

EVALUATION OF THE GLOBAL HEALTH COUNCIL

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ACRONYMS AND FOREIGN TERMS

AIDS	Acquired immune deficiency syndrome
APHA	American Public Health Association
BHR	Bureau for Humanitarian Response
CA	Cooperating agency
CEO	Chief Executive Officer
COO	Chief Operating Officer
CTO	Cognizant Technical Officer
DOTS	Directly observed treatment short course
GHC	Global Health Council
GRIPP	Getting Research into Policy and Practice
HIV	Human immunodeficiency virus
ID	Infectious disease
IR	Intermediate Result
MCH	Maternal and child health
MEDS	Monitoring, Evaluation and Design Support Activity
MSH	Management Sciences for Health
NCIH	National Council for International Health
NGO	Nongovernmental Organization
NIH	National Institutes of Health
NIS/CEE	Newly Independent States/Central Europe
PAHO	Pan American Health Organization
PHN	Population Health and Nutrition (now the Bureau for Global Health)
PPM	Program, Policy and Management
PVC	Private voluntary cooperation
PVO	Private voluntary organization
R&A	Research and Analysis
SO	Strategic Objective
TAACS	Technical Advisors in AIDS, Child Survival, Population, and Basic Education
TB	Tuberculosis
UN	United Nations
USAID	United States Agency for International Development
WHO	World Health Organization

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EXECUTIVE SUMMARY

This midterm evaluation of the USAID cooperative agreement with the Global Health Council assesses the accomplishments of the first three years of a five-year program. The agreement, anticipating total USAID funding of \$6.2 million, was signed in August 1999 only a year after the new GHC was created to replace the National Council for International Health. Based on recommendations from a blue-ribbon committee headed by C. Everett Koop as well as recommendations from a USAID-funded midterm evaluation in 1997, the governance structure of the NCIH (an unwieldy 36-member board of directors) was disbanded and replaced with a smaller 12-member board. A new and more efficient set of bylaws was established. The name of the organization was changed to GHC. A well-known, energetic new CEO was hired, and the staff of the organization was almost totally changed. The Koop report, however, found the existing mission of the NCIH to have continuing validity and did not recommend a major change in most of the major program activities. The new GHC leadership and staff gradually built upon the traditional program structure (an annual conference, monthly newsletter, HIV/AIDS partner support program) and reorganized the GHC's program objectives into three major components, known as the "ABCs" of the GHC:

1. Advocating for global health
2. Building global alliances
3. Communicating best practices

USAID's willingness to sign a five-year agreement with the new GHC was a clear and strong sign of long-term commitment for the organization reform taking place. When the agreement was signed, USAID was the major financial contributor to the newly restructured organization, providing approximately 48 percent of total GHC funds. This proportion has been reduced dramatically over the first three years of the agreement as GHC has successfully solicited funding elsewhere. USAID funding now constitutes only 16 percent of GHC funds.

This midterm evaluation of the agreement, carried out in July/August 2002, was structured to assess the following:

- Progress toward achieving the organizational vision of the GHC
- Progress toward meeting the major outcomes of the USAID cooperative agreement
- The relationships between the GHC and USAID, and the management of this agreement by both parties

Overall, the evaluation concludes that the GHC has made exceptional progress in achieving the first objective and has made good progress in meeting many of the major outcomes of the USAID cooperative agreement. The relationships between the GHC and USAID are much improved since the waning days of the NCIH. Management of the agreement by both GHC and USAID is effective.

PROGRESS TOWARD ACHIEVING THE ORGANIZATIONAL VISION OF THE GHC

Conclusions

The USAID cooperative agreement strongly supported the GHC reorganization, and also set out program management improvement objectives and targets. Progress toward meeting these objectives has been exceptional during the first three years of the cooperative agreement, and GHC has surpassed most benchmarks set for financial independence, improvements in staffing, and improvements in program efficiency.

