2010.<sup>3</sup>

Since then, largely through internal procedures of the Global Fund to Fight AIDS, TB and Malaria (Global Fund), we have learned of major financial irregularities. Although the amount so far unearthed is not obviously large (\$34 million) compared with the overall budget expenditure (\$13 billion), that is partly because the vast majority of countries have not yet been investigated for fraudulent activity. The Swedish and German governments are worried enough to halt financing of the Global Fund, totaling over \$250 million in 2011. Other nations are looking closely at their own support of the Global Fund. In the US, the Obama administration has criticized corruption but has predominantly championed the Global Fund, and last week approved \$1.05 billion in funding in the next fiscal year for the Global Fund. Senator Richard Lugar (R-IN) recently published a report for the minority Republican members on the Foreign Relations Committee demanding further investigations at the Global Fund to stem corruption and theft of funds. The Foreign Relations Committee, other US entities and other governments will probably turn their attention to drug theft shortly, because the sheer scale, discussed below, means it is only a matter of time before their focus is shifted.

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<sup>2</sup> Bate R, Hess K, Mooney L. Antimalarial medicine diversion: stock-outs and other public health problems. *Research and Reports in Tropical Medicine*. 2010;2010:1. DOI 10.2147/RRTM.S13242.

<sup>3</sup> Bate R. Do Aid Agencies Want to Know When Their Medicines Go Missing? *American Enterprise Institute for Public Policy Research*. 2010. Available at <http://www.aei.org/docLib/2010-HPO-05-g.pdf>.

## AFM Investigates Drug Theft

The following information has been learned through a mixture of our own direct investigations on the ground, analysis of Global Fund documents, and conversations with various stakeholders. Under the leadership of John Parsons, the Global Fund's Inspector General, the Global Fund has identified at least thirteen nations where drugs have been stolen, and roughly two thirds of the stolen drugs have been ACTs (the other third are antiretroviral drugs and other drugs to treat opportunistic infections for those with HIV). There have been instances of theft of bed nets and other commodities as well, which will be discussed in later briefings. The overwhelming culprits in most of the drug theft cases are the national government distribution systems, and primarily their national Central Medical Stores (CMS).

When we first analyzed drug theft it looked as though most of the stolen antimalarials were close to expiry. From our private sector procurements, the average remaining shelf-life of the diverted products was about two months, compared with 11 months for the non-diverted samples. We hypothesized, backed up by a few anecdotal statements from stakeholders, that because of poor logistics, national government distribution systems were too slow at getting products into the market. As a result, CMS staff were allowing drugs close to expiry to be stolen from CMS since they would otherwise be wasted, whereas at least if they were sold on the black market they could do patients some good. However, it was naïve to assume that CMS staff just wanted to make sure the drugs were being used. In reality brand new drugs are going missing too. The schemes to steal drugs have become increasingly sophisticated and involve reams of bogus paperwork, which describe drugs going to clinics that either don't exist or that never receive the drugs. Over two thirds of the drugs are stolen by "insiders", which depressingly include senior health management staff, security personnel and even doctors. In some instances the crimes are so rapid that drugs are stolen and diverted (usually by truck and then ship) to other African nations within hours of the drugs being received at CMS, and in at least one instance the drugs never even made it to the CMS, being stolen at the airport on arrival.

On a positive note, those donors which do not use CMS, seem to have far fewer diverted products. It therefore appears that Global Fund drugs are not particularly targeted, but that the Global Fund uses governmental distribution systems, which appear to be *the* major problem. While it is likely that some drugs are stolen in regional or district drug stores, AFM has not been able to investigate this possibility yet, although we have seen reports of phantom patients being used as a device to steal medicines in regional clinics.

At least 12 African government CMS have been involved in corrupt activities with drugs bought with donor money (overwhelmingly money from the Global Fund). Not far off \$100 million in drugs have probably gone missing, and the Global Fund is fully aware that the following countries have major problems at their CMS – Burundi, Central African Republic, Malawi, Nigeria, Sierra Leone, Swaziland, Tanzania and Togo.

One CMS currently under scrutiny is Malawi. Back in 2006, a colleague visited the Malawi CMS and expressed alarm that there was no climate control of any sort for the drugs; modern

stock management was almost non-existent; and physical security was very weak. These failings were obvious to him and any other competent observer.

