



GHI Mid-Term Review and a Way Forward

A Report of the Rethinking U.S. Foreign Assistance Program

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On May 5, 2009, President Obama announced the Global Health Initiative (GHI), a new way for the United States to do business in global health. Upon taking office, the Obama administration argued that the country's fragmented global health architecture generated inefficiencies and duplication and hindered efforts to maximize program impact and strengthen health systems abroad. The new administration launched the GHI to consolidate global health programs under a single banner and dismantle existing vertical structures in favor of an integrated, cooperative approach.

Thus, the GHI was created to unite global health programs under a single initiative and to build upon a decade of unprecedented U.S. foreign aid for global health, primarily the enormous investment in HIV/AIDS through the President's Emergency Plan for AIDS Relief (PEPFAR). President Obama announced that the GHI would expand that narrow HIV/AIDS focus toward broader global health challenges, including child and maternal health, family planning, and neglected tropical diseases. The president pledged to invest \$63 billion over six years toward achieving these goals.

By providing "proven cost-effective interventions" and supporting innovations to accelerate their impact on health outcomes, the GHI was buoyed by high aspirations to be a transformational force in U.S. global health assistance. As the GHI moves into its third year of implementation, we summarize the current status of this major development initiative, highlight the challenges for the GHI, and propose specific recommendations for a way forward.

