U.S. GLOBAL HEALTH POLICY

POLICY BRIEF

APRIL 2010

THE U.S. GLOBAL HEALTH INITIATIVE: Key Issues

SUMMARY

The recent release of the Obama Administration's consultation document on the *Implementation of the Global Health Initiative*[1], accompanied by the FY 2011 budget request[2], provide the most significant detail to date on this new initiative. First announced last year[3,4], the Global Health Initiative (GHI) was proposed as a $63 billion, six-year (FY 2009–FY 2014) effort to develop a comprehensive U.S. global health strategy, building on disease specific initiatives to combat HIV, TB and malaria, as well as expanding to encompass broader global health targets, including maternal and child health (MCH), family planning and reproductive health (FP/RH), nutrition, and neglected tropical diseases (NTDs), and to strengthen underlying health systems (see Box 1). The GHI consultation document includes specific goals and targets, core principles, and an operational plan for implementing each targeted area (see Box 2). The FY 2011 budget marks the half-way point in the Initiative's funding and, if approved by Congress, would bring cumulative GHI funding to almost $27 billion, or 43%, of the proposed six-year total.[5] The Administration has solicited public comment on the consultation document and several other next steps are expected, including the announcement of "GHI Plus" countries, a subset from among those receiving U.S. global health assistance to be selected for more intensified effort.

BOX 1: GHI Overview[1,3,4]

- Announced by President Obama on May 5, 2009
- $63 billion proposed over 6 years, FY 2009-2014
  - $51 billion for PEPFAR (HIV, TB, Global Fund) & Malaria
  - $12 billion for other global health priorities
- Integrated approach, government-wide strategy
- Continued commitment to PEPFAR, slated to receive more than 70% of cumulative funding
- Expanded focus to broader global health challenges, including maternal and child health, family planning/ reproductive health, neglected tropical diseases
- Emphasis on health system strengthening
- Emphasis on moving from process to outcomes, investing where significant returns can be achieved
- GHI budget includes: HIV, TB, malaria, Global Fund, maternal and child health, nutrition, family planning/reproductive health, neglected tropical diseases, avian influenza and other public health threats

Even as these developments continue to unfold, several significant and interrelated questions and issues remain on the table—rethinking a multi-pronged, multi-billion dollar investment that involves a myriad of global health challenges, programs, countries, and stakeholders, is an inherently complex undertaking, and one which is occurring against the backdrop of other broader assessments of U.S. foreign aid and development policy, as well as more general budgetary constraints. Given the complex environment, this policy brief highlights and summarizes some of the more pressing issues and questions on the GHI. They were identified based on review and analysis of recent reports in the field as well as public comments submitted in response to the GHI consultation document.[6,7,8,9,10,11,12,13]

BOX 2: GHI Core Principles, Implementation Components, and Target Areas[1]

Seven Core Principles

1. Women- and girl-centered approach
2. Strategic coordination and integration
3. Strengthen and leverage key multilaterals and other partners
4. Country-ownership
5. Sustainability through health systems strengthening
6. Improve metrics, monitoring and evaluation
7. Promote research and innovation

Four Main Implementation Components

1. Do more of what works, promote proven approaches
2. Build on and expand existing platforms
3. Innovate for results
4. Collaborate for impact/promote country ownership

Nine Target Areas

1. HIV/AIDS
2. Malaria
3. Tuberculosis
4. Maternal Health
5. Child Health
6. Nutrition
7. Family Planning/Reproductive Health
8. Neglected Tropical Diseases
9. Health Systems Strengthening

Eight distinct but interrelated issues were identified. These are briefly listed below, followed by a more detailed discussion that provides background and context on each as well as specific questions moving forward.

1. **HOW WILL THE LEADERSHIP AND GOVERNANCE OF THE GHI BE STRUCTURED?**

   How will coordination of the U.S. global health response be achieved across multiple agencies, programs, and Congressional committees? Is a new coordinating structure needed and if so, where is it best located—at the White House or within a federal agency? Are new Congressional authorities needed?

2. **HOW MUCH FUNDING WILL BE PROVIDED TO THE GHI AND HOW WILL FUNDING BE ALLOCATED WITHIN THE U.S. GLOBAL HEALTH PORTFOLIO?**

   Will the GHI reach $63 billion by FY 2014? Will further rebalancing of the portfolio occur and if so, how will funding be balanced between disease specific programs and broader, "horizontal" approaches? What criteria will be used to inform resource allocation decisions?

3. **HOW CAN THE GHI'S TARGETS AND IMPACT BE MEASURED?**

   What kinds of investments and structures are needed at the federal agency and country levels to foster greater monitoring and evaluation? How can new metrics and reporting requirements be implemented without increasing the burden on countries? What is the potential role, and limitations, of existing measurement tools? How can data gaps and limitations be overcome?

4. **HOW CAN THE U.S. BEST PARTNER WITH RECIPIENT COUNTRIES TO PROMOTE "COUNTRY OWNERSHIP"?**

   What is the appropriate balance between donor-defined and country-designed priorities? Is there a trade-off between country-ownership and accountability to donors? How will country-plans be developed with host country governments and other stakeholders, including civil society?

5. **HOW CAN U.S. ENGAGEMENT WITH OTHER INTERNATIONAL ACTORS, INCLUDING MULTILATERALS, DONOR GOVERNMENTS, AND THE PRIVATE SECTOR, FURTHER SUPPORT COORDINATION, LEVERAGE RESOURCES AND MAXIMIZE SHARED IMPACT?**

   What should the funding balance be between multilateral and bilateral programs? To the extent that U.S. investments are channeled through multilateral organizations, how can concerns about accountability be addressed? Are there opportunities for further assessing or strengthening U.S. engagement in international health treaties, regulations, and other partnerships and agreements?

6. **HOW WILL THE INCREASED EMPHASIS ON WOMEN AND GIRLS BE REALIZED IN U.S. GLOBAL HEALTH PROGRAMS?**

   How can a women- and girls-centered approach best be implemented at a country level? As country plans are developed or augmented, how can the importance of addressing women and girls be meaningfully incorporated? How can the U.S. reinforce and strengthen the global consensus that has emerged around the importance of addressing gender, women and girls?

7. **HOW WILL THE U.S. DEFINE, IMPLEMENT, AND MEASURE HEALTH SYSTEMS STRENGTHENING?**

   What targets—either existing or newly developed—can be used to help assess U.S. investments in health systems? How can health systems investments be linked to health outcomes? As the U.S. moves to strengthen health systems, adopting a broader, "horizontal" approach to global health, what will be the implications for disease-specific, vertical approaches?

8. **HOW WILL THE GHI BE COORDINATED WITH AND AFFECTED BY BROADER U.S. FOREIGN AID REFORM EFFORTS?**

   How will these different efforts affect the U.S. global health portfolio and the strategy outlined in the new GHI consultation document? What kinds of broader restructuring can be expected? Where can the U.S. global health response serve as a model for broader development reform efforts?