Nevertheless, many donors used the Malawi CMS until quite recently. The US Government stopped in early 2010 and the Global Fund followed its lead from mid-December 2010 - the Global Fund agreed to follow a parallel distribution system developed by the US Government. In the two years to that point, Malawi had received nearly \$35 million in drugs to treat malaria and HIV. AFM has no idea how many of these products have gone missing.

But in the past month or so, while investigating alternative options for drug storage and distribution in Malawi, the Global Fund team in Malawi concluded that in emergencies it had no other options than to allow the Malawi CMS to continue to be used to procure drugs, or risk undermining the fragile health systems it helped establish. And this in microcosm exemplifies a key problem for the Global Fund.

Malawi is a small country with even smaller capacity, yet its need is great: in 2009 there were over 5.4 million cases of malaria and over 6,500 deaths;<sup>4</sup> an estimated 920,000 people were living with HIV; and an estimated 51,000 died due to AIDS.<sup>5</sup> So it is entirely understandable that Global Fund staff want to help. But need is not enough of a reason to allow obviously corrupt organizations to remain involved. The Global Fund did try to get UNICEF and private contractor, John Snow International, to help with storage and distribution for emergency supply, but neither had the capacity to operate effectively at short notice.

The decision to continue to use Malawi's CMS in exceptional circumstances sends the wrong signals to medical staff in Malawi's poor health system; it might even encourage mismanagement. Malawi's CMS must not be used until it has been improved – a position agreed to by the US Government and the Global Fund last year.

## The Bigger Picture

In a January *Foreign Policy* column I explained how most of the malaria medicines donated to Togo by the Global Fund, had gone missing, stolen by that government's own procurement agency staff. I criticized the Global Fund for poor oversight and trying to do too much. What I wrote was obviously too much for the Executive Director of the Global Fund, Michel Kazatchkine, and the Global Fund's Inspector General, John Parsons, who posted the following reply: "To imply, as Mr Bate does, that only foreign oversight can secure drug distribution is an affront to the vast majority of honest, hardworking pharmacists, doctors and nurses who are successfully and conscientiously delivering drugs to patients in many countries around the world."

The inference that I'm a bit of a racist stung, and for sure it is a useful ploy to discredit one's opponents this way. But it also set me wondering about what the Global Fund considers an acceptable level of corruption. Rhetorically, like every other government and multilateral

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<sup>4</sup> World Health Organization. World Malaria Report 2010. Available at <http://www.who.int/malaria/publications/atoz/9789241564106/en/index.html>.

<sup>5</sup> World Health Organization. Global Health Observatory Database. Available at <http://apps.who.int/ghodata/>.

agency, the Global Fund claims to go after anyone shown to be engaging in illegal activity, but that doesn't mean they don't condone systemic fraud and failure.

After all, I've met many healthcare professionals in Africa who strike me as honest, diligent and caring, but so what? My colleagues and I have also visited many African CMS, and all of them had management flaws. The results of this are obvious. Theft from many CMS is not a rare occurrence: it is systemic. In some CMS, physical security is so weak that they should never have been used by the Global Fund for that reason alone. Most CMS need stock reconciliation, inventory management and supply chain training. When the US Government found persistent thefts in the Angola (and Malawi) CMS, it stopped using the Government Stores and established entirely different parallel distribution systems. Notwithstanding the compromises the Global Fund may occasionally make in Malawi, it will probably have to do likewise in most of those countries listed above, or face a revolt from its donors.

Since the Global Fund is more transparent than any other multilateral donor, we know about more of its problems. What is most troubling about the above-listed countries with failing CMS and distribution systems, is that the list does not include many of the worst examples of corruption, for which even the Global Fund has no idea how bad the situation has become.

The "recipient of last resort" for Global Fund money is the United Nations. In some countries where the private sector and governmental agencies are simply too corrupt or weak for even the occasionally lax Global Fund to use them, the UN Development Program (UNDP) steps in. Yet the UNDP won't provide its audit reports to the Global Fund even though the Global Fund has sent it over \$1 billion in grants for 27 of the poorest and most corrupt countries around the globe.

Senator Lugar's report is pressuring the US Government to prevent Global Fund from using the unaccountable UNDP, at least with US taxpayer funds. That is a good start. But more than that, the Full Committee must tell the Global Fund to go back to its core mission of buying commodities for countries which demonstrate they can be helped. The Global Fund was not established to be another inclusive UN agency which had to work with everyone, no matter how feckless, but that is what it has become.

