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Selected Comparison of Global Health Organizations

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Abstract

Due to a potential, worldwide adverse impact on health, transnational dependencies, and the need for effective response, global cooperation is imperative (Buchanan & Decamp, 2006). There are more than 100 global health agencies, including the World Health Organization. As the number of organizations increases, each with their own agendas, so does the concern for lack of coherence and collaboration among organizations in the effort of disease eradication and development of health systems (Beaglehole & Bonita, 2008). The focus of this study is on comparing the effectiveness of selected global health organizations in efforts to detect a need to either establish more similar type organizations or make current ones more efficient. The selected organizations are compared by their programs addressing Millennium Development Goals (MDG) #4, #5, and #6, strategic goals, measurable and reported outcomes, countries supported, and funding mechanisms. The results signify that while MDGs are addressed, there are major issues with accountability, mainly commitment through monitoring and evaluation (M&E) of programs. While the global health system is seen as a loose and fluid agglomeration with multiple, shifting centers of influence (Cerrell et al., 2007), the greatest need is to develop efficient M&E systems in existing organizations. Secondary actions should address additions of medical branches to long standing global health organizations leading to higher participation from medical students and health professionals, and the re-allocation of government funding from non-productive organizations to establish a Global Health Corps, which could be the first global health organization to implement such effective M&E systems.

Keywords: Global health agencies, Millennium Development Goals, monitoring and evaluation, Global Health Corps, Peace Corps

Selected Comparison of Global Health Organizations

Global health is a relatively new category of moral concern, empirical investigation, and institutional action (Buchanan & Decamp, 2006) that is being defined primarily by developed countries in terms of their working with developing countries (Macfarlane, Jacobs, & Kaaya, 2008). As the term "global health" is at times used interchangeably with international health, Jacobson defined it as *health concerns that cross national borders* (Jacobson, 2008). Whereas international health focuses on "control of epidemics across boundaries and between nations," global health implies "consideration of the health needs of the people of the whole planet above the concerns of particular nations" (Brown, Cueto, & Fee, 2006, p.1).

The term "global health" is suggested to have emerged as part of larger political and historical processes beginning in 1948, which involved redefining the role of the World Health Organization (WHO) across the international health community. Thus, it can be said that the WHO is an intergovernmental agency that exercises international functions with the goal of improving global health and emerging as a coordinator of global health initiatives (Brown, Cueto, & Fee, 2006).

The 1950s and 1960s presented changes in biology, economics, and politics transforming foreign relations and public health, and moving the WHO's narrow emphasis on malaria eradication to broader development of health services. Though the WHO did not invent "global health," it did help to promote interest in it (Brown, Cueto, & Fee, 2006). The growing awareness that some risks to health are global in scope has produced an influx of global health centered organizations. However, to be effective against such risks, these initiatives must involve global cooperation. Due to a potential, worldwide adverse impact on health, transnational dependencies, and the need for effective response, global cooperation is imperative (Buchanan &

Decamp, 2006). Included in the list of global health organizations are philanthropists, like Bill Gates and Warren Buffett, who have both channeled billions into public health initiatives (Brown, 2008). There are more than 100 global health agencies including the WHO. As the number of organizations increases, each with their own agendas, so does the concern for lack of coherence and collaboration among organizations in the effort of disease eradication and development of health systems (Beaglehole & Bonita, 2008). Single agendas, for example, can be observed by the number of organizations focusing on polio, which was 151 as of March 18, 2009 (World Health Organization, 2009). "Institutional innovation will be needed to achieve a more comprehensive, fair distribution of concrete responsibilities regarding global health and to provide effective mechanisms for holding various state and nonstate actors accountable for fulfilling them" (Buchanan & Decamp, 2006, Abstract). An indication of the importance of global health issues could be measured by the number of emerging global health leaders from developed and developing countries working on shared global agendas including leaders from academic initiatives with a global health focus (Macfarlane, Jacobs, & Kaaya, 2008).

Despite an increased interest in global health, there remains a need to investigate the efficiency of global health organizations. The assessment of efficiency can create accountability that will call for continual refocusing of aims (Beaglehole & Bonita, 2008). Though many articles discuss the need, many do not present statistical data or solutions for the issue. In response, many current studies have redirected their focus within the global community. This revamped priority is usually centered on the United Nation's Millennium Development Goals (MDG) (see Appendix 1). Ideas, such as the creation of a global health scorecard, have been proposed to measure progress, and to help suggest methods of improving the effectiveness of public health (Beaglehole & Bonita, 2008).

"Today's students want to contribute, to empower individuals and communities to take charge of their own health. I think they also intuitively realize that the world is their community and that the gains of the 21st century will be in global public health" (Brown, 2008). Attractive academic electives overseas provide exposure to different cultures, health systems, and career networking. An estimated 4,000 United States (U.S.) medical students per year request or participate in a "global health experience" (Macfarlane, Jacobs, & Kaaya, 2008). While global health academia is normally referred to students from developed countries, those in developing countries could also benefit from the international experience; however, they lack the opportunities afforded to their peers in developed countries.

The comparison of global health organizations lends significant value to three particular audiences. First, citizens should be aware of utilization of tax dollars, their global representation, and understanding their role in the global community. Second, as healthcare students and professionals, it is important to understand education and career options from entry level to senior level, from domestic to international. Third, as potential future leaders, it is important to understand mechanisms for change in relation to new challenges in an ever-evolving global community.

Statement of Purpose

The purpose of this study is to compare, and contrast selected global health organizations in terms of their effectiveness in efforts to observe a need to either establish more similar type organizations or make current ones more efficient. These organizations will be compared to the organizational structures of the already established Peace Corps and the idea of a potential Global Health Corps (GHC). The specific research questions are as follows:

1. Do the selected organizations fulfill the needs of Global Health?

2. What are selected organizations doing to accomplish global health needs as defined by Millennium Development Goals #4, #5, and #6?
3. Is there a need to strengthen the existing global health organizations?
4. If the selected organizations do not fill the needs of Global Health, is there a need for a new organization such as the Global Health Corps?

Literature Review

The practice of Global Public Health is the collective action taken worldwide toward improving health and health equity, aiming to bring the best available, cost-effective, and feasible interventions to all populations and selected high-risk groups (Beaglehole & Bonita, 2008). These collective actions are taken to ensure adequate health within the perspective of the current issues in global health.

So, what are the priorities of Global Health? For global health, the Disease Control Priorities Project, a collaboration of the Fogarty International Center of the U.S. National Institutes of Health, the World Bank, the World Health Organization, and the Population Reference Bureau, developed a list of the developing world's top ten most significant health problems as follows:

Top 10 Global Health Priorities

1. Ensure healthier mothers and children
2. Stop the AIDS pandemic
3. Promote good nutrition
4. Stem the tide of tuberculosis
5. Control malaria
6. Reduce the toll from cardiovascular disease

7. Combat tobacco use
8. Reduce fatal and disabling injuries
9. Ensure equal access to quality health care
10. Forge strong, integrated, effective health systems (Jacobson, 2008, pg. 280)

In reviewing the literature, the issue of accountability among global health organizations and the ability to assess their effectiveness were discussed frequently. However, there were only a few articles presenting solutions involving possible ways of assessment. This review focused on global health organizations, the MDGs, and effectiveness and efficiency.

Global Health Organizations

The need to strengthen global health organizations. "In reality, the global health system is a loose and fluid agglomeration with multiple, shifting centers of influence. It comprises the World Health Organization, the 22 assorted UN agencies with health programs of some sort, the World Bank, and new international bodies…." (Cerrell, Gayle, Morrison, & Godal, 2007, pg. 37, #2. Finding a Unified Vision, 3rd paragraph).

There is minimal accountability for achieving results. Foreign assistance is spent on countries with governments that are not serious about development or are in pursuit of objectives that do not favor development. Monitoring and evaluation systems are weak and tend to focus on resources spent, rather than strategic and developmental achievements of programs (Herrling & Radelet, 2008). U.S. global health agencies, though not alone, exhibit no unified, coordinated vision of efforts, but an array of fragmented initiatives. These efforts originate from many different decentralized, semiautonomous entities (Cerrell, Gayle, Morrison, & Godal, 2007).

Global health lacks a clearly defined structure, equipped with functional decision-making and governance mechanisms, which lead to proper means to analyze the efficiency and

effectiveness of organizations. Historically, global health was a back-burner issue—inadequately funded, underpowered, and largely ignored—where the lack of a coherent, unified system appeared to matter little. The call for accountability increased as global health became a foreign policy priority, health focused resources of developing countries increased noticeably and efforts became more visible. Complex existing problems for global health include: (a) the coordination and integration of efforts internationally, (b) sustaining momentum, while bringing forward adequate resources to meet true demands, and (c) difficulty focusing attentions and achieving results on the chronic health deficits in developing country workforces, which become scarce due to competitive, commercial recruitment to wealthier settings, or the "brain drain." These reasons constitute a highly prioritized need to strengthen existing global health organizations (Cerrell, Gayle, Morrison, & Godal, 2007).