BACKGROUND AND CONTEXT

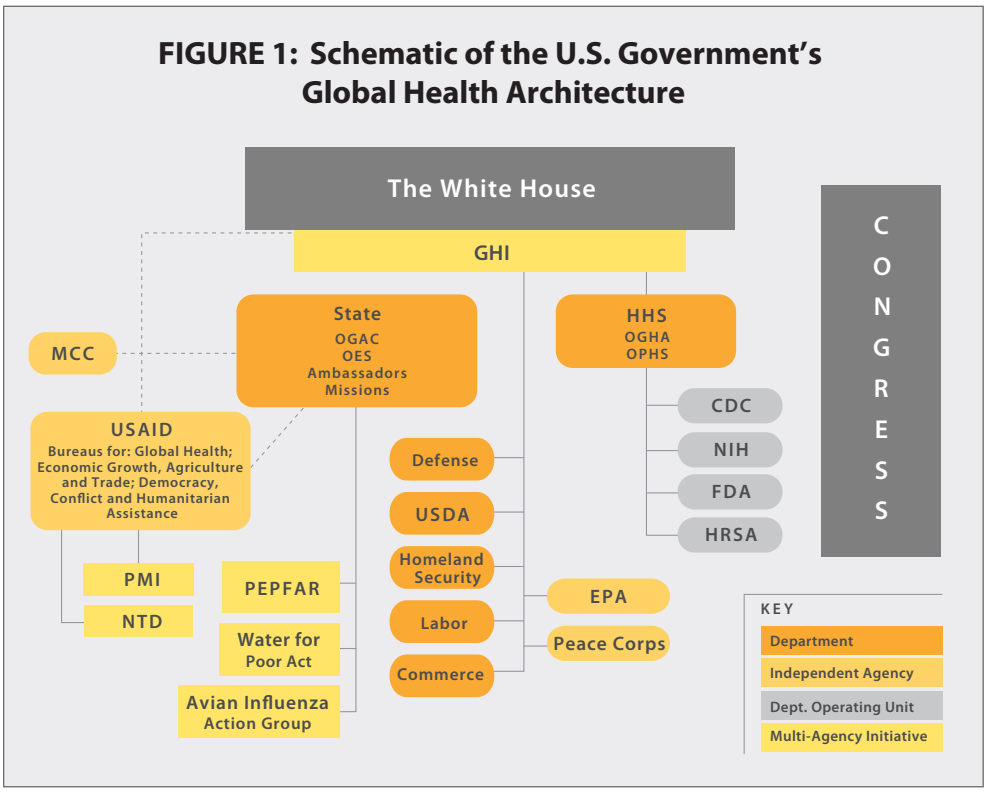
1. HOW WILL THE LEADERSHIP AND GOVERNANCE OF THE GHI BE STRUCTURED?

Background and Context:

The U.S. government's response to global health has grown significantly over time, and today, is a more than $10 billion annual effort, that includes the GHI as well as other U.S. programs and activities.[5] This effort spans seven executive branch departments, numerous departmental operating units, several independent agencies, and more than 15 Congressional committees[14] (see Figure 1). It encompasses multiple funding streams, programs, and initiatives, and operates in more than 80 countries. Yet historically, the U.S. global health architecture has had no formalized organizing mechanism or structure, having largely been built within separate agencies and around discrete "vertical", or disease-specific, initiatives rather than "horizontal", or more comprehensive, approaches that seek to address the multiple health challenges that often impact the same populations and communities simultaneously. Different U.S. agencies operate under different legislative authorities and mandates, have distinctive operating cultures, face unique and sometimes competing priorities, and control varying levels of funding for global health. For example, most global health funding is appropriated by Congress to foreign assistance agencies (the State Department and USAID), who in turn control the bulk of related programming; by contrast, little funding is provided directly to the Department of Health and Human Services (HHS), although its public health expertise is integral to carrying out the U.S. global health effort.[5,14] Within the Congress, multiple authorizing and appropriating committees have jurisdiction over different pieces of the U.S. global health portfolio, and funding decisions have historically been tied to earmarks for specific diseases, conditions, or individual programs, rather than a more comprehensive approach.[8,14]

This has resulted in a U.S. response that has been characterized as fragmented and stove-piped, inhibiting the opportunity to take advantage of synergies, be more strategic, maximize the U.S investment and, ultimately, do a better job in reaching the very populations who are the intended beneficiaries of U.S. global health assistance.[6,7,8,9,10,12,15] As such, a growing consensus has developed that better coordination is needed. Yet there is no clear path for doing so, and multiple recommendations have been promulgated over time. As early as 1997, the Institute of Medicine (IOM) called for the establishment of an interagency task force, recommending it be led by HHS given its scientific and technical expertise.[16] More recently, the IOM reaffirmed its recommendation for a task force, but situated its leadership within the White House, to give it convening authority and the ability to make policy recommendations directly to the President.[7] Other groups have also provided recommendations about leadership and structure.[8,9,11,13] A key issue raised by these organizations is the importance of Presidential leadership, which was central to the success of PEPFAR for example.

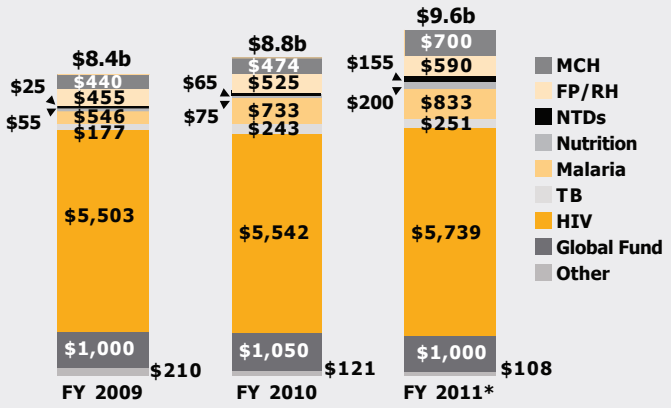
FIGURE 1: Schematic of the U.S. Government's Global Health Architecture



The GHI itself was an attempt to create a coordinated strategy for U.S. global health programs, by developing a "comprehensive whole of government approach[1]" centered on the ultimate beneficiary of U.S. global health aid—the individual. Strategic coordination and integration is a core principle of the GHI, including "upstream integration" at the agency and program level, and "downstream integration", at the point of contact or beneficiary

level. In terms of structure, the GHI was initially launched by the White House, under the auspices of the National Security Council (NSC) and the Office of Management and Budget (OMB), together with the State Department[17], and each has continued to play an integral role. The White House also convened an interagency task force that began meeting last summer. More recently, a "trifecta" structure of the State Department, USAID, and HHS—the three main agencies with assets in U.S. global health—has been carrying forward implementation. To date, however, no formal or permanent coordinating structure for the GHI has been announced and several questions and options remain.

FIGURE 2: U.S. Global Health Initiative (GHI), Funding by Sector, FY 2009-FY 2011*



*FY 2011 is President's Budget Request to Congress.

Key Issues:

- How will coordination of the U.S. global health response be achieved across multiple agencies, programs, and Congressional committees? Is a new coordinating structure needed and if so, where is it best located—at the White House reporting to the President, within a single agency, or at multiple agencies?
- Should there be a single designated "coordinator" for the GHI?
- Are new Congressional authorities needed to carry out aspects of the GHI, such as funding authority across multiple funding streams or agencies, or to support new programming needs?
- Can better coordination be achieved within Congress, including across Congressional committees and jurisdictions?

TABLE 1: GHI Funding and Budget Projections, FY 2009–FY 2014[5]

$ in billions	FY 2009 Enacted		FY 2010 Enacted		FY 2011 Budget		FY09-FY11 Subtotal		FY09-FY14 Proposed Total		FY09-FY11 % of Proposed Total	FY12-FY14 Amount Remaining
	$	%	$	%	$	%	$	%	$	%		
PEPFAR (HIV, TB, Global Fund)	*$6.68*	*79%*	*$6.84*	*77%*	*$6.99*	*73%*	*$20.50*	*76%*	>$44.1b*	–	–	–
Malaria	*$0.55*	*6%*	*$0.73*	*8%*	*$0.83*	*9%*	*$2.11*	*8%*	<$6.9b*	–	–	–
PEPFAR & Malaria	**$7.23**	**86%**	**$7.57**	**86%**	**$7.82**	**82%**	**$22.62**	**84%**	**$51**	**81%**	**44%**	**$28.38**
Other Global Health Priorities	**$1.19**	**14%**	**$1.26**	**14%**	**$1.75**	**18%**	**$4.20**	**16%**	**$12**	**19%**	**35%**	**$7.80**
GLOBAL HEALTH INITIATIVE TOTAL	**$8.41**	**100%**	**$8.83**	**100%**	**$9.58**	**100%**	**$26.81**	**100%**	**$63**	**100%**	**43%**	**$36.19**

*Estimate based on six-year GHI funding proposal.
Note: Amounts may not sum to totals due to rounding.