The Global Fund is correct that the health systems in most locations are simply too weak to deliver the drugs – indeed, this is a key reason why good quality drugs are scarce – from Angola to Zambia. But it is not the Global Fund's job to train these people; such mission creep at the Global Fund is a major cause of its failure to prevent rampant corruption. The example of Malawi is apposite. When Malawi's officials ask the Global Fund for help in health systems development, Global Fund staff know that no other agency will probably be able to help and so over time they agree to fund such activities. But this is a slippery slope; and although not intended, makes the Global Fund an enabler of the resulting corruption.

I hope the Global Fund's commendable effort to unearth corruption and improve its logistics will be an open process, which in the short run results in it bypassing many hopeless CMS and in the long run results in it funding fewer countries, dropping those consistently offending. This is surely the right outcome for both patients and donors. As the US President's Malaria Initiative (PMI) has shown, operating in a select group of targeted countries, that have the capacity to work

with the PMI, leads to enormous beneficial results. I suggest that the Global Fund may well be able to save more lives, as well as lower corruption, by focussing its effort on countries which take combating disease seriously, using their own tax revenue to build their own health systems, in order to take advantage of donor largesse to buy commodities.

If the Global Fund stops financing countries which have either corrupt or weak health systems (so they require UNDP to run matters) then this will probably lead to more short-run suffering. But ultimately supporting corrupt systems is a worse trade off. Medicines are a valuable commodity in Africa, almost as fungible as cash. Those who benefit from corruption are emboldened, expanding their power base, and in the case of medicines, even substituting fake products once they have a taste for the illicit trade. After all, bad actors are not deterred by stern words and open check books, but only by closing the check book. If the Global Fund doesn't do this voluntarily, it might be its country donors that stop cutting the checks. Until that time the Global Fund is enabling corruption, regardless of its rhetorical defiance and reasonable transparency.

## Additional Background Information

Aid agencies purchase medicines, some of them in significant amounts. Take malaria: the US Government's President's Malaria Initiative (PMI) bought 29 million treatments in 2009. Up to April 2010, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) had acquired 90 million treatment courses for sub-Saharan Africa alone.<sup>6</sup> In other words, the two largest agencies procured about 120 million treatments of the best antimalarial medicines in one year, primarily for use in Africa.<sup>7</sup>

Of course, the intention is that these 120 million treatments reach people with malaria, especially the poorest, who are unable to buy the best treatments. Inevitably, in many distribution systems there is waste, delay and theft, and this is certainly true with lifesaving malaria medicines in the world's poorest countries. But these problems are so severe that any short term benefit from well-meant inputs could be outweighed in the long run by unintended yet perverse outcomes.

### **Diversion: a euphemism for theft**

Anecdotal evidence of diversion is rife. Where it exists, free media report numerous examples of drugs not going where they are intended. Uganda, for example, found that in one district only 20% of antimalarials dispensed from clinics actually went to those with malaria. The other “patients” were speculators who hoard the top-quality free handouts for future use or sell them to dealers.<sup>8</sup> This is largely due to inadequate diagnosis – patients with fevers, especially children, are presumptively treated for malaria. The theft of medicines is widespread in Uganda, for instance. Dr. Stephen Malinga, the Ugandan Health Minister, referred to those stealing malaria drugs as “murderers,” and even identified that some drugs stolen from Ugandan government stores have been diverted to private pharmacies in Sudan.<sup>9</sup>

As established above the GFATM is a funding agency, and a thorough investigation is likely beyond its competence and even its remit. GFATM requires help from the police and other security agents within each country, and if that is not forthcoming their investigations are severely hampered. INTERPOL, which is the only international organization with any track record of coordinating action against pharmaceutical crime, is assisting GFATM, but even INTERPOL relies on local security agency support, since it is primarily a coordinating and data gathering and dissemination organization.

It will be interesting to see both what GFATM and INTERPOL investigate and how they report it.

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<sup>6</sup> The Global Fund to Fight AIDS, Tuberculosis and Malaria. Press Release, World Malaria Day: 2010 is critical year for global efforts to defeat malaria. 25 April 2010. Available from: [http://www.theglobalfund.org/en/pressreleases/?pr=pr\\_100414](http://www.theglobalfund.org/en/pressreleases/?pr=pr_100414). Accessed October 22, 2010.