Multi-purpose organizations, though not free from their own issues, present more opportunities for covering more global health priorities than single purpose organizations. In regard to resources, including setup and breakdown costs of campaigns, all organizations should be held more accountable for results-based analysis. Single purpose organizations or organizations solely focused on one disease or condition, have an advantage of devoting all resources to a direct cause. Unfortunately, a successful campaign can lead to the discontinuation of an organization, as detailed in the two following examples demonstrating possibilities of risk that may occur.

The first example is smallpox, the only disease to be eradicated by mass worldwide immunization and with no records of infection since 1979 (Jacobsen, 2008). The results were regarded as a global success. However, one could only imagine the number of organizations, clinics, laboratories, or programs that were shut down due to the eradication of smallpox. In this

example, the endings of operations presented minimal negative effects due to the global eradication.

The second example is research performed by pharmaceutical companies in developing nations that could have a positive impact on a host country. However, upon conclusion of studies a company may wrap up in the middle of treatments or when further treatments could be beneficial to the participants, such as follow-up visits for monitoring possible long-term side effects. Governments and most people of developing countries where new medical interventions are tested cannot afford them (National Bioethics Advisory Commission, 2001). Furthermore, clinical trials are performed in developing countries because of lower costs, the prevalence of diseases found rare in developed countries, and large numbers of impoverished patients (Abbas, 2007).

To further address the topic of minimal accountability for achieving results, obligation to care is discussed. It is important to recognize the obligation to care for research participants upon the completion of clinical trials. Justifying this obligation is the relationship between the researcher and research participant as well as the application of the concept "justice as reciprocity" (National Bioethics Advisory Commission, 2001).

Researcher-participant relationship. Research involving clinical trials may be deemed as treatment because of the possibility of altering health status of participants as a result of participation. Participants that benefit from experimental intervention may experience loss upon completion of projects. There is considerable evidence of major benefits through involvement with clinical trials deriving from not only the experimental intervention, but also from the general care provided by the research team. Though similar to the physician-patient relationship, distinguishing the two does not come without concern by ethicists regarding the obligation

researchers have to sponsors, institutions, and science (National Bioethics Advisory Commission, 2001).

Justice of reciprocity. This type of justice concerns what people deserve as a function of what they have contributed to an enterprise or to society. Within the broad range of justice, "distributive justice requires that no group or social class be disproportionately exposed to the risks and inconveniences of serving as participants in research that aims to develop medical interventions to benefit the entire population" (National Bioethics Advisory Commission, 2001, pg. 59, Justice as Reciprocity, 1st paragraph).

Means to improve health, welfare, and development of global communities. Since March 1, 1961, the late U.S. President John Fitzgerald Kennedy's Peace Corps has been the global representation for the American version of brotherly love. Since then, not only have presidents changed, but the global health focus has been shifting from disease burden to the need for establishment of effective health systems. These national health systems are increasingly being influenced by global factors that transcend international borders. This trend calls for cross-national comparisons of health systems to allow for sharing of information and the development of transnational research agenda. Moreover, the globalization of public health will act as a strong impetus for global actions to address these areas of shared concern (Yach & Bettcher, 1998).

Advance U.S. diplomacy. In the United States, global health is an economic and security priority, Institute of Medicine (as cited in Novotny, 2006). In June 2005, U.S. Surgeon General Richard Carmona confirmed the need for the U.S. Public Health Service to become a global response corps, responding to emergencies and the emerging global health issues (Novotny, 2006). As an option, efforts to address health issues through foreign policy may or may not contribute to the advances in diplomatic relations and enhance nation security; furthermore, the

integration of health issues into foreign policy may, at times, assist in providing greater visibility and greater funding (Katz & Singer, 2007).

President Kennedy expanded U.S. foreign assistance through the establishment of the Peace Corps, USAID, and the Alliance for Progress. These programs were part of the Cold War arsenal designed to slow the spread of communism and encourage development in the world's poorest countries (Herrling & Radelet, 2008). The Peace Corps was built upon the experience of existing private overseas volunteer programs such as the American Friends Service Corps. The GHC would be designed to complement, learn from, and expand upon an array of government and private programs that have been working for years to give enthusiastic young doctors and other health workers the opportunity to serve the poor of developing countries –Mead Over (Levine, 2008).

Adding an official medical branch to the Peace Corps. In the popular media one discussion entertained the possibility of adding an official medical branch to and within the Peace Corps. *Needed: A Medical Peace Corps,* a 2005 Boston Globe opinion piece by Robert Rotberg and Victoria Salinas, presents the idea of an expansion of the American Peace Corps. Rotberg and Salinas suggested that a medical component to the Peace Corps should be established to include newly credentialed physicians and health professionals for voluntary service abroad to combat HIV/AIDS in Africa.

Global Health Corps and Peace Corps. The U.S. foreign assistance cannot be effective when global health programs extend across nearly twenty agencies that each possesses different agendas, and ways of implementation. One broad agreement is that rectifying fragmented and institutional weaknesses is key to modernizing and strengthening foreign assistance to meet

today's challenges globally. While considering this situation in 2008, Herrling and Radelet, suggested four alternatives:

1. Creating a new cabinet-level Department for Global Development.
2. Fundamentally rebuild and reinvigorate USAID or create a new subcabinet or independent agency for foreign assistance programs.
3. Merge all foreign assistance programs into the State Department.
4. Name a cabinet-level coordinator for all foreign assistance programs.

Herrling and Radelet (2008) suggested that the best option for strengthening foreign assistance would be creating a new cabinet-level Department for Global Development. This would allow for: (a) streamlining bureaucracy, reducing duplication, and strengthening our ability to align major programs under consistent objectives; (b) establishing development as the primary mission; (c) elevating development as an equal with diplomacy and defense (three key pillars of U.S. foreign policy); and (d) shifting all aid programs, minus debt relief, under one roof. Two possible negatives of this approach would be: 1) creation of too much independence from and competition with the State Department and 2) implementation issues, such as with the Department of Homeland Security, that was not a smooth process (Herrling & Radelet, 2008).

Few studies have dealt with the topic of the Global Health Corps, or investigated whether there is a need for this type of organization. U.S. Senate Bill 850 declares that the GHC would contribute to the improvement of health, welfare, and development of communities globally, advance U.S. public diplomacy, and provide individuals in the U.S. with opportunities to provide health care and related services (U.S. Senate, 2005).

Levine (2008) indicated that the benefits of the GHC would not only benefit underdeveloped countries but would include benefits for medical students and health

professionals. These experiences may instill a deeper passion for helping those less fortunate than others, as well as performing a “greater good”. An ancillary benefit would be the experience of working in irregular conditions within the developing world and relying more on clinical skills than depending on technology. Professional exchanges would encompass short- and long-term training, and research opportunities domestically and abroad. Currently, exchanges of these types exist but are poorly funded. The result of building up such programs would contribute both to the diplomatic mission of health aid and help to build capacity to deliver health services. One example of this type of exchange in action could be the GHC (Levine, 2008).

At George Washington University, incoming medical students select electives in global health by a rate of 2 to 1 over other opportunities in areas such as research and teaching (Mullan, 2007). However, the lack of opportunities that present rational time commitments and school loan compensations prevent many health professionals from pursuing careers in the field of Global Health. The centerpiece of a United States global health initiative should be a dedicated, federally funded corps of health professionals with both public health and clinical skills, serving as a new interagency task force on global health within the U.S. government (Mullan, 2007). This is needed to bring coherency and coordination among global health focused federal agencies (Levine, 2008). This would be a conceptual blend of the Peace Corps and the National Health Service Corps (Mullan, 2007). In the shadow of already established organizations like the Peace Corps (1961) and the Public Health Service Corps (1989), the idea of a Global Health Corps reached the U.S. Senate floor on April 19, 2005, but remains in committee today.

Another example is a study based on the HIV Corps, which is structured similar to the Peace Corps and presents ways of obtaining quantifiable results. The HIV Corps, which was created in 2004, presents opportunities for premedical, medical, and public health students to

assist in HIV care and prevention initiatives. Volunteers are provided housing on site and living stipends at rates that are comparable to that of the Peace Corps. The three objectives of this organization are: 1) to provide support for various HIV related service projects, 2) to provide volunteers an opportunity to work in international settings, and 3) to foster collaboration between Americans and Zambian students (Benjamin et al., 2006). Although this organization is not multifaceted like the Peace Corps, their objectives are similar to that of the Peace Corps and to those of the proposed GHC. Finally, the HIVCorps report presented data that can be used to measure the effectiveness of the organization. Such data included biographical and educational background of each volunteer, survey results from how the volunteers felt about the experience, whether or not they would pursue a career in international or public health, retention rates of volunteers in the program, and the number of volunteers that remain in the field of study following the experience. However, the conclusion was that measuring the ultimate effectiveness of the program was very difficult, as they were unable to compare the implementation or service delivery with others because of lack of current data within the field of study.