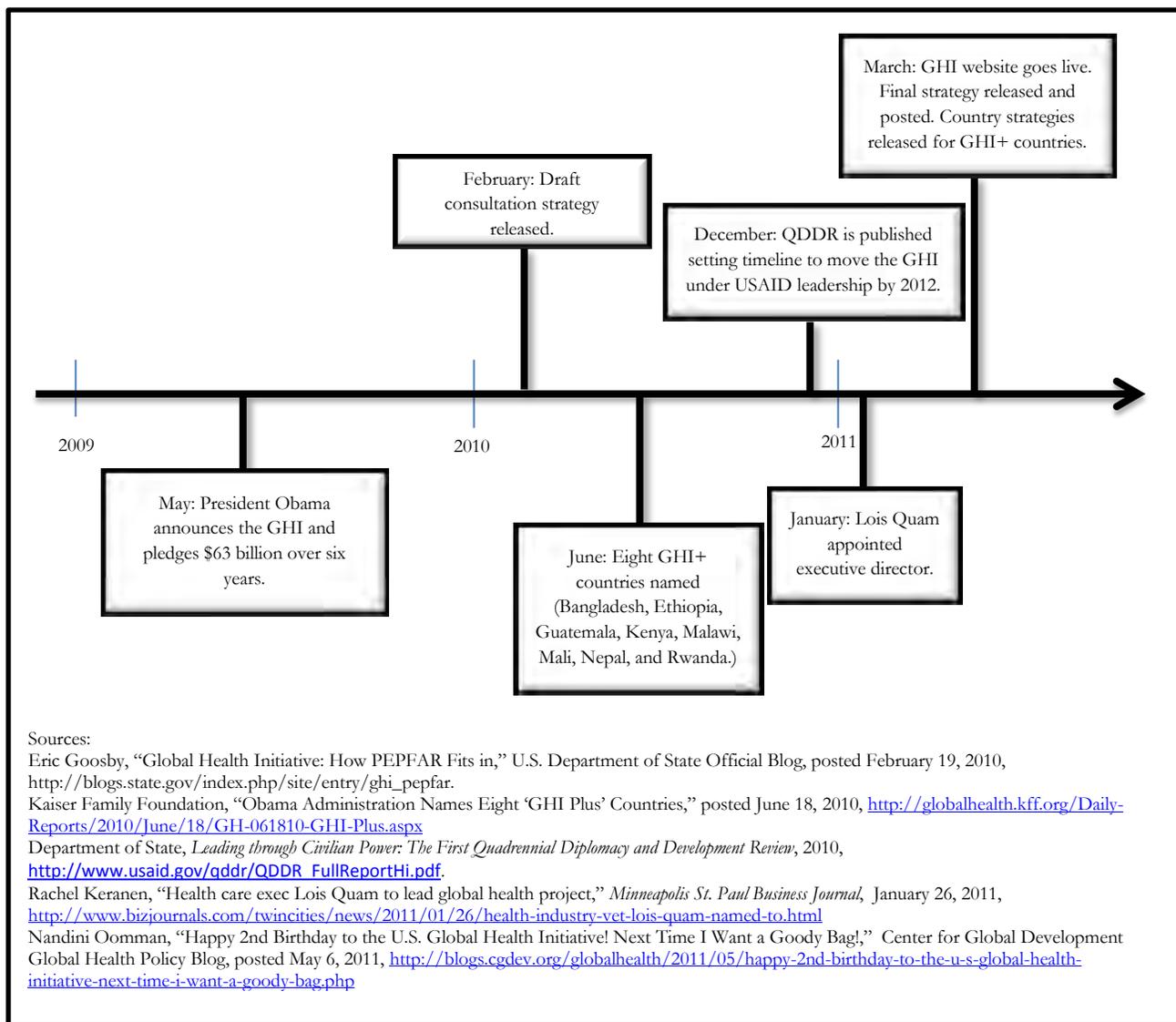
Current Status

In this section, we summarize the structure and leadership, and report progress and funding of the GHI to assess its potential for success.

Structure

The GHI is intended to coordinate health activities across three U.S. agencies, USAID, the State Department's Office of the Global AIDS Coordinator (OGAC), and the Centers for Disease Control

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and Prevention (CDC),² and four multi-agency initiatives, PEPFAR, the President’s Malaria Initiative (PMI), Feed the Future (FTF), and the Neglected Tropical Disease Initiative (NTD). The GHI also incorporates a broader set of government agencies through the GHI strategic council; however, the role of the strategic council in implementation is currently unclear.³ Before March 2011, Secretary of State Hillary Clinton was the *de facto* leader of the GHI. In January 2012, Lois Quam was appointed executive director, and currently coordinates the GHI from her office

² U.S. Global Health Initiative, "U.S. Government Agencies," accessed January 2012, <http://www.ghi.gov/about/agencies/index.htm>

³ U.S. Global Health Initiative, "GHI Leadership," accessed January 2012, <http://www.ghi.gov/about/leadership/index.htm>

within the State Department.⁴ Quam oversees the GHI Operations Committee comprised of Dr. Rajiv Shah, administrator of USAID; Ambassador Eric Goosby, U.S. Global AIDS Coordinator; and Dr. Thomas Frieden, director of the CDC.⁵ According to the December 2010 Quadrennial Diplomacy and Development Review (QDDR), control of the GHI is targeted for transfer to USAID by September 2012, but only after USAID meets a set of benchmarks that demonstrate its ability to lead the GHI. PEPFAR is the only exception to this consolidation and will remain under the OGAC.⁶ It is currently unclear what GHI leadership really means and whether USAID will assume this role.

GHI Targets

- **HIV/AIDS:** Support prevention of more than 12 million new infections, care for more than 12 million people, and treatment for more than 4 million people.
- **Child health:** Reduce under-five mortality rates by 35 percent in assisted countries.
- **Maternal health:** Reduce maternal mortality by 30 percent in assisted countries.
- **Tuberculosis:** Treat a minimum of 2.6 million new sputum smear positive TB cases and 57,200 multi-drug resistant cases of TB by 2014.
- **Malaria:** Reduce the burden of malaria by 50 percent for 450 million people.
- **NTDs:** Reduce the prevalence of 7 NTDs by 50 percent among 70 percent of the population affected by NTDs.
- **Family planning:** Prevent 54 million unintended pregnancies.
- **Nutrition:** Reduce child under-nutrition by 30 percent in food-insecure countries in conjunction with Feed the Future.

Measuring and Reporting Success

Overall, the GHI has set eight high-level targets to achieve by 2015, at the conclusion of the six-year initiative.⁷ In addition, the GHI published a list of seven core principles—including country ownership, health-systems strengthening, and improved monitoring and evaluation (M&E)—to serve as guidelines for overall implementation.⁸ However, the GHI has not defined interim success metrics to help evaluate progress toward those goals; nor has the GHI published *any* interim results on its website. There are a few updates on implementation, but they are generally presented as country-specific “success story”-style press releases and case studies. It

⁴ U.S. Global Health Initiative, “Biographies of Global Health Initiative Officials: Lois Quam, Executive Director, Global Health Initiative,” accessed January 2012, <http://www.ghi.gov/about/leadership/biographies/157459.htm>

⁵ U.S. Global Health Initiative, “GHI Leadership,” accessed January 2012, <http://www.ghi.gov/about/leadership/index.htm>

⁶ Department of State and USAID, *Leading through Civilian Power: The First Quadrennial Diplomacy and Development Review*, 2010, http://www.usaid.gov/qddr/QDDR_FullReportHi.pdf.