<sup>7</sup> In this article I primarily deal with antimalarials, but it is clear that diversion and counterfeiting is a significant problem ranging across many therapeutic medicines types.

<sup>8</sup> Kaheru H. Shortage of malaria drugs is largely artificial. The Monitor. 2010 September 21. Available from: <http://allafrica.com/stories/201009210515.html>. Accessed October 22, 2010.

<sup>9</sup> Honigsbaum M. The killing season. Al Jazeera. 2010 May 30. Available from: <http://english.aljazeera.net/focus/2010/05/20105261374999817.html>. Accessed October 22, 2010.

In an October 2010 review of the pharmacies originally sampled in 11 cities, colleagues found diverted drugs in only one city (Nairobi), whereas eight months earlier nine cities were found to have diverted drugs. But diverted products are still readily available outside of city pharmacies. Investigators addressing the problem now will find the game has changed; much trade has been driven away from the previously lucrative and substantial market of urban pharmacy trade into informal or rural markets. We found diverted and counterfeit products at every street market in all six towns surveyed on both sides of the Benin–Nigeria border. Diversion knows no borders.

If my study, along with other research findings and anecdotal reports of hundreds of different batch numbers of stolen products, accurately represent the scale of diversion, out of the 100 million high-quality antimalarial dosages donated to Africa, approximately 30 million are diverted. About 20% of these drugs are informally diverted by individuals from clinics. More disturbing to taxpayers and humanitarians alike, the vast majority of diversion (80% or 24 million treatments) takes place directly from government-run storage and distribution facilities, with either the support of local government officials—or at least without their interference. Some of these stolen products find their way to the police, army and other branches of government. Malaria is poorly treated among the lower ranks and their families, and diversion ensures ample high-quality supplies for military personnel. Some may be complicit in the trade; more accept drugs as payoffs for not preventing smuggling.

## **Donor responses**

Given the rhetoric of donors and recipients alike, one would think efforts would be made to curtail this trade. But donors do not like to discuss bad news. While some individuals may care enough to risk their jobs by talking, most keep their heads down and their mouths shut.

And one can see why: no one suffers in the short run, other than patients (and taxpayers). Even though the drugs are stolen, the decision-makers (donors, drug companies, recipient finance and health departments, and even some clinicians) all benefit from the current system. Financial incentives in drug companies, and career advancement in aid groups, are related to how much product is delivered, not on how many lives are saved. Of course, product delivery and saving lives are linked. But international health aid programs have rarely monitored health outcomes—that is, whether their aid actually reduces disease. In fact, certain parties actually benefit more when orders have to be duplicated due to theft. So, given the lack of incentives to expose the problem, donor responses have generally been limited. Most do not publish any information about product theft. Some donors, notably PMI, publish audit reports and are robust enough to insist that the most egregiously corrupt recipients are removed or bypassed. When repeated thefts occurred from Angolan Government stores, PMI began using only bonded private warehouses.<sup>10</sup>

Yet concerns over misuse of grant money in several countries led Sweden and Germany to recently withhold funding from GFATM.<sup>11</sup> Zambia is one example of this misuse of funds. A

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<sup>10</sup> President's Malaria Initiative. Malaria Operational Plan – Year Five (FY2010) Angola. Available from: [http://www.fightingmalaria.gov/countries/mops/fy10/angola\\_mop-fy10.pdf](http://www.fightingmalaria.gov/countries/mops/fy10/angola_mop-fy10.pdf). Accessed October 22, 2010.

<sup>11</sup> Usher AD. Defrauding of the Global Fund gives Sweden cold feet. *The Lancet*. 2010. doi:10.1016/S0140-6736(10)62081-8

2009 audit conducted by GFATM's Office of the Inspector General (OIG) found that all of the principal recipients of grant monies in Zambia (including two government ministries) have "shown evidence of significant financial management and control weaknesses, episodes of misappropriation and fraud."<sup>12</sup> It is a positive step that GFATM publishes this information, but despite this it continues to work extensively in Zambia. Furthermore, it has not discussed the quantity of drugs diverted (unlike PMI) and gives the impression that the problem is minimal.<sup>13</sup> If 30 million treatments are going missing, the vast majority are likely from GFATM donations, both due to the organization's quantity of donations and its lack of efficacy in combating diversion.