Millennium Development Goals

HIV/AIDS and inadequate health systems have helped to increase the interest in the global health field. As conditions worsen and more lives are affected, the global community works to address the cries of those seeking assistance. At present, there exists an estimated shortage of the global health workforce in 57 countries, 36 of which are in Africa. Factors leading to the shortage include migration, mobility, early retirement, morbidity, and premature mortality among workers, among others (Kinfu, Mercer, Dal Poz, & Evans, 2006). Though much attention has been focused on the shortage of the clinical workforce, it is imperative to point out

that the global public health workforce is also deficient in numbers and competencies, and poorly linked to the communities served (Beaglehole & Bonita, 2008).

In September 2000, world leaders arrived at the United Nations (UN) headquarters in New York to participate in the adoption of the United Nations Millennium Declaration. This declaration sought to create a new global partnership and to achieve targeted MDGs (United Nations, 2009). These eight UN-adopted MDGs were targeted for completion by 2015 and listed in the following as reported by Jacobsen (2008):

1. Eradicate Extreme Hunger and Poverty
2. Achieve Universal Primary Education
3. Promote Gender Equality and Empower Women
4. Reduce Child Mortality
5. Improve Maternal Health
6. Combat HIV/AIDS, Malaria, and other Diseases
7. Ensure Environmental Sustainability
8. Develop a Global Partnership for Development

In efforts to improve human development, three of the eight MDGs, eight of the 16 targets within the MDGs, and 18 of the 48 indicators within the MDG targets have direct relations to health (Beaglehole & Bonita, 2008). The three MDGs with direct relations to health are MDGs #4, #5, and #6 and are described below: (Jacobsen, 2008).

***Goal 4: Reduce child mortality*.** The infant mortality goals are to reduce by two-thirds by 2015, both under-five mortality rate and the infant mortality rate, and increase the proportion of 1-year-old children immunized against measles.

In 62 countries the under-five mortality rate is not declining fast enough to meet the MDG target by 2015; furthermore, in 27 countries the rate is either stagnant or declining. Financial assistance has increased from $2.1 billion in 2003 to $3.5 billion 2006, but still projected to be insufficient to meet the MDG timeline. One of the world's most successful global health initiatives, the Measles Initiative, was led by the American Red Cross, United Nations Foundation (UNF), World Health Organization (WHO), United Nations Children's Fund (UNICEF), and the U.S. Centers for Disease Control and Prevention (CDC). Reported results show vaccinations of over 500 million children and a reduction in measles mortality by 68%. To reach MDG #4, increased access to reproductive health, education and employment, health-care systems, and engagement of community health workers will need to be established. Global health teams could be dispatched and utilized to meet these needs (United Nations, 2008).

Goal 5: Improve maternal health. The major goals are to reduce the following groups by three-quarters by 2015: (a) maternal mortality ratio (MMR) and (b) births not attended by skilled health workers. Other sub-goals include: (a) improving contraceptive prevalence rates, (b) reducing adolescent birth rates, (c) increasing antenatal care coverage, and (d) increasing family planning.

According to 2005 WHO data, a woman dies from pregnancy complications and childbirth every minute. The MMR remains the least progressive area among all MDGs. The area that has the highest numbers remains in sub-Saharan Africa. Over the years, increased access to family planning, trained health workers providing emergency care, mobile clinics, and repair of fistulas has been very beneficial in the progression towards the MDG. There is a need to establish dedicated national programs assuring access to care, increased numbers of trained workers, and implementation of policies that protect the poor in catastrophic conditions. The

need for an effective health system that will meet the needs of the female population must be met. Health disparities around the world show that there is still much ill-treatment towards women. Utilizing global health initiatives to construct, train, and support health systems and workers will assist in a decline in mortality rates (United Nations, 2008).

Goal 6: Combat HIV/AIDS, malaria, and other diseases. Goal 6 targets for HIV/AIDS include increased: (a) use of condoms; (b) knowledge of HIV/AIDS for ages 15-24; (c) access to antiretroviral drugs, and school attendance.

In 2007, 33 million people were estimated to be living with HIV/AIDS, which was an increase from 29.5 million in 2001. To combat the increase, anti-retroviral treatment services and condom dispensing measures have increased. The number of newly infected people was reported to be 2.7 million in 2007, down from 3 million in 2001. To maintain a continual decline in both newly infected people and those living with HIV/AIDs, sustainable national health systems that deliver quality services and retain professional staff will be needed. Global health initiatives providing programs for students and professional health workers from developed countries could ensure those needs are met (United Nations, 2008).

Goal 6 targets for malaria and other major diseases include: (a) increased number of children under 5 sleeping under insecticide-treated bed nets; (b) appropriate treatments with anti-malarial drugs; and (c) increased detection and treatment of tuberculosis.

With between 315 million and 500 million cases of malaria each year, increases in funding have accelerated to expand malaria control activities in many countries. Much progress has been made due to the use of insecticide treated mosquito bed nets. Continual global partnerships can ensure great efforts continue (United Nations, 2008).

MDGs and Global Health Organizations

The U.S. needs strong monitoring and evaluation processes aimed at keeping programs on track and guiding allocations of resources toward result-based initiatives (Herrling & Radelet, 2008). These process solutions for global health initiatives often begin at the regional and national levels rather than at the individual or household levels. Global health organizations must also have in place internal processes that ensure their priorities not only line up with the MDGs, but also include performance measures to ensure sustainable success (Jacobsen, 2008).

Efficiency and Effectiveness of Organizations

Efficiency and effectiveness were originally industrial engineering concepts that surfaced in the early twentieth century. The words efficiency and effectiveness are often considered synonyms. Efficiency is doing things right, while effectiveness is doing the right things (Pryor, 2007). It is important not to lose sight of differences between the private and public sectors. Historically, elected officials have lauded the efficiency of businesses and urged government agencies to be more like them. These fundamental differences should create caution when dealing with implementation strategies because the industry demands efficiency, while the public sector is based on effectiveness. As the government frequently tries to become more businesslike, it starts to contract out the majority of needed functions, and results display visibly public failures (Colvard, 2001).

A clear discrepancy was found in the language utilized by global health actors regarding their activities. “Virtually all global health actors claim to support health systems, but instead they focus on disease-specific interventions or on activities targeting health system functions essential for implementation of their own programs” (Marchal, Cavalli, & Kegels, 2009, A Selective Approach to HSS, 2nd sentence). Also, global health actors tend to emphasize, in their

strategic documents, the importance of interventions that can achieve simpler, but measurable short-term outcomes, rather than the longer-term goal of health system strengthening. Although they identify weak health systems as major barriers to the success of programs, their responses tend to focus on their own specific objectives. Careful monitoring and evaluation processes for both the health systems and organizations will be needed to produce more accountability within global health (Cerrell, Gayle, Morrison, & Godal, 2007).

Systems monitoring and evaluation. Over the past five to 10 years, investments in health have risen substantially. This rise has contributed to the change in relations between the WHO and stakeholders, who expect transparency, accountability, and measurable results. As a key player in public health, the WHO must remain effective and efficient in a continuously evolving environment (World Health Organization, 2005). Among the stake holders are governments, parliaments, citizens, the private sector, nongovernmental organizations (NGOs), civil society, international organizations, and donors (Kusek & Rist, 2004). To maintain efficiency, the right managerial tools and strong informational technology platforms are required (World Health Organization, 2005). The need for enhanced results-based monitoring and evaluation of organizations, policies, programs, and projects can be found through a public management tool called Monitoring and Evaluation (M&E) (Kusek & Rist, 2004). Table 1 shows the details M&E as quoted from Kusek & Rist, 2004.

Table 1

Roles of Results-Based Monitoring and Evaluation

Monitoring	Evaluation
• Clarifies program objectives • Links activities and their resources to objectives • Translates objectives into performance indicators and sets targets • Routinely collects data on these indicators, compares actual results with targets • Reports progress to managers and alerts them to problems	• Analyzes why intended results were or were not achieved • Assesses specific casual contributions of activities to results • Examines implementation process • Explores unintended results • Provides lessons, high-lights significant accomplishment or program potential, and offers recommendations for improvement

Developing Countries. There must be a clear understanding that developing countries are responsible for all activities and their development, and that any outside development assistance is subsidiary and complementary. This understanding leads to the needed involvement of the M&E system by citizens of the developing countries to promote credibility and commitment (Development Assistance Committee, 1991). Though not a new idea, the introduction of a results-based M&E system allows for further assessment of whether and how goals are being achieved over time. History reveals more than 5,000 years ago, the ancient Egyptians monitored their country's outputs in grain and livestock production, which demonstrated the tremendous power in measuring performance (Kusek & Rist, 2004).