⁷ U.S. Global Health Initiative, “GHI Targets,” accessed January 2012, <http://www.ghi.gov/about/goals/index.htm>

⁸ U.S. Global Health Initiative, “Factsheet,” accessed January 2012, <http://www.ghi.gov/newsroom/factsheets/2011/161412.htm>

is nearly impossible for outsiders to evaluate whether the GHI is on track to meet its goals, or even to understand the current status of its on-the-ground implementation.

Funding

In May 2009, President Obama pledged \$63 billion to the GHI over six years.⁹ Seventy percent of the proposed funding was allocated for PEPFAR, with another 11 percent set aside for malaria. All other global health funding under the GHI would total only 19 percent, or \$12 billion.¹⁰ In the current political climate, however, budget austerity threatens to reduce available funding. The final FY2012 allocation for the GHI totaled \$8.3 billion, bringing cumulative funding for the program's first four years (FY2009–2012) to about \$34 billion, or 55 percent of the proposed \$63 billion. To reach that target, budgets for FY2013 and 2014 would need to average \$14.3 billion per year, a 72 percent increase from current funding levels. Funding for the GHI is primarily channeled through the State Department (\$5.5 billion in FY2012), followed by USAID (\$2.6 billion), the Department of Health and Human Services (HHS) (\$1 billion), and a small allocation to the Department of Defense.

GHI Funding FY2009 to FY2012 (Kaiser 2011)

	Total Requested	Total Appropriated
FY2009	\$8.4 billion*	\$8.4 billion
FY2010	\$8.7 billion	\$8.9 billion
FY2011	\$9.6 billion	\$8.9 billion
FY2012	\$9.8 billion	\$8.3 billion**
TOTAL	\$36.5 billion	\$34.3 billion

Source: Kaiser Family Foundation, "Budget Tracker: Status of U.S. Funding for Key Global Health Accounts," Fiscal Years 2010 to 2012, <http://www.kff.org/globalhealth/8045.cfm>.

*Amount unknown. Estimate based on total appropriated.

**2012 estimate is calculated from the 2012 appropriations bill

⁹ Kaiser Family Foundation, "Resources on the U.S. Global Health Initiative," posted October 12, 2011, <http://www.kff.org/globalhealth/Resources-on-the-US-Global-Health-Initiative.cfm?RenderForPrint=1>

¹⁰ Kaiser Family Foundation, "Fact Sheet: The U.S. Global Health Initiative," March 2011, <http://www.kff.org/globalhealth/upload/8116-02.pdf>.

Challenges and Risks

At its launch, the GHI was met with great excitement and showed much promise as a coordinating mechanism to streamline U.S. global health funding and improve aid effectiveness. Thus far, however, the initiative has been plagued by problems with transparency, leadership, coordination, funding, and implementation, leading to deep skepticism both within and outside the U.S. government.

First, from the start there was a notable lack of transparency on the implementation of the GHI, leaving stakeholders both in the U.S. and abroad confused about what, exactly, the GHI was meant to do. For the first year and a half of its existence, the GHI lacked a basic website; even now, there is almost no reporting or publically posted data on progress toward the GHI's specific targets.

Over time the structure has become more complicated, and doubts remain about the feasibility of meaningful interagency coordination given separate funding streams and persistent power struggles between agencies. Currently, the GHI is housed within the State Department under the leadership of Executive Director Lois Quam. USAID should take control of the GHI well before September 2012, but the decision is contingent upon the completion of several benchmarks, many of which appear somewhat arbitrary.¹¹ A nontransparent process for assessing USAID's readiness to assume leadership of the GHI constrains our ability to comment on this issue, but word-of-mouth reports from within the GHI point to interagency infighting, and it remains to be determined whether other agencies will accept USAID leadership. Moreover, PEPFAR, which represents 70 percent of GHI funding, will remain under the aegis of OGAC rather than USAID, calling into question whether USAID will ever exercise meaningful control over the entire initiative.¹²

GHI Principles

- Focus on woman, girls, and gender equality
 - Encourage country ownership and invest in country-led plans
 - Build sustainability through health-systems strengthening
 - Strengthen and leverage key multilateral organizations, global health partnerships and private sector engagement
 - Increase impact through strategic coordination and integration
 - Improve metrics, monitoring, and evaluation
 - Promote research and innovation
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¹¹ Department of State and USAID, Quadrennial Diplomacy and Development..