GFATM has pressured recipients to punish those involved in theft. A hefty criminal conviction of a high-level official for embezzling GFATM money was recently upheld by the Ugandan Government, but as local media notes, only low- and mid-level operators were sanctioned.<sup>14</sup>

One reason that GFATM has been less aggressive than PMI is that it was established to help poor countries manage their own drug procurement and delivery processes. And while that is a sensible long term strategy, in the short run drugs are being stolen, almost certainly with high level political support; consequently, not a great deal is being done about it. Some wish to return to the older, arguably more paternalistic, model of separate distribution systems to bypass the greatest corruption problem: African government officials. To a certain extent, this is what the US Government and PMI in particular are doing in extreme circumstances. In places like Angola, PMI is outsourcing distribution to various private sector contractors, which are expensive but reliable. These parallel systems are surely required if one's short run aim is to improve access to medicines.

GFATM's integrated approach follows the predominant international health policy goal for at least the past 40 years: to assist poor nations in building up their own competence to deliver healthcare to their own people. Not only is this aim noble, it is also essential since no level of foreign assistance can, on its own, improve another nation's health for an extended period. If the local health systems do not evolve, aid has little effect in the long run. The crux of the problem is that too many poor nations, and their identified drug recipients, are simply not capable of doing the job. If GFATM's approach helps these countries move in the right direction, one could make the case that the aid is worthwhile even if only 20% of malaria drugs reach the patients. But working against progress is the above-mentioned dependency culture in the aid system, which makes even successful programs perform poorly over time.

A second problem is the impact on drug suppliers if theft continues. Criminal groups will continue to gain a foothold as large-scale networks develop to distribute stolen and fake drugs. Kenya has already been named a "safe haven" for such cartels by the World Health

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<sup>12</sup> Garmaise D. OIG Finds Serious Deficiencies in Performance of All Four PRs in Zambia. *Global Fund Observer*. Issue 132 (November 2, 2010). <http://www.aidspace.org/index.php?issue=132&article=1>. Accessed November 2, 2010.

<sup>13</sup> In the case of Zambia, we found stolen drugs from these Zambian PRs (principal recipients) in our peer-reviewed study.

<sup>14</sup> Maseruka J. Corruption Watchdog Hails Cheeye Conviction. *New Vision*. October 21, 2010. <http://www.newvision.co.ug/D/8/13/735743>. Accessed October 23, 2010.

Organization.<sup>15</sup> Evidence from countries in the Middle East indicates that what starts out as a smuggling operation can quickly become one devoted to the higher profits of counterfeiting.<sup>16</sup> And with more counterfeit medicines comes the danger of increased drug resistance. Currently, the concern about drug resistance to the newest antimalarial products is confined to Southeast Asia (primarily Burma, Cambodia and Thailand), but counterfeit antimalarials could easily bring the problem to Africa, with disastrous results. If that happens, patients will be without recourse to any effective drugs.

A third problem is not as self-evident—boredom and frustration among those within GFATM and other agencies. Put yourself in their shoes: the entrepreneurs who started the organization established channels and raised funds to buy medicines for poor nations, and they garnered a lot of positive publicity as a result. It was exciting, and they loved the attention and the prospect of success. But sadly, the fun was short-lived. They or their successors subsequently encountered the difficult slog of maintaining funding every year, which requires that they report their programs' efficacy—often resulting in significant exaggerations. Reports, and especially projections about expected future performance, require a masterful sleight of hand, because the organizations do not systematically gather performance data; their arcane modeling exercises do not actually measure lives saved, just how many drugs are distributed. And where systematic investigations are undertaken, we find that many recipient nations are simply incapable of delivering the drugs to the patients who need them.

The result is blind advocacy, which is surprisingly effective at raising funds, regardless of a lack of actual evidence of prior success in combating disease. The majority of those in Congress, who recently supported increases in support for GFATM, have never even pushed for a proper investigation of the efficacy of these disbursements. Most of the supporters – 101 Democrats in the House of Representatives signed a letter of support – like the idea of supporting multilateral efforts like GFATM;<sup>17</sup> it is the mantra of the Obama administration to do more with multilateral partners. But it appears that neither the White House nor Congress actually wants to know that their chosen method – multilateral distribution of funds – often does not work.