Bringing results-based information into the public arena can change the dynamics of institutional relations, budgeting and resource allocations, personal political agendas, and public perceptions of governmental effectiveness (Kusek & Rist, 2004). M&E systems can help identify potentially promising programs or practices, and aid in promoting greater transparency and

accountability within organizations and governments. Organizational and political costs and risks are associated with results-based M&E systems; however, there are also costs and risks involved in not implementing such systems. Implementation monitoring is considered the old way, while results-based are competitively designed to increase result levels (Kusek & Rist, 2004).

Developing countries have multiple obstacles to surmount in building M&E systems. Results-based M&E systems are a continuous work in progress for both developed and developing countries, but when implemented properly provide a continuous flow of invaluable feedback, which assists policymakers toward achieving desired results. The challenge of designing and building a results-based M&E system in a developing country is difficult and not to be underestimated. Currently some developing countries lack the basic capacities, such as technically trained staff and managers, to successfully measure input, activities, and output. Other negatives include demand for and ownership of such a system and opportunities to do longer-term strategic economic, investment, and policy planning (Kusek & Rist, 2004).

Global health organizations assessment. In *Global Public Health: A Scorecard*, published in the journal *Lancet* by Robert Beaglehole and Ruth Bonita in 2008, an idea for a scorecard was introduced. The introduction was due to an unpredictable level of interest in the global health field, the potential for increased global cooperation and progress, and the measurement of the effectiveness and efficiency of global health organizations. The global public health scorecard was proposed as a simple way to assess progress and suggest actions by global public health practitioners and their organizations for the improvement of the effectiveness of public health. The scorecard identifies five areas, not only key to the agenda of global public health, but very much similar to MDGs #4, #5, and #6, as listed in the following:

1. Maternal, newborn, and child health (MDG #4 & #5)

2. Infectious diseases (MDG #6)
3. Chronic non-communicable disease
4. Global environmental changes
5. Social determinants of health

The scorecard was also designed to assess four key components of global public health: leadership, infrastructure, evidence fraction dependent upon health information, and cost-effective interventions along with health systems response. The next steps in the development of the scorecard are agreements on criteria for 1) measurement of status and progress, 2) development of national scorecards for public health, and 3) development of a more sophisticated global scorecard based on regional and national scorecards (Beaglehole & Bonita, 2008).

The MDGs have been influential by providing a clear strategy for evaluation. Assessed data allows for cost-benefit analysis that determines whether a program is being efficient and effective (Jacobsen, 2008). The preparation of data analysis that assesses the progress made towards the MDGs is coordinated by the United Nations Statistics Division. To assist in progress tracking, international and national statistical experts chose indicators to be utilized within the time frame of 1990 to 2015 (United Nations Statistics Division, 2009). Recent progress in global public health, especially for infectious diseases and child health, is the result of charity, security, and the developmental focus of the MDGs. Conversely, one failure of global public health, which has resulted in health equity remaining elusive, is the lack of progress of socioeconomic determinants of health. This lack of progress is resulted from: (a) policies focused on market-based solutions to health problems, (b) difficulty of intersectoral action, (c) the focus by development agencies, (d) foundations and politicians with short-term goals, and (e) absence of

strong global movements toward improvement of health and health equity (Beaglehole & Bonita, 2008).

The MDGs have drawn much attention to the need for good quality data to measure global health progress. Along with the utilization of the MDGs, there is a need to make the most of existing institutional arrangements and increasing the accountability to all people (Beaglehole & Bonita, 2008). One step in that direction involves the 2008, G8 Toyako Framework for Action on Global Health document, which describes the current global health situation, principles for action, and actions to be taken on global health. The framework suggests that health-system evaluation be monitored to track and assess health-system performance (MacDonald, 2008). As health system performance moves more distinctly under the magnifying glass, so will global health organizations which establish these systems.

Summary

Crucial studies that have directed the focus of this research included a review of global health organizations, MDGs, and effectiveness and efficiency of organizations.

Reviewed organizations clearly demonstrate, through their growing numbers of volunteers, the increasing interest of students and health professionals willing to make the commitment to the global health community. Information presented on the HIV Corps assists in the notion that an international or global health corps is not only possible but may also be effective. MDGs #4, #5, and #6, add another dimension to the study by assisting in comparing the global effectiveness of the selected organizations. The concept of the GHC needs consideration as being a potential mechanism, along with organizations from other countries, to address all MDGs. Monitoring and evaluation systems in developing countries are crucial to the expansion of global health initiatives. It is imperative that countries receiving assistance be a part

of the evaluation system, ensuring organizational and desired goals of the host country are met. Careful evaluation will ensure resources are used efficiently and organizations are held accountable. The scorecard topic brought to the forefront a potential solution to assessing the effectiveness of the current global health organizations in line with the MDGs.

Methodology

Textual analysis was used to encompass the emergence of questions and procedures, collect data within researched settings, induce qualitative analysis of data, expound upon themes, and establish interpretations of meanings within data (Creswell, 2009).

Data Collection

Using a two-part process, data were obtained from organizational websites, professional literature, journals, interviews, annual reports, and statistics. Part one included a keyword search on www.google.com using words such as corps, global, and global health. These words were chosen in relation to the field of study, global health; spectrum of organization, global; and corps, in relation to the U.S. Peace Corps, Public Health Service Corps, and the Global Health Corps. The search followed case studies, theories, government documents, a list of global health organizations, and information from and about senior fellow Dr. Mead Over of the Center of Global Development, who introduced the idea of the GHC (Over, 2008).

The second part involved two processes. First, the selection of organizations by size, and purpose. To assist in the process, the organizational list of 623 members on the Global Health Council website was utilized. Organizations were chosen based on those closely identifying the following three purposes: health focus, U.S. public diplomacy or HIV/AIDS, and opportunities for highly skilled volunteers and students. These purposes are linked to MDGs #4, #5, and #6 as follows:

- *Health Focus*: Demonstration of programs focused on achieving targeted MDGs #4 and #5, which also may deal with health concerns within a primary care approach.
- *U.S. public diplomacy or HIV/AIDS*: Demonstration of programs focused on development of communities in select foreign countries and regions and achieving targeted MDG #6. Linkage also may be evident through partnership with U.S. agencies.
- *Opportunities for volunteers/ students*: Demonstration of opportunities within programs associated with targeted MDGs #4, #5, and #6.

All selected organizations and their information were recorded on a three-section spreadsheet with the described purposes as the headings. Second, the list of organizations was further analyzed, and two organizations were disqualified based on previous criteria. Global health organizations were more closely analyzed and contrasted by the three purposes listed, this time with a more U.S.-focused approach. Other characteristics for consideration included: means to improve health, welfare, and development of communities globally; advance U.S. public diplomacy; and provide individuals in the U.S. with the opportunity to provide health care and related services (U.S. Senate, 2005).

Results

The five organizations selected for comparison were U.S. Peace Corps, Cooperative for Assistance and Relief Everywhere (CARE), Management Sciences for Health (MSH), International Medical Corps (IMC), and Project Hope. Demographic information about the organizations is presented in Table 2. Results are categorized with respect to MDG #4, #5, and

#6 by presenting the strategic goals of each organization and discussing their respective programs.

Table 2

Selected Global Health Organizations Demographic Information

Organization	Peace Corps	CARE	MSH	IMC	Project Hope
Type	Government	Non-Profit	Non-Profit	Non-Profit	Non-Profit
Founding Date	1960	1945	1971	1984	1958
Reported Budget Funding	$332,700	$362,668	$14,936,282	$13,457,272	$54,917
# of Countries Active In	74	65	140	25	35
Target Areas	Africa Asia Caribbean Central America South America Europe Middle East	Africa Asia Latin America Middle East Eastern Europe	Africa (Sub-Saharan) Asia Europe Eurasia Latin America Caribbean	Africa Asia Middle East, including Iraq, Darfur, Somalia, and Afghanistan Eurasia Africa (Sub-Saharan)	Africa Asia Central and Eastern Europe Russia Eurasia The Americas

Strategic Goals for MDG #4 Reductions in Child Mortality

The strategic goals toward MDG #4 and examples of relevant programs of each selected global health organization are presented in the following and summarized in Table 3.

Peace Corps

1. Health education with an emphasis on maternal and child health issues.
2. Identifying local leaders to teach families about maternal and child health, basic nutrition, or sanitation
3. Training on nutrition, sanitation, or oral rehydration therapy
4. Organizing groups to raise money for healthcare materials

For example, in the Dominican Republic, the Peace Corps' Healthy Home project focuses on empowering the citizens through showing them they have control over change in their

communities. Bad sanitation within the community has led to diarrhea caused by worms, parasites, and bacteria. The original amount of funding requested was $4,352.79 with $4,337.79 remaining. The goal of this project is to establish hygiene courses and the construction of twenty latrines within the community. Currently, families face preventable health risks through exposures of waste that directly affect infants and children. No status or data was provided through the website.