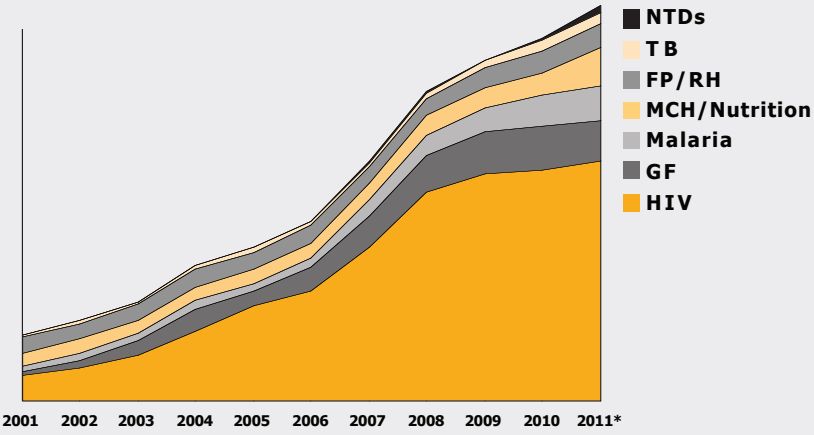
2. HOW MUCH FUNDING WILL BE PROVIDED TO THE GHI AND HOW WILL FUNDING BE ALLOCATED WITHIN THE U.S. GLOBAL HEALTH PORTFOLIO?

Background and Context:

International development assistance for global health provided by the U.S. and other donors has increased significantly in recent years,[18,19] although it still falls short of need, according to recent estimates from *The Taskforce on Innovative International Financing for Health Systems*.[20] Moreover, the recent economic crisis has likely exacerbated the needs of low- and middle-income countries at the very time that it has strained the budgets of donor governments and raised concerns about the ability to fill this gap in the future.[20,21,22,23] As the largest donor of health assistance in the world, U.S. funding will play a critical role in this equation.

While the GHI was proposed as a six-year, $63 billion initiative, it is not yet known what its overall funding level will be or how funding will be allocated within the U.S. global health portfolio. This is because all funding for U.S. global health programs is considered "discretionary spending"—that is, spending that must be appropriated by Congress each year (vs. "mandatory" or "direct" spending, such as for entitlement programs, that is determined by statutes other than appropriations acts and is generally automatically obligated each year). Not only are overall global health funding levels determined this way, but so is much of the funding allocated to individual global health programs or areas, historically through program or issue specific Congressional earmarks. Funding, therefore, is one of the most visible and explicit markers of policymaker priorities and often seen as a major policy lever in debates about U.S. global health policy and programming. When announcing the GHI, the Obama Administration indicated an intention to rebalance the global health portfolio, moving from what has largely been a disease specific approach to a broader, population-based one. This has raised questions about how such a shift would impact current disease programs, such as HIV treatment (where even keeping all those currently on treatment will require new resources in the future), as well as how the positive effects of vertical programs on broader health systems and capacity would be accounted for.[9,24,25]

FIGURE 3: Distribution of Funding for Programs in the U.S. Global Health Initiative (GHI), by Sector, FY 2001-FY 2011*



*FY 2011 is President's Budget Request to Congress.

With FY 2011 marking the half-way point in the GHI's six-year budget, more information about these policy priorities is available, including whether the GHI is on track to reach $63 billion. The FY 2011 request, if approved by Congress, would bring GHI funding to date to $26.8 billion, or 43% of the proposed six-year total. Funding over the remaining period (FY 2012–FY 2014) would need to total $36.2 billion (an average of $12 billion per year) to reach $63 billion, requiring a steeper rate of increase relative to the first three years of the GHI (see Table 1).[5]

The $63 billion six-year GHI proposal included $51 billion for PEPFAR (HIV, TB, and the Global Fund) and malaria combined, and $12 billion for other global health priorities. If Congress approves the FY 2011 budget request, funding for PEPFAR and malaria would reach 44% of this total and would need to more than double to reach $51 billion; funding for other global health priorities would be at 35% and would need to almost triple to reach its funding target (see Table 1).[5] Congress provided another marker of funding priorities in the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008 (Lantos-Hyde) for the FY 2009–FY 2013 period; to reach the levels authorized by Lantos-Hyde, funding for PEPFAR and malaria combined would need to more than double in the next two years (see Table 2).[26]

TABLE 2: Funding for PEPFAR & Malaria Compared to Lantos-Hyde Reauthorization Levels, FY 2009 – FY 2013[5]

$ in billions	FY 2009 Enacted	FY 2010 Enacted	FY 2011 Budget Req	FY09-FY11 Subtotal	Lantos-Hyde FY09-FY13	
					Authorized	Difference
PEPFAR: HIV & Global Fund	$6.50	$6.59	$6.74	$19.83	$39	$19.17
PEPFAR: TB	$0.18	$0.24	$0.25	$0.67	$4	$3.33
Malaria	$0.55	$0.73	$0.83	$2.11	$5	$2.89
PEPFAR (HIV, TB, Global Fund) & MALARIA TOTAL	**$7.23**	**$7.57**	**$7.82**	**$22.62**	**$48**	**$25.38**

Note: Amounts may not sum to totals due to rounding.

Looking further within the global health portfolio shows that some rebalancing has already begun to occur. Although HIV continues to make up the lion's share of the GHI budget, its more recent increases have begun to slow, and funding for other global health priorities has risen at a faster rate. The fastest increases over the three-year period have been for NTDs, followed by MCH; MCH received the greatest amount of increase and therefore was the biggest driver of growth in the GHI's budget (see Figure 3 and Table 3). These trends would need to continue if the GHI's proposed six-year budget parameters are to be met. Yet it is not clear how best to make such resource allocation decisions moving forward. In addition, while the Administration has continued to request increased funding for global health, in contrast to a proposed freeze on all domestic discretionary spending[2], and Congress has historically demonstrated strong bi-partisan support, it is not clear how current budgetary pressures will affect this calculus in the future.

Key Issues:

- Will GHI funding reach $63 billion by FY 2014? Will Lantos-Hyde funding levels be reached for HIV, TB, malaria and the Global Fund? How will budgetary pressures on the U.S. government affect funding?
- Should the U.S. global health funding portfolio be further rebalanced? If so, should rebalancing apply to existing or to future resources only? Can a "zero-sum" be avoided? Should there be a "hold harmless" approach?
- What criteria should be used to make resource allocation decisions? Should a greater emphasis be placed on lower-cost interventions or on diseases that have received less attention in recent years? On diseases and conditions that currently exert the greatest burden or on those which have the potential to be eliminated? Should smaller benefits to a larger number take priority over larger benefits to a few? What is the right balance between targeting "low-hanging fruit" and the more difficult, but equally critical, challenges? What is the appropriate balance between prevention, care, and treatment? To what extent should the availability of other donor resources play a role in targeting U.S. investments?
- How can these different criteria best be assessed to guide U.S. policymakers and program implementers? What is the appropriate role of cost effectiveness analysis? Can simulation modeling be used to inform resource allocation decisions?