The secondary effect is to utilize any semi-viable option for increasing the appearance of performance. Two notions adopted by GFATM spring to mind – health system strengthening and the AMFm (the Affordable Medicines Facility for malaria).

Although GFATM was established to fund commodities like pharmaceuticals, it is also funding health system strengthening in poor nations, partly because it belatedly realized that country systems are too weak to deliver the drugs they are providing. Fair enough, except that GFATM is not competent to develop health systems; it has allowed its own mission to creep without the

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<sup>15</sup> Omondi G and Muiruri M. WHO names Kenya as safe haven for fake drug cartels. *Business Daily Africa*. November 10, 2010.

<http://www.businessdailyafrica.com/Corporate%20News/WHO%20names%20Kenya%20as%20safe%20haven%20for%20fake%20drug%20cartels/-/539550/1050938/-/jud3flz/-/index.html>. Accessed November 12, 2010.

<sup>16</sup> Bate R. Lessons from a Syrian drug bust. *Wall Street Journal*. April 28, 2010.

<sup>17</sup> Letter to President Obama from 101 Democrat members of the House of Representatives. Full text available at: [http://www.results.org/uploads/files/global\\_fund\\_3\\_year\\_pledge\\_letter\\_to\\_president\\_7-29-10\\_final\\_with\\_list\\_of\\_co-signers.pdf](http://www.results.org/uploads/files/global_fund_3_year_pledge_letter_to_president_7-29-10_final_with_list_of_co-signers.pdf). Accessed October 28, 2010.

requisite competence to complete the mission. (Recall that it does not even attempt to properly measure whether its core mission is working.)<sup>18</sup>

Secondly, GFATM backed and now runs the AMFm, a financing mechanism for subsidizing high-quality malaria treatments in the private sector. AMFm is arguably a smart intervention in some locations, but GFATM does not have the competence to manage this either. It does not understand local private markets (no one does--they have not been properly investigated), and it relies on self-serving reports which allegedly show the system will work.<sup>19</sup> AMFm does not even address the question of product theft, and it barely considers the possibility of counterfeit AMFm products. It claims that special packaging will be used to identify its discounted products – failing to realize that counterfeiters copy packaging for a living, and that AMFm packaging will be no exception.

The GFATM/AMFm then publicly declared that it had no intention of showing whether the “pilot phase,” costing hundreds of millions of dollars, ever achieved its aim. In 2010, the director of the AMFm and the director of the strategy, performance and evaluation cluster at GFATM wrote: “Expectations of attributable and rapid increases in measures of service delivery at the household level, which are neither new nor unique to AMFm, are inappropriate and unrealistic within the duration of the pilot studies.”<sup>20</sup> In other words, taxpayers could subsidize another scheme that strengthens criminal networks, and no one will even measure whether or not it has a positive effect.

This position of the AMFm Secretariat is also in direct contradiction to the demands of the Global Fund Board. As one Board member, who asked not to be identified, told me recently: “failure to provide evidence on whether there has been an increase in the use of good quality ACTs, including by the poorest two quintiles, will be a red line [a reason to cancel the project] for many Board delegations.”

AMFm distributions are underway and anecdotal reports indicate that AMFm drugs are already and quite predictably being diverted.

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<sup>18</sup> For a review of the problem of mission creep at the Global Fund, see Shakow, Alex, “Global Fund and World Bank HIV/AIDS Programs: A Comparative Advantage Study,” prepared for the Global Fund to Fight AIDS, Tuberculosis and Malaria and the World Bank HIV/AIDS Program, available at <http://siteresources.worldbank.org/INTHIVAIDS/Resources/375798-1103037153392/GFWBReportFinalVersion.pdf>.

<sup>19</sup> See, for example, “Affordable Medicines Facility – malaria,” The Global Fund to Fight AIDS, Tuberculosis and Malaria, [http://www.theglobalfund.org/documents/amfm/AMFmFAQs\\_en.pdf](http://www.theglobalfund.org/documents/amfm/AMFmFAQs_en.pdf). Accessed October 29, 2010.

<sup>20</sup> Adeyi O, Atun R. Universal access to malaria medicines: innovation in financing and delivery. *Lancet*. 2010. doi:10.1016/S0140-6736(10)61189-0.