CARE

1. Malnutrition prevention teaching techniques and practices, including proper breast feeding
2. Educating families and communities about cultivation and preparation of nutritious complementary food
3. Strengthening local health systems

In 2006, CARE conducted early research and pilot programming with use of the "5x5 Model", designed to integrate critical needs into a holistic and replicable program delivering early childhood development interventions in resource constrained areas, catering for the 2–8-year-old age group. Comprehensive interventions necessary for helping young orphans and vulnerable children (OVC) survive include: 1) food and nutrition, 2) child development, 3) economic strengthening, 4) health, and 5) child protection. Under the 5x5 model, the child is the central focus and the childcare setting is the critical entry point for interventions. The goals are to reduce vulnerability and isolation, improving quality of life and long-term developmental outcomes through sustainable, holistic, community-based interventions during early childhood. Preliminary evidence on the 5x5 model indicates dimensions contained in the model lead to more cost effective and sustainable interventions with emphasis on community ownership. Initial

pilots in resource-constrained environments (i.e., urban slums, transport corridors, and rural communities) provide evidence that the model can be readily adapted and contextualized. Locations for use of the program include Kenya, Uganda, Rwanda, Zambia, and South Africa. Program sponsors include CARE USA, USAID (via the Hope for African Children Initiative), Conrad N. Hilton Foundation, and Covance, Inc. (CARE, n.d.a).

MSH

1. Coordinating with stakeholders to develop appropriate policies that increase: skilled care, illness management programs, and quality medical supplies
2. Expanding interventions that incorporate state-of-the-art, evidenced-based practices
3. Improving staff development at all levels to strengthen health systems
4. Mobilizing Global Partnership to focus donor strategies and attract international resources for child health

MSH is involved with the Basic Support for Institutionalizing Child Survival (BASICS) program. This program's area of focus includes newborn birth, immunizations, integrated management of childhood illness, and child health and nutrition interventions by families, communities and health systems. The USAID funded project BASICS began in 1993 (Management Sciences for Health [MSH], 2009a). The mission is to assist Ministries of Health and partners in the implementation of large-scale, evidence-based interventions effective in treating major causes of newborn and childhood mortality (Basic Support for Institutionalizing Child Survival [BASICS], 2006).

IMC

1. Educating new mothers on feeding practices

2. Immunizations
3. Growth monitoring
4. Prevent and treat– acute respiratory infections, malaria, and diarrhea.
5. Deliver primary and secondary care for expectant mothers and small children including emergency obstetric care

In 2003, IMC launched an emergency program to provide health care and nutrition therapy for conflict-affected communities in northern Uganda. The focus of the early childhood development (ECD) programs was improvement of overall health and nutritional status of women and children under the age of five. The goal of the program was to improve children's overall development through improvements in education, health, social capital, and equality. In January 2007 a newly launched combined psychosocial and nutrition program was activated in three pilot sites. The program teaches mothers to support their children's development through love, play, and communication. Results include: (a) Toy-making, most Ugandan children in Internally Displaced Persons (IDP) camps don't have a single toy – during the mother-to-mother group, IMC staff members teach mothers how to make simple toys, and (b) Nutrition programs: nutrition support staff members make home visits to follow up with caregivers and children reinforcing health education messages. Outreach workers incorporate a psychosocial component in visits as well (Naiboka, n.d.).

Project Hope

1. Nutrition: immediate and exclusive breastfeeding, Vitamin A, Iron Folate, and other micronutrients, complementary feeding, growth monitoring and promotion; malnutrition prevention and recuperation

2. Control of communicable, diarrheal, and vector borne Diseases through Immunization promotion
3. Integrated Management of Childhood Illness (IMCI and C-IMCI) programs
4. Education on maternal and reproductive health, and nutrition

In 2005, Project Hope's USAID funded Orphans & Vulnerable Children Program was allocated $14 million. This program utilizes a low literacy "Parenting Map" that is comprised of measurable child-specific indicators (i.e., health, nutrition, shelter/care, education, protection, and psycho-social), designed to be used as a road map of each child's well-being, that in turn identifies service needs and provides immediate feedback to caregivers (Children, Youth, and Economic Strengthening, 2009). The first data collection occurred between July – October 2008 for 605 orphan children (20%) and 2,382 vulnerable children (80%). A second round of data collection was completed in February 2009 to document changes and progress in satisfaction of the child-specific indicators for 1,302 children, including 308 orphans and 995 vulnerable children. In comparing the findings to the initial results for the same 967 children in both assessments, the results were recorded as:

- Average well-being score increased from 72% to 87%
- Most at risk population (those below 75%) decreased from 65% to 14%
- 84% of OVC reported increased scores in the second collection, averaging 15% improvement
- Average # domains achieved increased from 1.6 to 3.4
- Improvement averaged 29% across the domains
- Orphans reported slightly increased rates of improvement

Overall, all 30 indicators grouped into 6 domains of service (health, nutrition, shelter/care, education, protection, and psycho-social) showed improvement. It was observed that some of the improvements may be related to greater staff and participant familiarity with indicator questions. No areas showed declines, but minimal increases were found including: the education indicators average 4% improvement, having a birth certificate (6% increase), and doing appropriate and similar work in house as others (4% change) (Newton, 2005).

Table 3 shows that efforts for MDG #4 are mainly focused on African countries. USAID is reported as the major funding source for the majority of programs. A majority of these programs have been initiated within the last ten years.

Table 3

Global Health Organizations and Programs (MDG #4 Reduction of Child Mortality)

Organization	**Peace Corps**	**CARE**	**MSH**	**IMC**	**Project Hope**
Program	Healthy Homes	5x5 Model	BASICS	Early Childhood Development (ECD)	Orphans and Vulnerable Children (OVC) program
Initial Year	N/A	2006	1999	2003	2005
Strategic Goals Defined	YES	YES	YES	YES	YES
Measurable	YES	YES	YES	YES	YES
Measures Reported	NO	N/A	YES	YES	YES
Funding	$4353	USAID	USAID	N/A	$14 mil
# of Countries Supported	1 Dominican Republic	5	N/A	1 Uganda	2 Mozambique and Namibia

Strategic Goals for MDG #5, Improve Maternal Health

Strategic goals for MDG #5 and examples of relevant programs for each selected global health organization are summarized in the following and in Table 4.

Peace Corps

1. Health education with an emphasis on maternal and child health issues.
2. Identifying local leaders to teach families about maternal and child health, basic nutrition, or sanitation
3. Training on nutrition, sanitation, or oral rehydration therapy
4. Organizing groups to raise money for healthcare materials

The Peace Corps is taking on the reconstruction of a 1974 maternity building in Mali. This building is used for pre- and post-natal checkups. Currently the building is worn-out and barely functional, 50 yards away from the closest water source, and has inadequate space for visitors. This project is a continuation of a previous project that failed due to financial reasons. The original requested amount was $7,277, of which $5,497 is still needed. Currently the building is a set of walls with no ceiling or floor, and piles of excess materials. Proposed funding will provide modern type facility upgrades, such as solar powered water heating, vital windows with screens to protect newborns from malaria incidents and waiting areas. No status was provided as to progress on the project (Peace Corps, n.d.b).

CARE

1. Confront fundamental issues of gender and sexuality
2. Advocate policies to improve health systems and access to care
3. Assist in lobbying efforts of marginalized groups (i.e., young people, ethnic minorities, lower castes and sex workers)
4. Lobby against marginalizing traditions and practices towards women and girls (i.e., domestic violence, female genital cutting and forced marriage)
5. Integration of reproductive health into emergency and relief efforts

In 2000, CARE's project, The Foundations to Enhance the Management of Maternal Emergencies (FEMME) began work in five countries: Peru Tajikistan, Rwanda, Tanzania, and Ethiopia. Funds and technical support for this project were received from the Bill and Melinda Gates Foundation (Jones & Fontenot, 2003). Within the 18 district hospitals in the five countries, CARE's goal was to improve access to quality emergency obstetric care (EmOC) by enhancing the capacity of health facilities and staffing to manage obstetric complications (CARE, n.d.b). FEMME worked with not only women, but their families, community, health workers, and policymakers. In Peru, there was a percentage increase in the number of women who needed and were able to access emergency obstetric services, from 30 percent to 75 percent. In addition, the maternal death rate decreased from 240 per 100,000 live births in 1999 to 120 in 2005 (CARE, 2007). In Ethiopia, successes included: 50% increase in Caesarian section rates, needs met for Em0C more than doubled, and three hospital facilities were upgraded (Jones & Fontenot, 2003). Challenges in Peru included: families unable to recognize when a pregnant woman needs medical attention and lack of access to transportation (CARE, 2007). Ethiopia faced shortages of oxygen, blood, essential drugs, and trained staff (Jones & Fontenot, 2003).