TABLE 3. GHI Funding: Amount and Percent Change by Sector, FY 2009-FY 2011[5]

$ in billions	FY 2009 Enacted	FY 2010 Enacted	FY 2011 Budget Req	FY10-FY11 ($ and % change)	FY09-FY11 ($ and % change)
HIV/AIDS	$5.50	$5.54	$5.74	$0.2 (4%)	$0.24 (4%)
TB	$0.18	$0.24	$0.25	$0.01 (3%)	$0.07 (42%)
Malaria	$0.55	$0.73	$0.83	$0.1 (14%)	$0.29 (53%)
Global Fund	$1.00	$1.05	$1.00	$-0.05 (-5%)	$0 (0%)
MCH	$0.44	$0.47	$0.70	$0.23 (48%)	$0.26 (59%)
Nutrition	$0.05	$0.08	$0.20	$0.13 (167%)	$0.15 (264%)
FP/RH	$0.46	$0.53	$0.59	$0.06 (12%)	$0.14 (30%)
NTDs	$0.03	$0.07	$0.16	$0.09 (138%)	$0.13 (520%)
Other	$0.21	$0.12	$0.11	$-0.01 (-11%)	$-0.1 (-49%)
PEPFAR Subtotal	$6.68	$6.84	$6.99	$0.15 (2%)	$0.31 (5%)
PEPFAR & Malaria Subtotal	$7.23	$7.57	$7.82	$0.25 (3%)	$0.6 (8%)
Other Global Health Priorities Subtotal	$1.19	$1.26	$1.75	$0.49 (39%)	$0.57 (48%)
GLOBAL HEALTH INITIATIVE TOTAL	**$8.41**	**$8.83**	**$9.58**	**$0.75 (8%)**	**$1.16 (14%)**

Note: Amounts may not sum to totals due to rounding.

3. HOW CAN THE GHI'S TARGETS AND IMPACT BE MEASURED?

Background and Context:

Related closely to the issue of investment choices is that of measurement and assessing progress. A core principle of the GHI is to improve metrics and enhance monitoring and evaluation (M&E) of global health interventions, to move from process to outcomes, and be "results-oriented rather than expenditure- or input-based." An additional core principle is to promote research and innovation, including scaling-up operational and implementation research. The GHI includes specific targets in each of its major health areas over the life of the initiative, yet moving in this direction poses numerous challenges. These include both measurement challenges, as well as broader issues related to the GHI targets. Health is a complex domain, encompassing multiple dimensions, components, and levels making the measurement of investments particularly difficult. For example, while most would agree that measuring HIV incidence (new infections) is the best outcome measure for assessing HIV prevention interventions, it is one of the most difficult outcomes to measure and often cannot be measured directly (instead, proxy measures must sometimes be used) or within a time frame that matches donor budgeting cycles.[27] There are also concerns about the limitations of existing measurement tools used to assess global health interventions, such as cost effectiveness analysis, which is a standard tool used to compare health interventions, but does not necessarily capture the benefits gained in one area due to a health intervention in another (e.g., impact of HIV treatment on maternal health[24]) or the benefits of health interventions on non-health measures (e.g., improved school attendance).[28] In addition, U.S. investments intermingle with the investments of other donors and recipient countries, making it difficult to attribute outcomes directly to the U.S. or any other single funder. A further concern is the lack of data and information systems, particularly at the country level, for measuring impact. Finally, as the U.S. moves toward a more outcomes-based M&E framework, it will be important to consider and address not only the capacity of recipient countries in this area, but the potential to cause additional measurement burden on countries, many of which are already confronted by multiple and distinct reporting frameworks.

Beyond these measurement challenges are considerations and questions about the GHI targets themselves, including their relationship to: current global needs and burden; other global health targets, such as the Millennium Development Goals (MDGs),[29] commitments made by the G8[30], and Lantos-Hyde[26]; and actual GHI investments over time. Additionally, while the GHI approach is intended to be a broad and comprehensive one, promoting synergies and maximizing impact across interventions, the targets developed are specific to each health area; measuring interaction and integration will likely prove to be more difficult and there may be a need to develop new measures and measurement strategies in this area.

There are several U.S. agencies already involved in global health operations research, including the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), and the U.S. Agency for International Development (USAID), although global health research activities have not always been coordinated across them. Moving forward, there may be additional opportunities to coordinate and build on their existing research networks and expertise in this area.

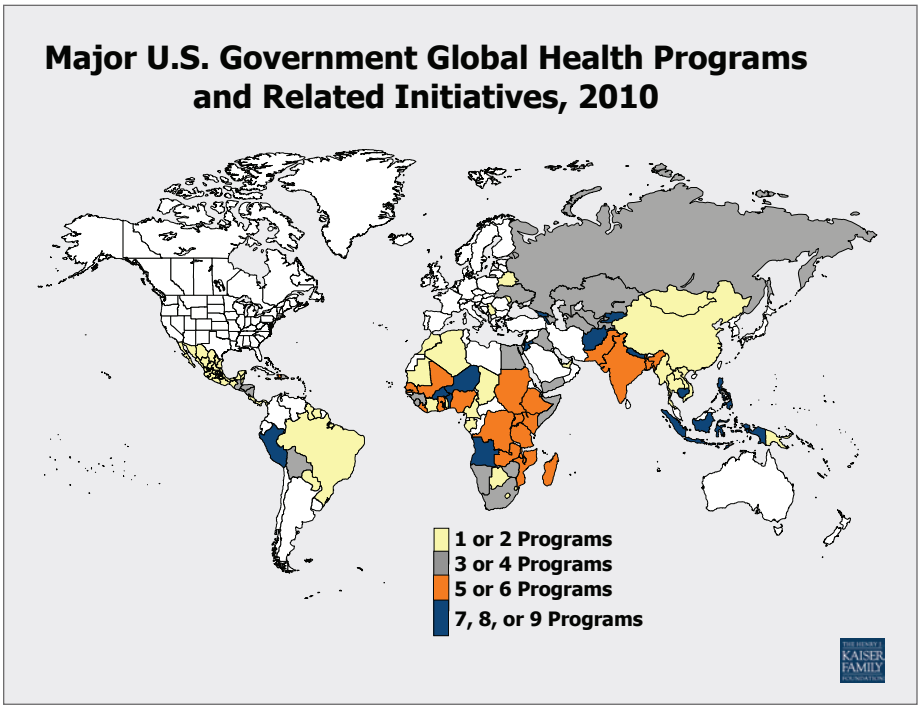
Key Issues:

- What kinds of investments and structures are needed at the federal agency and country levels to foster greater M&E? What will it cost to implement M&E? How much is enough or too much—would it be better to invest in health programs, or are the efficiency gains enough to offset M&E costs?
- How can new metrics be implemented without increasing an already heavy and complex reporting burden on countries?
- How do the GHI targets track against current global health needs and burden, and compare to other global health targets and commitments, such as the MDGs?
- What is the potential role, and limitations, of existing measurement tools? How can data gaps and limitations be overcome? Where might proxy measures still be needed and how will their use be incorporated into an outcomes-based system?