¹² *ibid.*..

Still, the QDDR initially appeared to settle the leadership question with a compromise solution. Upon closer inspection, however, the QDDR merely punted a strained and difficult discussion until a later date. From one perspective, USAID *should* lead the GHI, as it is best equipped within the U.S. government to promote and deliver development assistance for health, particularly because health also incorporates many other areas of USAID's attention, including nutrition, clean water, sanitation, education, and research and development. Only USAID holds the requisite technical expertise in *health as development*, and taking leadership of the administration's signature initiative would be a key step toward restoring USAID's prestige and position within the government's global health architecture.

Despite these advantages, however, USAID leadership only makes sense if it holds a clear mandate to steer the initiative to success through budgetary, policy, and legal leverage. At the moment, leadership appears to mean something rather different. GHI leadership does not entail budget authority, and it would not grant USAID decision-making authority for other agencies within the GHI's purview. It is also highly unlikely to restructure the current reporting lines within the government, meaning that the heads of other GHI implementing agencies would not report to the USAID Administrator Raj Shah. Essentially, the GHI leader would hold only a vague mandate to "coordinate" the GHI agencies, with the exception of OGAC (see above), which is already coordinating USAID through PEPFAR. In sum, USAID would coordinate activities representing only 30 percent of the GHI's total budget, with no authority over funding allocations, decision-making, or the actions of other agency leaders.

By burdening USAID with eventual responsibility for the GHI's success but with no authority or leverage to make it happen, the QDDR has inadvertently placed USAID and the GHI in an impossible situation. If the State Department reneges on its publically stated plans for leadership transition, it will appear to perceive USAID as ill-equipped to lead. Alternatively, granting USAID nominal "leadership" of the GHI, absent real authority, will push both the agency and initiative to likely failure.

Funding for the initiative also remains uncertain, and the president's pledge of \$63 billion over six years appears unlikely to materialize. If funding remains at FY2012 levels for the following two years, cumulative GHI funding will fall over \$12 billion short of its original target. Realistically, given Washington's current austerity climate, funding is likely to be cut dramatically, critically endangering the GHI's prospects for achieving its six-year targets. Moreover, the funding is channeled through several different streams, making it difficult for agencies to integrate health services across intervention types.

Additional confusion remains over the seven guiding GHI principles. Though they emphasize best practice development ideas such as country ownership, a focus on women and girls, and improved M&E, the GHI has not clearly shown how the application of these principles will affect implementation strategy and translate into more concrete programs. According to reports, the

GHI may establish working groups to help measure the implementation of those principles, but they seem more like guiding concepts and values than areas to demonstrate measurable results.

All of these concerns, however, fall under a larger question: will the GHI succeed? Ultimately, success will be seen on the ground when more children live to adulthood; when the burden of malaria falls throughout Africa; and when treatment saves the lives of millions of men, women, and children suffering from HIV/AIDS. And indeed, the GHI has eight ambitious high-level goals for improving global health by 2015. But with the current lack of interim success metrics and regular, reliable reporting, it's hard to know if the GHI is making any progress toward its targets. And with challenges at every level—funding, coordination, and implementation—the GHI's ultimate success remains an open question.

What Next? Four Bad Options

While these concerns may paint a gloomy picture for the GHI's prospects, there is still time to turn things around. Transparency and strategic reporting would go a long way. We know that implementers supply significant amounts of data to their funding agencies, but none of that information has been made available for public consumption. Likewise, the GHI website still does a poor job of explaining *what the GHI does*, both at the interagency level at home and in-country abroad. To counter these issues, the GHI should release country reports for every GHI country, detailing the programs, funding, and progress in achieving results toward the GHI's high-level benchmarks.

Also, the GHI should compile a single, comprehensive midterm progress report for FY2009 to 2011, discussing implementation and results at the initiative's midpoint. Ad-hoc "success stories" are good but insufficient; this information must be released in a systematic, comprehensive manner.