MSH

1. Coordinating with stakeholders to develop appropriate policies that increase skilled care, illness management programs, and quality medical supplies
2. Expanding interventions that incorporate state-of-the-art, evidenced-based practices
3. Improving staff development at all levels to strengthen health systems
4. Mobilizing global partnership to focus donor strategies and attract international resources for child health

The MSH 2005 Leadership, Management & Sustainability Program (LMS) Program develops managers and leaders in the areas of reproductive health, HIV/AIDS, infectious disease, and maternal and child health (MSH, 2007). These managers and leaders then work with health organizations in the public and private sectors creating sustainable programs and systems (MSH, 2009b). Funding of this program is from USAID's Office of Population and Reproductive Health, in the Bureau of Global Health (MSH, 2007). Three defined goals are: 1) improving management and leadership of priority health programs, 2) improving management systems in health organizations and priority programs, and 3) increasing sustainability and ability to manage change (MSH, 2007). Results include the following: (a) one district increased first-time family planning visits by 68% in one year, (b) In Nicaragua the Ministry of Health initiated the training program which was expanded in 2004 to reach more than 4,000 managers throughout the country, and (c) improvement of leadership capabilities of more than 800 health professionals from 29 countries (MSH, 2007).

IMC

1. Community-based approach serving local populations and involving them as active partners
2. Awareness of cultural sensitivities to avoid conflict involving religion, social/ community traditions
3. Antenatal and postnatal care delivery

IMC’s 18-month Community Midwifery Education Project focused on rural area training of health providers in maternal and newborn health services. Afghanistan is a global leader in maternal mortality and unfortunately has an inadequate number of trained doctors, nurses, midwives, and other health professionals. The project goal was to improve the quality of clinical

services in maternity wards throughout the province (International Medical Corps [IMC], 2006). Reported results included: (a) more than 2,000 Afghan women completed their education as midwives; (b) started midwifery refresher courses to update skills for those already working in the field; and (c) winning the backing of conservative leadership, convincing them that education of young women and allowing them to work as midwives would not weaken their communities (IMC, n.d.). IMC's Parwan Province midwifery program was named the best in the country in 2006 by Afghan government's National Midwifery Education Accreditation Board (NMEAB) (Reliefweb, 2006).

Project Hope

1. Maternal and newborn care intervention involving: antenatal, postnatal and neonatal care, labor and delivery.
2. Nutrition: immediate and exclusive breastfeeding, Vitamin A, Iron Folate, and other micronutrients, complementary feeding, growth monitoring and promotion; malnutrition prevention and recuperation
3. Education on maternal and reproductive health, and nutrition
4. Promotion of healthy behaviors within communities
5. Health facility improvements

The Health of Women and Children of Project HOPE is focused on the reduction of morbidity and mortality among woman and children. This program impacts the lives of over two million women of reproductive age (15 – 49) and 1.1 million children under age five. A 4-year-old child survival project cost $1.8 million dollars. Generous contributions include pharmaceuticals, medical supplies and equipment. Goals of the program include: 1) Improving the quality of care formally for Ministry of Health doctors, nurses, midwives etc., and informally

for community health workers and traditional birth attendants; 2) Promotion of healthy behaviors among communities; and 3) Health facility improvement (i.e., essential medicines and equipment). The 2006 fiscal year included 12 projects in the following countries: Nicaragua, Guatemala, Haiti, Mozambique, Indonesia, Kyrgyzstan, Uzbekistan, Tajikistan, and Turkmenistan. Results include rates of exclusive breastfeeding among target mothers in Malawi increased from 18% to 80% between 1998 and 2002; the percent of vaccinated children in Guatemala increased from 42% to 81% between 2001 and 2005; and care-seeking for Kyrgyz children with diarrhea increased from 27% to 50% between 2002 and 2004 (Project Hope, n.d.a).

Timelines and funding are essential to assessing the effectiveness of all listed programs. Table 4 displays the lack of reported information on the date of conception of programs, and detailed financial contribution amounts made to these programs. All organizations reported clearly defined strategic goals that are measurable over the lifespan of the programs.

Table 4

Global Health Organizations and Programs (MDG #5 Improve Maternal Health)

Organization	**Peace Corps**	**CARE**	**MSH**	**IMC**	**Project Hope**
Program	Maternity Construction	Foundations to Enhance Management of Maternal Emergencies (FEMME)	Leadership, Management and Sustainability (LMS)	Community Midwifery Education Project	The Health of Women and Children Unit (HWC)
Initial Year	N/A	2000	2005	N/A	N/A
Strategic Goals Defined	YES	YES	YES	YES	YES
Measurable	YES	YES	YES	YES	YES
Measures Reported	NO	YES	YES	YES	YES
Funding	$7277	N/A	USAID	YES	$1.8 mil
# of Countries Supported	1 Mali	5	N/A	1 Afghanistan	9*

*As of 2006

Strategic Goals for MDG #6 Combat HIV/AIDS, Malaria, and Other Diseases

Peace Corps

1. Provide HIV/AIDS education, including nutrition and hygiene classes
2. Provide business initiatives and computer resources
3. Provide assistance in HIV centers and orphanages with HIV-positive children
4. Implementation of programs for at-risk youth
5. Provide counseling and support services to local residents

The Peace Corps currently has 3,112 volunteers working in HIV/AIDS activities assisting 702,849 persons (Peace Corps, 2009). Volunteers in the Peace Corps provide long-term capacity development support to non-governmental, community-based, and faith-based organizations emphasizing community-initiated projects and programs providing holistic support to those infected (The United States President's Emergency Plan for AIDS Relief [PEPFAR], n.d.). It is reported that 92% of the young men and 67% of young women engage in sexual activity before the age of 20. Plan Today, Live Tomorrow: Teaching Sexual and Reproductive Responsibility in Secondary Schools is a Peace Corps project located in Nicaragua. The original request for funds was $2,994, with community contributions of $1,585, with the $2,359 still needed. Funding will be shared among the Ministries of Education and Health, and partnership contributions. The specified goal is to provide 66 high school teachers with materials to teach lessons to 3,198 students (Peace Corps, n.d.b).

CARE

1. Ensure educational opportunities for children orphaned and made vulnerable by the pandemic
2. Protect the rights of vulnerable survivors, such as widows and orphans

3. Raise awareness in communities in order to combat discrimination and stigma associated with HIV/AIDS
4. Help communities deal with the loss of productive workers who supported the economic and social infrastructure of their societies

CARE's program called SAKSHAM, is an HIV/AIDS program that promotes strategic involvement of government in HIV prevention efforts. SAKSHAM, which means empowered in Hindi, began in 2004 (CARE, 2006d). Though the budget for this program is not listed, CARE projects are made up of multilateral, bilateral, private, and individual donors, foundations, associations and corporations (CARE, 2006a). Such organizations include the Department for International Development (DFID), the United States Agency for International Development (USAID), the European Union (EU), and the Gates Foundation (CARE, 2006c). While there was no numerical data accessible, results included increased rates of condom use, increased access to services, and decreased levels of violence (Gayle, 2008). The goals of the SAKSHAM are: (a) mobilizing vulnerable communities to access their rights (b) building access and utilization of services, and (c) developing an enabling environment (CARE, 2006b).

MSH

1. Strengthens the health systems by use of a results-oriented strategic framework
2. Building public-private partnerships, coordinating multi-sectoral initiatives, and helping governments and other partners mount a comprehensive response to HIV and AIDS
3. Provide the full range of services in prevention, care, treatment, and management
4. Family-focused approach puts the family in the center of all activities

In June 2007 Management Sciences for Health (MSH) introduced one of its select country programs in Ethiopia named HIV/AIDS Care and Support Program (HCSP). No financial amount is listed but, HCSP is a three-year USAID PEPFAR-supported project. The focus of this program was expanding antiretroviral therapy (ART) services and strengthening and increasing comprehensive and integrated HIV/AIDS services in facilities and communities. HCSP successfully achieved or exceeded most of its first-year targets. Results included the following: (a) 371,400 clients were served during the reporting period; (b) expansion of care and services at 500 health centers (HC), with 255 HCs now offering comprehensive ART services; (c) 398 individuals selected to receive training; and (d) counseling and testing were provided to 892 health workers (MSH, n.d.).