4. HOW CAN THE U.S. BEST PARTNER WITH RECIPIENT COUNTRIES TO PROMOTE "COUNTRY-OWNERSHIP"?

Background and Context:

In recent years, there has been an increasing focus by the U.S. and other donors on the need to work with recipient countries differently, in partnership, to promote country-ownership. This is not only one of the core principles of the GHI, it has also been emphasized in several other, large-scale U.S. health and development initiatives, including the Millennium Challenge Corporation (MCC), created in 2004 as a new model for U.S. foreign assistance built on country "compacts" or partnerships[31], and, more recently, in PEPFAR's new five-year strategy[32] and the Administration's new Global Hunger and Food Security Initiative (GHFSI)[33]. The emphasis on country-ownership and partnership has been motivated by several factors, including a growing recognition that in order to move toward longer-term sustainability of programs, recipient country governments and other country stakeholders need to be integrally engaged in determining what is best for their needs and populations, designing and implementing programs, and building their health systems.[34] In addition, there has been increased recognition that donor-funded programs at the country-level are often uncoordinated, fragmented, and duplicative, with multiple donors operating on similar issues and even individual donors operating multiple programs that may or may not be coordinated with one another.[9] In many countries that receive U.S. global health and related development assistance, for example, there are six, seven, or even more distinct U.S. programs operating at the same time (see Figure 4).[35]



The GHI approach, as stated in the consultation document, includes supporting partner countries in "managing, overseeing, and operating the functions of their national health systems" ensuring that "investments are aligned with national priorities" and supporting "partner government's commitment and capacity so that investments are maintained in the future."[1] This is further described as investing in country-led plans, beginning with an assessment of existing plans as well as country health systems, financing gaps, and capacity to implement programs effectively. This approach will also designate a subset of countries, from among those receiving U.S. health assistance, as "GHI-Plus" countries, or countries that "provide significant opportunities for impact, evaluation, and partnership with governments."[1] GHI-Plus countries will be targeted with a more intensified effort, including additional funding ($200 million across GHI-Plus countries in FY 2011), and chosen based on several criteria, ranging from partner country interest in participation to the severity of health problems and challenges to be addressed.

Moving ahead in this direction, however, will not be easy. First, country-ownership is not an easily defined or measured concept and there can be a tension, indeed a delicate balance, between donor defined and country determined priorities. This tension may also arise around the issue of donor accountability; that is, as more program ownership is vested in countries themselves, it may become more difficult to be accountable to donors. A further issue involves the need to change the way the U.S. government does business in countries, moving from what has become a heavy reliance on contracting with private (often U.S. based) entities to implement country-programs to working directly with host country governments. While both the Administration and Congress have stated their intention to shift in this direction, they have also acknowledged the challenges of doing so, including the need to bolster agency and field-level capacity in some cases.[34,36,37,38,39,40]

Other areas to consider include the appropriate role of civil society (e.g., non-governmental organizations, community groups, indigenous groups, charitable organizations, faith-based organizations, etc.) in designing and implementing programs, particularly in countries where civil society has not been previously engaged; the implications of recipient government policies, such as those concerning the rights of women, in assessing partnership parameters; and the need to need ensure coordination not only among U.S. programs but with other donors to minimize the implementation and reporting burden on countries. Additionally, while a key goal of the GHI is to foster country ownership to enable countries to sustain programs over time, many of the countries facing the greatest health crises and challenges are those that have the least capacity or ability to sustain programs, and may require longer term U.S. investment to achieve such goals. Finally, while the GHI-Plus effort is designed to target a subset of countries to accelerate impact, it is not yet known whether the additional resources made available to them will be sufficient for this purpose.

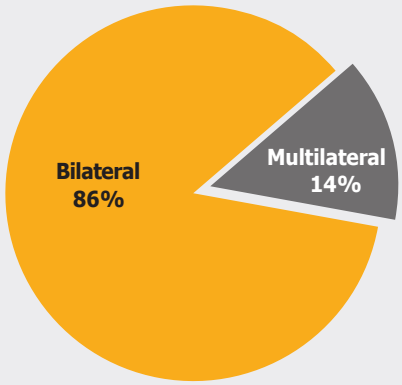
Key Issues:

- What is the appropriate balance between donor-defined and country-determined priorities? What is the trade-off between accountability to Congress and other policy-makers and country-ownership?
- How will country-plans be developed with host country governments and other stakeholders? What should be the role of civil society in defining, determining, and owning programs?
- What role should the U.S. play in using its investments to foster policy change?
- Will the additional effort provided to GHI-Plus countries be enough to show a differential impact?

5. HOW CAN U.S. ENGAGEMENT WITH OTHER INTERNATIONAL ACTORS, INCLUDING MULTILATERALS, DONOR GOVERNMENTS, AND THE PRIVATE SECTOR, FURTHER SUPPORT COORDINATION, LEVERAGE RESOURCES, AND MAXIMIZE SHARED IMPACT?

Background and Context:

FIGURE 5: Distribution of Bilateral & Multilateral Funding in the U.S. Global Health Initiative (GHI), FY 2009 – FY 2011*



*FY 2011 is President's Budget Request to Congress.

The U.S. government's engagement in global health has long involved working with international partners and organizations, including participation in the International Sanitary Conferences of the 19th Century, as well as helping to create the Pan American Health Organization (PAHO), the World Health Organization (WHO), and, more recently, the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund).[14] U.S. involvement in multilateral health organizations includes several different kinds of activities, ranging from signing onto international health treaties and agreements to organizational membership, governance, technical assistance, partnering, and funding. Some multilateral organizations themselves serve as financing vehicles to address global health challenges, such as the Global Fund and the Global Alliance for Vaccines and Immunisations (GAVI), and U.S. contributions to these organizations provide another avenue for the U.S. to expand its reach and impact; the U.S. is the largest donor to both the Global Fund[41] and GAVI.[42]

Despite the U.S. government's long standing and significant involvement in international organizations, the U.S. response to global health, as measured by funding and programs, has largely been bilateral—approximately 86% of U.S. funding for global health over the last decade has been channeled bilaterally[5]; this has continued with the GHI[54] (see Figure 5). This is due to several factors including the significant field presence of U.S. programs and staff around the world, as well as a U.S. policy preference for targeting funding to certain countries and programs, allowing for U.S. defined priorities and accountability to Congress. As a result, some have called for increased multilateral engagement given the global nature of health challenges, the need to leverage U.S. investments with others and sustain programs over time, and concerns about the financial stability of international financing organizations such as the Global Fund. They have pointed to the emergence of new, innovative financing vehicles for global health, such as the International Financing Facility (IFF)[43], Advance Market Commitment (AMC)[44], and UNITAID,[45] which may provide additional avenues for U.S. impact. However, such vehicles, as multiyear and contingent financial commitment mechanisms, have posed legal and administrative barriers to U.S. involvement.[46] Others have highlighted potential opportunities for the U.S. to re-examine its engagement in international treaties and agreements. For example, while the U.S. is a party to many such agreements, others have yet to be ratified, such as the WHO Framework Convention on Tobacco Control (WHO FCTC)[47,48] and the U.N. Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).[49] Other international coalitions, such as the International Health Partnership (IHP+)[9,50], a partnership of donors and developing countries to better harmonize donor funding commitments and improve health systems, may also provide new opportunities for the U.S. (the U.S. is not currently one of the 13 donor government members of the IHP). Finally, there has been recent attention to the lack of a multilateral financing vehicle for MCH, prompting some to point to the need to assess whether an existing or new multilateral vehicle should be pursued for this purpose.[71] The outcome of such a move could pose new options for the U.S. funding portfolio.

Most recently, the Obama Administration has stated an intention to reinvigorate multilateral engagements and international partnerships on health and development generally and for the GHI specifically.[1,51,52] In fact, a core principle of the GHI is strengthening and leveraging key multilateral organizations, global health partnerships, and private sector efforts, including commitment to achieving the Millennium Development Goals, and support for GAVI, the Global Fund, and other international partnerships and mechanisms. For example, Secretary Clinton recently stated support for ratifying CEDAW.[53]

Key Issues:

- What is the appropriate funding balance between multilateral and bilateral programs?
- To the extent that U.S. investments are channeled through multilateral organizations, how can health impacts be attributed to the U.S. specifically? How can concerns about accountability be addressed?
- Are there opportunities for further assessing or strengthening U.S. engagement in international health treaties, regulations, and other partnerships and agreements? Are there innovative financing mechanisms that can be further explored?
- To what extent is the GHI's success predicated on increased engagement with international partners?