Most important, the Obama administration needs to quickly clarify its calibrated vision of the GHI, and then clearly articulate that vision to stakeholders. This imperative exists because the GHI was flawed from the beginning, as it was launched without any clear vision about how it could be operationalized under the current U.S. foreign assistance structure, and the administration is now floundering to implement its whole-of-government strategy in reality. Moving forward, the administration should consider the following options, along with their respective trade-offs, constraints, costs, and benefits:

1. **Move PEPFAR to USAID.** This option would make the most sense programmatically by enabling unified leadership, horizontal integration with reproductive health, and other such benefits. Under this scenario, OGAC would remain intact but transition to a sub-agency within USAID. However, OGAC is protected as an independent entity until PEPFAR's authorizing legislation expires in 2013.

2. **Move the GHI to OGAC.** As with option 1, giving OGAC leadership of the GHI would enable integration between PEPFAR and other global health efforts, leveraging PEPFAR's existing platform and OGAC's current mandate for coordination. From a political perspective, however, this option is equally unfeasible; USAID is highly unlikely to relinquish its global health mandate. Moreover, expanding OGAC's mandate would entrench global health fragmentation within the U.S. government, making it even more difficult to dismantle and consolidate at a later date.
3. **Keep the GHI at State.** Under this scenario, the State Department would renege on its highly public QDDR plans to move the GHI to USAID, and would maintain control of the initiative under an executive director. State could realistically serve as a coordination point between the GHI agencies, as it has done thus far. However, global health is not the State Department's area of technical expertise, and this option could become a public-relations nightmare; the State Department would need to protect USAID's reputation by being clear about its rationale for the decision, emphasizing the structural considerations and why it is best for the success of the GHI. However, this option will inevitably damage the administration's efforts to build USAID as the premier U.S. development agency.
4. **Remove PEPFAR from the GHI.** If USAID is to lead the GHI but not PEPFAR, then PEPFAR, operationally, will cease to be a part of the GHI, especially because it has its own reporting line to Congress. In this scenario, the administration would formally remove PEPFAR from the GHI portfolio and eliminate the targets for HIV/AIDS treatment and prevention. USAID would focus its energy on the remaining GHI programs and goals—those which it actually controls—and could be accountable for the corresponding results. However, this course of action would *fundamentally* alter the original intent and design of the GHI to build on PEPFAR's "platform" of interagency collaboration and integration. Forfeiting the opportunity to integrate HIV/AIDS programs with reproductive health efforts, for example, would turn the GHI in to a more "business as usual" health program approach to global health.

Conclusion and a Better Way Forward

That this analysis has largely focused on organizational roadblocks is revealing; to date, on-the-ground developments have taken a backseat to interagency squabbling and power struggles. Amidst all this drama, the GHI has lost touch with the very elements that excited the global health community at its launch: a focus on results, integration at the program level, and a solid foundation of guiding principles. While this analysis has focused on ways to salvage the GHI superstructure, there are, of course, other options. At this critical juncture, the administration might be wise to consider cutting its losses, eliminating the problematic interagency "umbrella,"

and instead implementing a pared-down GHI that honors the original intent while bypassing the organizational constraints discussed in this analysis. GHI 2.0 could take shape as follows:

- **Forget interagency cooperation in Washington (for now).** Eliminate the coordination meetings and the endless debates about leadership; at this point, they are unproductive and distracting. The GHI agencies would continue to manage their own budgets and programs as they did before the GHI's launch. The State Department would maintain an executive director post with a vastly modified mandate. The executive director would be responsible for collecting and aggregating implementation and results data across the implementing agencies, and producing a quarterly report on that data for Secretary Clinton and public distribution. The administration could revisit interagency integration and cooperation when PEPFAR comes up for reauthorization in 2013.
- **Focus on programs and results.** Relieved from the interagency infighting, the agencies could return to their core focus on programs in the field. The agencies should use the GHI principles to inform program design as appropriate; of course, not every program will fall under every principle. And instead of trying to measure amorphous principles, each agency should simply maintain a running list of all its global health programs tagged with the applicable principles. This information would be reported to the executive director on a quarterly basis, alongside results and progress toward the GHI targets.
- **Facilitate in-country coordination.** While the agency leaders seem burdened by high-level cooperation, there would still be opportunities to work together on the ground, at the concrete program level to discuss programming and opportunities for integration.

While the initiative has reached its midpoint and the deadline for the GHI's transition to USAID is fast approaching, the administration still has the opportunity to make some important decisions if it acts quickly. The president's global development legacy is at stake if one of his biggest development initiatives is seen to fail.