IMC

1. Active involvement of local communities
2. Integration of HIV/AIDS prevention, care and treatment, including voluntary confidential, counseling and testing, and education and training into our primary health care activities
3. Addressing the clinical, social, and economic aspects of HIV/AIDS
4. Integrating circumcision into its ongoing HIV/AIDS treatment, prevention, and education program

IMC is active in 24 countries, with 12 locations in sub-Saharan Africa. The website promotes IMC's involvement but does little to list the individual program names, except in their IRS Form 990 where only locations of programs are listed (IMC, 2009). In 2008, IMC assisted the government of Burundi to overcome health care service delivery and nutrition gaps by building the capacity of health providers and community groups. How this was achieved was not

specified. IMC also reported the expansion of the school feeding program in Rutana Province to 31 schools and 22,709 school-children. An improvement in attendance rates was reported but no statistical data were given. Program service expenses were reported as $550,786, and un-named foreign grants reported as $126,255 (IMC, 2008).

Project Hope

1. HIV risk reduction, and voluntary counseling and testing expansion
2. Antiretroviral therapy (ART) scale up and capacity building
3. HIV/AIDS prevention and education programs
4. Orphan support programs

Testing, voluntary counseling, HIV risk reduction, and prevention are Project Hope's focus for HIV prevention. Project Hope's efforts include the following: 8,759 health care workers trained, and 14,655 students and community members educated about HIV care in Hubei Province, China, and HIV/AIDS Prevention Education Center established in Mexico along with training 500 current and future professionals in care and treatment of HIV (Project Hope, n.d.b). One particular program is the HIV Prevention Education in Reproductive Health Programs that is active in 17 countries. Funding is shared among local partners, non-governmental organizations, Ministries of Health, educational institutions, and medical facilities. The components of this program include: (a) Voluntary Counseling and Testing (VCT), (b) Orphans and Vulnerable Children (OVC), and (c) Ministries of Health Youth Friendly Services programs. The goals are to raise awareness, increase participation in programs for those with and without HIV/AIDS, and education. VCT service providers reported that nearly 1,000 youth ages 18 to 24, and 3,000 youth ages 10 to 17 have received HIV/AIDS focused counseling. The OVC

component reports that in Mozambique and Namibia over 10,000 have participated in curriculums (Project Hope, n.d.c).

The majority of selected organizations reported joint efforts in the approach towards MDG #6. Table 5 displays comparison results that highlight strategic and measurable goals, but also highlight the lack of detailed financial data reported.

Table 5

Global Health Organizations and Programs (MDG #6 Combat HIV/AIDS, Malaria, and Other Diseases)

Organization	Peace Corps	CARE	MSH	IMC	Project Hope
Program	Plan Today, Live Tomorrow	SAKSHAM (India)	HIV & AIDS Care and Support Program (HCSP).	Non-specific name	HIV Prevention Education in reproductive health programs
Initial Year	1991	1987	2007	N/A	1996
Strategic Goals Defined	YES	YES	YES	YES	YES
Measurable	YES	YES	YES	YES	YES
Measures Reported	NO	N/A	YES	YES	YES
Funding	$2995	$183 mil	N/A	N/A	N/A
# of Countries Supported	1 Nicaragua	40	N/A	24	17

*IMC presents records of programs as "HIV/AIDS programs" but does not list specific names of programs, only locations.

Discussion

"Is the global health system broken? Yes and no. Can it be improved? Yes, incrementally, with effort, a long-term view, and commitment" (Cerrell, Gayle, Morrison, & Godal, 2007, pg., 37, #2 Finding a Unified Vision, 1st paragraph).

The results signify that although the selected global health organizations have in place initiatives to address the MDGs, there are major issues with accountability, mainly commitment

through monitoring and evaluation of programs. Monitoring and evaluation (M&E) systems are needed to assist in promotion of greater transparency and accountability within and between organizations (Kusek & Rist, 2004). Ensuring the coherence and collaboration among the organizations is a major challenge (Beaglehole & Bonita, 2008). However, results-based information can change dynamics between institutions, which include budget and resource allocations, as well as program effectiveness (Kusek & Rist, 2004). The need for M&E is clearly evident. For discussion purposes, Kusek & Rist's (2004) M&E Table (Table 1) was used as a guide to organize both available and missing information.

1. **Clarifies program objectives:** The results show that selected programs displayed identifiable goals. Goals for some organizations did not stand out but were dispersed within paragraphs, while other organizations presented clear objectives and goals.
2. **Links activities and their resources to objectives:** The MDGs have drawn attention to the need for good quality data to measure global health progress (Beaglehole & Bonita, 2008); however, when reviewing selected organization none of their mission statements directly reflected any of the MDGs (Appendix 2).
3. **Translates objectives into performance indicators and sets targets**: There remain high levels of interest in ensuring progress and the effective use of financial aid, even when targets remain unachievable (Beaglehole & Bonita, 2008). Most of the organizations did not indicate targets but instead provided summations of program results or target areas without providing confirming detailed information. The information provided is sufficient for a general

understanding of the activities of the organizations, but there was minimal statistical data.

4. **Routinely collects data on these indicators, compares actual results with targets:** There were four issues for comparisons of results with targets: 1) Outcome measures and indicators on most programs were not available, 2) Main organization websites failed to organize and link to pages dealing with specific information on MDGs or related initiatives, 3) Funding contributions and partnerships were difficult to access (see Table 6 in Appendix 3); organizations listed several funding sources as contributors but did not list the contribution amounts or how they contributed, and 4) Countries supported were unclear. Many organizations referred to continents and not the actual countries involved in the programs (see Table 2).
5. **Reports progress to managers and alert them to problems:** The main question for non-profit global health organizations is, "to whom do they report?" The global health system is seen as a loose and fluid agglomeration with multiple, shifting centers of influence that is comprised of the World Health Organization, the 22 assorted UN agencies with health programs, the World Bank, and other new international bodies (Cerrell, Gayle, Morrison, & Godal, 2007).

Health focus. Each selected global health organization displayed a program focused on MDGs #4, #5, and #6 (see Tables 3, 4, and 5). However, financial statements were either too broad or lacked statistical data to determine funding amounts dedicated to MDGs.

U.S. public diplomacy or HIV/AIDS. Each selected organization displayed efforts towards MDG #6; however, only the Peace Corps demonstrated a focus on promotion of U.S.

public diplomacy. This was expected due to the Peace Corps being a direct component of the U.S. government.

Opportunities for volunteers/ students. A majority of the selected organizations advertised non-patient care medical opportunities. Most of these opportunities are built around assisting contracted physicians from the organizations themselves or from local areas. Furthermore, the bulk of these opportunities center on health education and teaching positions.

Conclusions

Do the selected organizations fulfill the needs of Global Health? With the information presented on the websites, it was found that selected organizations addressed less than half of the stated needs of Global Health (see Table 7 in Appendix 3) and no more than three MDGs; however, any conclusion on this point may be inaccurate due to less than adequate monitoring and evaluation by the organizations, which is related to the lack of accountability of global health organizations.

What are selected organizations doing to accomplish global health needs as defined by MDG Goals #4, #5, and #6? It was evident that each organization participated in addressing MDGs #4, #5, and #6. One observation is that MDG #6 has several components: HIV/AIDS, Malaria, and other diseases. The selected organizations differ by which of the components they cover. HIV/AIDS, the most widely covered component, may be the only component covered, while malaria and other disease initiatives are non-existent.

Is there a need to strengthen the existing global health organizations? Yes, in the area of accountability and M&E. To increase effectiveness and efficiency of organizations and their programs the needed data must be present. Ideas such as Beaglehole & Bonita's (2008) global health scorecard would assist in analysis to further answering this question.

If the selected organizations do not fill the needs of Global Health, is there a need for a new organization such as the Global Health Corps? The Global Health Corps could be the first global health organization to implement effective M&E systems. The present U.S. administration's strategy to make government spending transparent to the American people may be favorable to new M&E systems. To be cost effective, government funding for organizations that have presented minimal results should be re-allocated to the development of the Global Health Corps (GHC) so that no extra burden is placed on the American citizens. The GHC would serve the purpose of better efficient spending, demonstration of U.S. commitment to global health, and increased participation of students and health professionals.

Presently, before trying to create another organization, there is a greater need to put into place efficient M&E systems in existing organizations. This suggestion is derived from the overwhelming number of single purposed U.S. sponsored organizations; however, the exception to this idea is the case of historically pandemic related disease focused organizations. Financial support should be allocated to multi-purpose organizations, like the Peace Corps, assisting in organizational redevelopment. This redevelopment may add components similar to medical branches to global health organizations that would lead to more participation from medical students and health professionals. Historically because of weak loan reimbursement programs in comparison to their schooling cost, health professionals would not usually participate, but have expressed the desire to do so.

Future research on similar study topics could be very beneficial to global health initiatives by focusing on M&E of global health organizations and accountability. Longitudinal studies of accountability would add to efforts such as the global health scorecard to shape and advance global governance that will help to save lives. A research question that should be

answered is, “why have some global health organizations not published their data?” Though it is rhetorical, this question may lead to truths about accountability, profits, and secondary purposes.