6. HOW WILL THE INCREASED EMPHASIS ON WOMEN AND GIRLS BE REALIZED IN U.S. GLOBAL HEALTH PROGRAMS?

Background and Context:

There has been a growing recognition of the need to elevate a focus on women and girls in U.S. global health programs, particularly in the last decade. While U.S. programs have long funded interventions that address the health needs of women and girls, such as through MCH and FP/RH programs, as well as HIV, TB, and malaria, this approach has rarely targeted women and girls explicitly. Some of the programs that most directly affect women and girls, such as MCH and FP/RH, have received less funding historically and even seen decreases at times.[5] The impetus for increased attention to women, girls, and gender more broadly has been twofold: both the recognition that women and girls have had proportionately less access to global health programs and face greater disparities, along with the evidence that interventions that target the health of women and girls have high returns for the entire family unit. In fact, some have said that the global health response of the U.S. and others cannot be fully successful unless the health needs of women and girls are more explicitly addressed.

In launching the GHI, as well as several other new U.S. efforts, including the creation a new office of Global Women's Issues and the position of Ambassador-at-Large for Global Women's Issues at the State Department,[55] the Obama Administration has further heightened attention and focus on women and girls. The Administration has also taken steps to enhance its international engagement in this area, including restoring funding for the United Nations Population Fund (UNFPA),[56] and supporting calls for the creation of a new UN special agency for women.[53] The first core principle of the GHI is to implement a women-and girls-centered approach and the consultation document discusses several general measures for doing so, including supporting systemic long term changes to remove barriers and increase access for women and girls, enhancing monitoring and evaluation of the health of women and girls, improving the training of health providers on gender issues, and involving women and girls in decision-making about program implementation. The GHI also includes several targets in MCH and FP/RH, areas that directly affect the health of women and girls.

While there is widespread agreement on the importance of women and girls in global health programs, there are limited models on how to integrate such an approach at the agency or country level. There are also potential challenges that may arise if host countries have policies in place that may inhibit involvement and access of women and girls, and otherwise restrict their rights. In addition, there remain difficult political divisions in the U.S. and elsewhere around some key service areas that are important to addressing the health of women and girls, particularly family planning and access to safe abortion. Finally, there may be opportunities to further reinforce the global consensus that has emerged on women and girls with international partners, including the near term marker of the G8 Summit this June, at which the Canadian government is expected to champion a major new initiative on maternal, child, and newborn health, calling on donor governments to participate.[57] In addition, although the U.S. has not yet ratified CEDAW, Secretary Clinton has indicated support for doing so.[53]

Key Issues:

- How can a women and girls centered approach best be implemented at a country level?
- As country plans are developed or augmented, how can the importance of addressing women and girls be meaningfully incorporated? Are incentives to do so needed and if so, what are appropriate incentives? What should the U.S. role be in countries that may have policies that are harmful to women and girls?
- How comprehensively should services for women and girls be defined within the global health portfolio? Should non-health interventions that target women and girls, such as improved access to education, be accounted for?
- How can the U.S. reinforce and strengthen the global consensus that has emerged around the importance of addressing gender, women and girls, both to keep it on the agenda and to support other countries in their own efforts to do so?

7. HOW WILL THE U.S. DEFINE, IMPLEMENT, AND MEASURE HEALTH SYSTEMS STRENGTHENING?

Background and Context:

In recent years, the U.S. government, other donors and international organizations, and recipient countries have increasingly emphasized the necessity of strengthening health systems for reaching global health goals and improving the health status of those in low-and middle-income countries. At the launch of the GHI in May 2009, the President emphasized this goal, stating "…we will not be successful in our efforts to end deaths from AIDS, malaria, and tuberculosis unless we do more to improve health systems around the world…".[3] Similarly, stronger health systems are essential for the longer term U.S. foreign aid goal of shifting from an "emergency" response to one of sustainability—a core principle of the GHI is promoting sustainability through health systems strengthening (HSS). Finally, the U.S. has also noted that strengthening health systems in developing countries is important to U.S. self interest, particularly in the area of pandemic preparedness and prevention of health threats.

Although there is a consensus about the critical need to strengthen health systems for short and long term success of global health programs, it is one of the more difficult areas to define and operationalize. Connecting U.S. investments in health systems and capacity building to health outcomes is often more difficult to measure than other areas and agreed upon targets are not readily available, complicating efforts to demonstrate impact to U.S. policymakers, particularly those in Congress. The GHI targets for HSS, for example, are the only set for which measures have yet to be developed; rather, the U.S. has indicated that it will seek to develop measures working with other donors and partner countries. In addition, despite recognizing the importance of strengthening health systems, some have worried that a more horizontal approach could come at the expense of disease specific vertical approaches and not account for the role played by vertical programs in strengthening health systems.[24] Finally, others have drawn attention to existing networks for addressing HSS, such as the IHP+, that the U.S. has not yet been directly involved in.[9]

Despite these difficulties, there are several efforts underway to define and measure HSS that have or could further inform U.S. efforts. These include the WHO's health systems framework which identifies six building blocks of health systems (service delivery; health workforce; information; medical products, vaccines and technologies; financing; and leadership and governance[58]) and associated measurement toolkits for countries,[59] in addition to the work of the Global Fund[60] and GAVI[61], both of which fund and evaluate HSS projects, and the work of the IHP+.[50]

Key Issues:

- What targets—either existing or newly developed—can be used to help assess U.S. investments in health systems? How can health systems investments be linked to health outcomes?
- What can be learned from other efforts, including those of the Global Fund and GAVI about design, implementation, and metrics for HSS projects?
- How will the U.S. balance the need to strengthen health systems, particularly in countries with the least infrastructure and capacity, with the need to also respond to more immediate health challenges?
- As the U.S. moves to strengthen health systems, adopting a broader, "horizontal" approach to global health, what will be the implications for disease-specific vertical approaches? How can the role of disease-specific vertical approaches in strengthening health systems best be recognized, assessed, and accounted for?

8. HOW WILL THE GHI BE COORDINATED WITH AND AFFECTED BY BROADER U.S. FOREIGN AID REFORM EFFORTS AND OTHER NEW INITIATIVES?

Background and Context:

In recent years, there has been increasing focus on the need to reform the U.S. foreign assistance framework and programs, including reauthorizing the Foreign Assistance Act of 1961, which created the statutory basis for U.S. foreign assistance, but has not been comprehensively amended since 1985.[34,62,63,64] Calls for reform have gained momentum,[37,38] particularly in the last year, and several broad reform efforts have either been introduced in the Congress or are already underway in the Administration. These include: foreign aid reform legislation introduced in both the House[39] and Senate[40]; a Presidential Study Directive (PSD) on Global Development, signed by the President in August 2009,[65,66] that calls for a government-wide interagency review of global development policy; and the State Department's Quadrennial Diplomacy and Development Review (QDDR),[67] announced by Secretary Clinton in July 2009, which introduced a new process for reviewing and developing blueprints for State and USAID diplomatic and development policy and structure. In addition to these reform efforts, the Administration recently launched a major new food security initiative, the Global Hunger and Food Security Initiative (GHFSI),[33] which is still being developed, and has also signaled new attention to climate change efforts, including appointing a Special Envoy for Climate Change at the State Department.[68]

The preliminary results of some of these efforts are expected very soon, and while none is health-focused, global health has regularly been cited by the Administration as a key example of its diplomacy and development efforts around the world and the GHFSI, GHI, and climate change issues have been talked about in tandem.[69,70] Given that most global health funding and programs is located within foreign assistance agencies, what happens with these broader initiatives will almost undoubtedly affect the U.S. global health response. In addition, many of the core principles and objectives of the GHI are also being pursued through these other efforts, such as an enhanced focus on coordination and integration, country-ownership, and measurement and evaluation. At the same time, these initiatives are being developed or explored while the GHI itself is still in formation and as health programs and services continue to be delivered on the ground. Thus, it will be important to monitor their progress and status and assess their implications for the U.S. global health response.