As new legislation is introduced in the U.S. Senate there are strides being made to increase the accountability not only in global health, but also in foreign assistance programs. In 2009, five bills directly related to global health and foreign assistance were introduced and are currently being reviewed by committees (see Table 8 in Appendix 3). The following bills all reflect topics addressed in this study.

U.S. Senate Bill #589, Global Service Fellowship Program Act of 2009. The purpose of this program closely resembles Senate Bill#850, the Global Health Corps Act. S.589 and S.850 both contain: health focus, U.S. public diplomacy or HIV/AIDS, and opportunities for volunteers/ students. A notable difference is that S.589 specifically addresses all MDGs and creates fellowships for volunteers, while S.850 creates both an official office and a branch similar to that of a military branch.

U.S. Senate Bill #1382, Peace Corps Improvement and Expansion Act of 2009. This bill is targeted at expanding the Peace Corps to take a larger role in the promotion of global economic and social development. Unfortunately, this bill presents an opposing view to Rotberg and Salinas (2005), and does not include expansion and creation of a medical branch within the Peace Corps. If included, this missing component would attract medical students and health professionals that are willing, but due to the length of service and minimal coverage of school loans, will not participate.

U.S. Senate Bill #355, Increasing America’s Global Development Capacity Act of 2009. This act calls for support to increase the numbers of Foreign Service Officers. These persons will be used to strengthen USAID and fill opportunities overseas. Again, I feel that it would be more

beneficial to create the Office of Global Development as suggested by Herrling and Radelet, 2008, and then assign personnel to USAID ensuring not only personnel but also quality and skill sets.

U.S. Senate Bill #1524, Foreign Assistance Revitalization and Accountability Act of 2009. This act states, "The current law governing foreign assistance is outdated, cumbersome, and lacks relevance for modern challenges…it allows the budget process to drive priorities, rather than setting clear priorities that drive resource decisions." This much-needed act calls for strengthened M&E and accountability among global organizations.

U.S. Senate Bill #1591, 21st Century Global Health Technology Act of 2009. This act is to bring the Foreign Assistance Act of 1961 current, with the advancement of research and development technologies focused on improving global health. This is a much-needed bill to meet the new challenges of the 21st century. New structuring of organizations may need to include departments of technology and logistics to cover implementation issues.

Limitations

Limitations of this study were generally caused by the difficulty to obtain results-oriented data from organizational websites, annual reports, and publications. The study started with seven organizations but was narrowed down to five due to lack of information provided. The organizational websites presented minimal interest in providing functions that would make it easy to obtain results from their projects and programs. The links connected to showcased programs and led to summations that lacked start and end dates, financial information, and other significant data needed for results-based analysis. The annual reports added to the confusion, reflecting on budgets that did not mirror reports of funding. The reports combined programs into general categories that made it hard to determine the success and failure of projects. Publications

by organizations were presented in story book form and left out biographical information on programs and even the organizations themselves. Listed sponsors were mentioned without their contributed amounts of financial support. Some organization publications even implied that they were the single organization involved with a project, while unnoted sponsors listed the same projects on their own sites.

The research design could have improved by selection of organizations that presented detailed information on their programs and have sufficient websites that present easy access to this data. Research design could also reflect a more focused approach by focusing on one MDG or possibly on one key element of an organization.

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Appendix 1: Millennium Development Goals and Targets

Goal 1: Eradicate extreme poverty and hunger

Target 1.A: Reduce by half the proportion of people whose income is less than one dollar a day

Target 1.B: Achieve full and productive employment and decent work for all, including women and young people

Target 1.C: Reduce by half the proportion of people who suffer from hunger

Goal 2: Achieve universal primary education

Target 2.A: Ensure all boys and girls complete a full course of primary schooling

Goal 3: Promote gender equality and empower women

Target 3.A: Eliminate gender disparity in the primary and secondary education levels

Goal 4: Reduce child mortality

Target 4.A: Reduce by two-thirds the under-five mortality rate

Goal 5: Improve maternal health

Target 5.A: Reduce by three quarters the maternal mortality ratio

Target 5.B: Attain universal access to reproductive health

Goal 6: Combat HIV/AIDS, malaria and other diseases

Target 6.A: Halt and begin to reverse the spread of HIV/AIDS

Target 6.B: Attain universal access to treatment for HIV/AIDS for all those in need

Target 6.C: Halt and begin to reverse the incidence of malaria and other major diseases

Goal 7: Ensure environmental sustainability

Target 7.A: Integrate principles of sustainable development into country policies and programs; reverse loss of environmental resources

Target 7.B: Reduce biodiversity loss and achieve a significant reduction in the rate of loss

Target 7.C: Reduce by half the proportion of people without access to safe drinking water and basic sanitation

Target 7.D: By 2020, achieve a significant improvement in the lives of at least 100 million slum dwellers

Goal 8: Develop a global partnership for development

Target 8.A: Development of trading and financial systems

Target 8.B: Address special needs of the least developed countries

Target 8.C: Address special needs of landlocked developing countries and island developing States

Target 8.D: Deal with the debt of developing countries through national and international measures

Appendix 2: Mission Statements

Peace Corps:

The Peace Corps' mission has three simple goals:

1. Helping the people of interested countries in meeting their need for trained men and women.
2. Helping promote a better understanding of Americans on the part of the peoples served.
3. Helping promote a better understanding of other peoples on the part of Americans.

Cooperative for Assistance and Relief Everywhere (CARE):

"Our mission is to serve individuals and families in the poorest communities in the world. Drawing strength from our global diversity, resources and experience, we promote innovative solutions and are advocates for global responsibility. We facilitate lasting change by:

- Strengthening capacity for self-help
- Providing economic opportunity
- Delivering relief in emergencies
- Influencing policy decisions at all levels
- Addressing discrimination in all its forms

Guided by the aspirations of local communities, we pursue our mission with both excellence and compassion because the people whom we serve deserve nothing less."

Management Sciences for Health (MSH):

"Our mission is to save lives and improve the health of the world's poorest and most vulnerable people by closing the gap between knowledge and action in public health. Together

with our partners, we are helping managers and leaders in developing countries to create stronger management systems that improve health services for the greatest health impact."

International Medical Corps (IMC):

"To improve the quality of life through health interventions and related activities that build local capacity in underserved communities worldwide. By offering training and health care to local populations and medical assistance to people at highest risk, and with the flexibility to respond rapidly to emergency situations, International Medical Corps rehabilitates devastated health care systems and helps bring them back to self-reliance."

Project Hope:

"To achieve sustainable advances in health care around the world by implementing health education programs and providing humanitarian assistance in areas of need."

Appendix 3 – Tables 6, 7, and 8

Table 6

Dollar Amounts Donated Towards MDG #4, 5 & 6 (in thousands)

Organization	Peace Corps	CARE	IMC	Project Hope	MSH
Most Current Records	2007	2008	2008	2008	2008
MDG #4 Child Mortality	$360,000	$10,367	N/A	$8,590	N/A
MDG #5 Maternal Health	N/A	$40,517	N/A		N/A
MDG #6 HIV/AIDS	N/A	N/A	N/A	N/A	N/A

*Project Hope data is recorded as dollar amount for Women and Children Health initiatives.

Table 7

Selected Organizations and Website Information

Organization	Peace Corps	CARE	MSH	IMC	Project Hope
Ensure healthier mothers and children	YES	YES	YES	YES	YES
Stop the AIDS pandemic	YES	YES	YES	YES	YES
Promote good nutrition	YES	YES	YES	YES	YES
Stem the tide of tuberculosis	YES	YES	YES	YES	YES
Control malaria	YES	YES	YES	YES	YES
Reduce the toll from cardiovascular disease	NO	NO	NO	YES	NO
Combat tobacco use	NO	NO	NO	NO	NO
Reduce fatal and disabling injuries	NO	NO	YES	YES	NO
Ensure equal access to quality health care / SOCIAL CHANGE	NO	YES	NO	NO	YES

Table 8

U.S. Senate Bills introduced in 2009

US Senate Bill #	Name	Purpose
#355	Increasing America's Global Development Capacity Act of 2009	A bill to enhance the capacity of the US to undertake global development activities, and other purposes. (Increase the number of Foreign Service Officers)
#589	Global Service Fellowship Program Act of 2009	A bill to establish a Global Service Fellowship Program and to authorize Volunteers for Prosperity, and for other purposes.
#1382	Peace Corps Improvement and Expansion Act of 2009	A bill to improve and expand the Peace Corps for the 21st century, and for other purposes.
#1524	Foreign Assistance Revitalization and Accountability Act of 2009	A bill to amend the Foreign Assistance Act of 1961, to establish the Health Technology Program in the United States Agency for International Development (USAID) to research and develop technologies to improve global health, and for other purposes.
#1591	21st Century Global Health Technology Act	A bill to strengthen the capacity, transparency, and accountability of US foreign assistance programs to effectively adapt and respond to new challenges of the 21st century, and for other purposes.