Key Issues:

- How will these different efforts affect the U.S. global health portfolio and the strategy outlined in the new GHI consultation document? What kinds of broader restructuring of development can be expected?
- Where can the U.S. global health response serve as a model for broader development reform efforts?
- Given the multiple reform efforts, assessments and initiatives, and uncertainty in their timing, how can the U.S. government best ensure coordination and synergies at the agency, program, and country-level, as well as with international partners?
- How can the global health community coordinate with other development stakeholders to best take advantage of new opportunities presented by reform efforts?

This policy brief was prepared by Jen Kates of the Kaiser Family Foundation. All figures in this brief, and others, can be downloaded from Kaiser Slides, http://facts.kff.org/results.aspx?view=slides&topic=76&start=1&num=4, located on the Foundation's global health gateway, http://globalhealth.kff.org/. Kaiser slides are regularly updated with the most recent data available.

ENDNOTES

[1] U.S. Government. *Implementation of the Global Health Initiative: Consultation Document*; February 2010, www.pepfar.gov/ghi/index.htm.

[2] White House. *Budget of the United States Government, Fiscal Year 2011*; February 2010, www.whitehouse.gov/omb/budget/Overview/.

[3] White House. *Statement by the President on Global Health Initiative*; May 5, 2009, www.whitehouse.gov/the_press_office/Statement-by-the-President-on-Global-Health-Initiative/.

[4] White House. *Fact Sheet: American Leadership on Global Health*; May 5, 2009, www.whitehouse.gov/the_press_office/Statement-by-the-President-on-Global-Health-Initiative/.

[5] Kaiser Family Foundation analysis of data from the Office of Management and Budget, Agency Congressional Budget Justifications prepared by individual agencies, Congressional Appropriations Bills, and White House Statement by the President on Global Health Initiative. Also see: Kaiser Family Foundation, *The U.S. Global Health Initiative: Overview & Budget Analysis*; December 2009.

[6] Institute of Medicine. *The U.S. Commitment to Global Health: Recommendations for the New Administration*; Washington DC: National Academies Press; December 2008, www.iom.edu/Activities/Global/USandGlobalHealth.aspx.

[7] Institute of Medicine. *The U.S. Commitment to Global Health: Recommendations for the Public and Private Sectors*; Washington DC: National Academies Press; May 2009, www.iom.edu/Activities/Global/USandGlobalHealth.aspx.

[8] Levine R. "Healthy Foreign Policy: Bringing Coherence to the Global Health Agenda" in *The White House and the World: A Global Development Agenda for the Next U.S. President*, Nancy Birdsall, editor. Washington, DC: Center for Global Development; August 2008, www.cgdev.org/content/publications/detail/16560.

[9] Report of the CSIS Commission on Smart Global Health Policy. *A Healthier, Safer, and More Prosperous World*. Washington DC: Center for Strategic and International Studies; March 18, 2010, http://smartglobalhealth.org/content/report.

[10] Morrison JS, Kates J. *Five Emerging Key Challenges For US Policy Approaches On Global Health*; April 21, 2009, http://media.csis.org/globalhealth/commissioners/five_emerging_challenges.pdf.

[11] Morgan L. *What's on the Agenda in Global Health? The Experts' List for the Obama Administration*; Washington, DC: Center for Global Development; June 2009, www.cgdev.org/content/publications/detail/1422228.

[12] Salaam-Blyther T, Moss K. *U.S. Global Health Assistance: Background, Priorities, and Issues for the 111th Congress*. Congressional Research Service. R40740; July 27, 2009.

[13] Comments submitted by the following organizations and coalitions were reviewed (comments submitted by individuals were not included): The Center for Global Development; The Global Health Council; The Global Health Initiative Working Group; The Public Health Institute; The Center for Health and Gender Equity (CHANGE); Joint comments from Advocates for Youth, CHANGE, Family Care International, and The International Women's Health Coalition; The Foundation for AIDS Research (amfAR); The Global AIDS Alliance; Joint comments from Aeras Global TB Vaccine Foundation and The Global Alliance for TB Drug Development; IDSA Center for Global Health Policy; Joint Comments from Malaria No More, Friends of the Global Fight, Population Services International, Path Malaria Vaccine Initiative, Path Malaria Control and Evaluation Partnership in Africa, and Africa Fighting Malaria; and IPAS.

[14] Kates J, Fischer J, Lief E. *The U.S. Government's Global Health Policy Architecture: Structure, Programs, and Funding*; Menlo Park, CA: Kaiser Family Foundation; April 2009, www.kff.org/globalhealth/7881.cfm.

[15] Emanuel EJ. "The Global Health Initiative". Presentation at the Consortium of Universities for Global Health Annual Meeting, National Institutes of Health, Bethesda, Maryland; September 14, 2009, www.cugh.org/?q=meetings/2009-annual/presentations.

[16] Institute of Medicine. *America's Vital Interest in Global Health: Protecting Our People, Enhancing Our Economy, and Advancing Our International Interests*. Washington DC: National Academies Press; 1997, www.nap.edu/openbook.php?record_id=5717.

[17] The White House. Office of the Press Secretary, Press Briefing by Press Secretary Robert Gibbs and Deputy Secretary of State Jack Lew; May 5, 2009, www.whitehouse.gov/the_press_office/Briefing-by-White-House-Press-Secretary-Robert-Gibbs-5/5/09/.

[18] Kates J, Lief E, Pearson J. *Donor Funding for Health in Low- & Middle- Income Countries, 2001-2007*. Menlo Park, CA: Kaiser Family Foundation; July 2009, www.kff.org/globalhealth/7679-03.cfm.

[19] Ravishankar N, Gubbins P, Cooley RJ, Leach-Kemon K, Michaud CM, Jamison DT, Murray CJL. "Financing of Global Health: Tracking Development Assistance for Health From 1990 to 2007", *The Lancet*, Volume 373, Issue 9681, pp. 2113 – 2124; June 29, 2009, www.thelancet.com/journals/lancet/article/PIIS0140-6736%2809%2960881-3/abstract.

[20] Taskforce on Innovative International Financing for Health Systems. *More Money for Health, and More Health for the Money*; September 2009, www.internationalhealthpartnership.net/pdf/IHP%20Update%2013/Taskforce/Johansbourg/Final%20Taskforce%20Report.pdf.

[21] World Health Organization, www.who.int/topics/financial_crisis/en/. See in particular, *The Financial Crisis and Global Health: Report of a High-level Consultation, Geneva, Switzerland – 19 January 2009*, www.who.int/topics/financial_crisis/financialcrisis_report_200902.pdf.

[22] International Monetary Fund. *The Impact of the Financial Crisis on Low-Income Countries*; March 2009, http://imf.org/external/pubs/ft/books/2009/globalfin/globalfin.pdf.

[23] World Bank. *Global Economic Prospects 2010: Crisis, Finance, and Growth*; January 2010, http://go.worldbank.org/7NIPEVSMO0.

[24] Walensky RP, Kuritzkes DR. "The Impact of The President's Emergency Plan for AIDS Relief (PEPfAR) beyond HIV and Why It Remains Essential", *Clinical Infectious Diseases*. Volume 50, Issue 2, Page 272–275; Jan 2010.

[25] See for example organizational comments submitted on the GHI consultation document from amfAR, the Global AIDS Alliance, and the IDSA Center for Global Health Policy.

[26] The Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008, P.L. 110-293; July 2008.

[27] See, for example: Brookmeyer R, "Measuring the HIV/AIDS Epidemic: Approaches and Challenges", *Epidemiologic Reviews*, March 4, 2010; WHO, HIV Incidence, www.who.int/diagnostics_laboratory/links/hiv_incidence_assay/en/; Diaz T, "Methodological challenges of Measuring HIV Specific Impacts For Design Considerations for Evaluating the Impact of PEPFAR", IOM Workshop, April 30 - May 1, 2007.

[28] Jamison DT, Breman JG, Measham AR, Alleyne G, Claeson M, Evans DB, Jha P, Mills A, Musgrove P. "Cost–Effectiveness Analysis." Disease Control Priorities Project, *Priorities in Health*, ed. , 39-58. New York: Oxford University Press; 2006, www.dcp2.org/pubs/PIH/3/FullText.

[29] UN Millennium Development Goals, www.un.org/millenniumgoals/

[30] G8 Research Group. *G8 Commitments on Health*, 1975-2009; December 2009, www.g7.utoronto.ca/evaluations/g8-commitments-health-to-2009.html.

[31] Millennium Challenge Corporation, www.mcc.gov/mcc/panda/programs/compacts/index.shtml.

[32] State Department, Office of the Global AIDS Coordinator. *The U.S. President's Emergency Plan for AIDS Relief: Five-Year Strategy*; December 2009, www.pepfar.gov/strategy/index.htm.

[33] State Department. *Global Hunger and Food Security Initiative: Consultation Document*; September 2009, www.state.gov/s/globalfoodsecurity/.

ENDNOTES (continued)

[34] Hillary Rodham Clinton, Remarks at the Center for Global Development, Washington, DC, January 6, 2010, www.state.gov/secretary/rm/2010/01/134838.htm.

[35] Kaiser Family Foundation analysis.

[36] Jacob Lew, Anne Marie Slaughter, Alonzo Fulgham, Remarks at The US Global Leadership Coalition, October 14, 2009, www.usglc.org/2009/10/14/putting-smart-power-to-work-dialogue-on-qddr-%E2%80%93-october-14-2009/.

[37] Herrling S, Radelet S, "Modernizing U.S. Foreign Assistance for the Twenty-first Century" in *The White House and the World: A Global Development Agenda for the Next U.S. President*, Nancy Birdsall, editor. Washington, DC: Center for Global Development; August 2008, www.cgdev.org/content/publications/detail/16560.

[38] Modernizing Foreign Assistance Network. *New Day, New Way: U.S. Foreign Assistance for the 21st Century*; June 2008, http://modernizingforeignassistance.net/newdaynewway.html.

[39] H.R. 2139 - Initiating Foreign Assistance Reform Act of 2009, http://hdl.loc.gov/loc.uscongress/legislation.111hr2139.

[40] S. 1524 - Foreign Assistance Revitalization and Accountability Act of 2009, http://hdl.loc.gov/loc.uscongress/legislation.111s1524.

[41] Global Fund to Fight AIDS, Tuberculosis and Malaria, Pledges and Contributions, as of April 6, 2010, www.theglobalfund.org/en/pledges/?lang=en.

[42] Global Alliance for Vaccines and Immunisations, Donors, as of April 6, 2010, www.gavialliance.org/support/donors/index.php.

[43] International Finance Facility for Immunisation, www.iff-immunisation.org.

[44] Advance Market Commitment, www.vaccineamc.org.

[45] UNITAID, www.unitaid.eu/.

[46] Hecht R, Palriwala A, Rao A, *Innovative Financing for Global Health: A Moment for Expanded U.S. Engagement*, Washington DC: Center for Strategic and International Studies; March 2010, http://csis.org/publication/innovative-financing-global-health.

[47] WHO Framework Convention on Tobacco Control, www.who.int/fctc/en/

[48] McGrady B, *U.S. Engagement in International Tobacco Control*, Washington DC: Center for Strategic and International Studies; June 2009, http://csis.org/publication/us-engagement-international-tobacco-control.

[49] UN Convention on the Elimination of All Forms of Discrimination against Women, www.un.org/womenwatch/daw/cedaw/.

[50] International Health Partnership, www.internationalhealthpartnership.net/en/home.

[51] Barrack Obama. Address to the United Nations General Assembly. September 23, 2009. New York, NY, www.america.gov/st/texttrans-english/2009/September/20090923110705eaifas0.3711664.html

[52] State Department, Foreign Press Center, Testimony of Assistant Secretary Esther Brimmer, "U.S. Engagement With Multilateral Organizations," October 22, 2009, www.state.gov/p/io/rls/rm/2009/130998.htm.

[53] Hillary Rodham Clinton, Remarks at the UN Commission on the Status of Women, UN Headquarters, March 12, 2010, www.state.gov/secretary/rm/2010/03/138320.htm.

[54] Kaiser Family Foundation analysis. Multilateral funding includes the Global Fund, GAVI, IAVI, UNAIDS, Global TB Drug Facility, and Microbicides. Other U.S. contributions to multilateral organizations, such as to the WHO, are not currently counted as part of the GHI.

[55] State Department, www.state.gov/s/gwi/

[56] UNFPA, www.unfpa.org/public/site/global/lang/en/pid/1562.

[57] Stephen Harper, Canada's G8 priorities, January 26, 2010, http://pm.gc.ca/eng/media.asp?id=3093.

[58] WHO, *Everybody Business : Strengthening Health Systems To Improve Health Outcomes : WHO's FrameworkFor Action*, Geneva: WHO; 2007, www.who.int/healthsystems/strategy/en/.

[59] WHO/World Bank, www.who.int/healthinfo/statistics/toolkit_hss/en/index.html.

[60] www.theglobalfund.org/en/performance/effectiveness/hss/

[61] www.gavialliance.org/support/what/hss/index.php

[62] Epstein SB, Veillette C. *Foreign Aid Reform: Issues for Congress and Policy Options*, Congressional Research Service, RL34243; January 27, 2009.

[63] Epstein SB, Weed MC, *Foreign Aid Reform: Studies and Recommendations*, Congressional Research Service, R40102; July 28, 2009.

[64] GAO. *Foreign Aid Reform: Comprehensive Strategy, Interagency Coordination, and Operational Improvements Would Bolster Current Efforts*. GAO-09-192; April 2009, www.gao.gov/products/GAO-09-192.

[65] www.modernizingforeignassistance.org/blog/2009/08/31/mfan-new-presidential-study-directive-on-global-development-an-unprecedented-step-forward-on-development/.

[66] Testimony of Dr. Rajiv Shah, Administrator, U.S. Agency for International Development, Regarding the Fiscal Year 2011 Budget Requests, Before the Committee on Foreign Affairs, United States House of Representatives, March 3, 2010, www.usaid.gov/press/speeches/2010/ty100303.html.

[67] State Department, www.state.gov/r/pa/prs/ps/2009/july/125956.htm.

[68] State Department, Appointment of Special Envoy on Climate Change, Todd Stern, January 26, 2009, www.state.gov/secretary/rm/2009a/01/115409.htm.

[69] Testimony of Hillary Rodham Clinton, Secretary of State, Regarding the President's Proposed Budget Request for FY2011 for the Department of State and Foreign Operations, Before the Senate Appropriations Subcommittee on State, Foreign Operations, and Related Programs, United States Senate, February 24, 2010, www.state.gov/secretary/rm/2010/02/137227.htm.

[70] Testimony of Dr. Rajiv Shah, Administrator, U.S. Agency for International Development, Regarding the Fiscal Year 2011 Budget Requests, Before the Subcommittee on State, Foreign Operations, and Related Programs Committee on Appropriations, United States House of Representatives, March 4, 2010, www.usaid.gov/press/speeches/2010/ty100304.html.

[71] Horton R, "Maternal Mortality: Surprise, hope and urgent action," *The Lancet*; April 12, 2010.

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