The new CEO persuaded a prestigious group of senior public health leaders to join the new board of directors. Led initially by a skilled and experienced board chairperson, the board has been instrumental in providing overall direction to the CEO, establishing an organizational vision working with the CEO and staff, establishing appropriate financial procedures, and raising funds to deepen and diversify GHC's financial resource base. GHC objectives of becoming financially solvent and less dependent on any single donor have been met in exemplary fashion. Annual GHC revenues have grown from \$2.4 million in 1999 to \$7.7 million in 2002, with funding provided by a wide variety of well-known foundations. Another welcome source of increased GHC funding has been a 400 percent increase in revenues from membership dues, conference fees, and sales of GHC publications. Excellent financial internal controls have been established by a well-qualified director of finance with the advice of the board treasurer. Annual outside audits have issued no qualifying opinions, nor found any material weaknesses.

The GHC staff has grown commensurate with the growth in GHC revenues (about fourfold). Twenty-five staff members now work in the main office in Vermont and 19 work in a smaller office in Washington, D.C. Overhead rates have increased from 34 percent to 39 percent, but appear to be reasonably managed. A major objective of the Koop report and the USAID agreement was to "professionalize" the GHC staff and to reduce the rapid staff turnover that characterized the NCIH. Progress has been made in establishing a professional cadre at GHC. The CEO and the new director for research and analysis have credentials and reputations that enhance the organization's reputation. A human resources director was hired in February 2002 and the full range of HR-related procedures are now in place (i.e., formalized hiring practices, wage surveys, annual personnel reviews, new hire orientation, and staff training programs). Staff retention has been good, especially in Vermont. However, one senior staff (both well known by USAID counterparts) departed from GHC's Washington office within the past year.

Key Recommendations

Progress in restructuring GHC staff, budget, financial management, and organizational procedures has been outstanding. Only a few recommendations are needed, as follows:

1. Give GHC membership some choice in selecting new board members

The present system of replacing board members via a "set slate" with no options is unusual for a membership organization. The board should consider giving the membership some choice in the selection of new board members, perhaps by presenting a slate of four or five choices to fill the three positions that need to be replaced annually.

2. *Focus on overhead management for the long term*

GHC should carefully consider ways to assure the “core costs” of its operations over the long term. Options include the following:

- Optimize annual revenues from membership, conference fees, and publication sales
- Maintain USAID multiyear support that includes significant funding for core costs
- Solicit similar multiyear support from other donors
- Establish an endowment whose investment returns would provide, along with the first bullet above, funding to cover GHC core costs annually

PROGRESS TOWARD MEETING THE MAJOR OUTCOMES OF THE AGREEMENT

The USAID agreement provides support for GHC’s three primary objectives:

1. Advocating for global health
2. Building global alliances
3. Communicating best practices

USAID support now ranges from 25-80 percent of the total cost of these three objectives. Excellent progress has been made on the goal of decreasing GHC reliance on USAID for overall organization funding. Since the beginning of the cooperative agreement, USAID funding comprised 48 percent of the total GHC budget. In this current year, the USAID funding share is only 16 percent of the total GHC budget due to increased support from private sources. Each year of the cooperative agreement, GHC, along with the USAID Cognizant Technical Officer (CTO), and the five Strategic Objective (SO) team leaders whose SOs contribute funding to the agreement, have developed a detailed work plan. The work plan includes funding for “core costs” for essential GHC functions and for specific activities (e.g., briefings concerning the World Summit for Children, a local-global health forum on Infectious Diseases in New York, a technical report on HIV/AIDS and TB, etc.).

Advocating for Global Health

Conclusions

- *Congressional educational/technical briefings.* These and other contacts with Washington-based decision makers are viewed as valuable and effective. However, both GHC and USAID recognize that improvements can be made to better target issues and more efficiently use congressional staffer time. Public policy updates on Capitol Hill are opportunities for member organizations to meet policy makers; these sessions are well-used and appreciated by GHC member organizations and individuals. USAID’s recent establishment of three new communications officer positions in the Global Health Bureau along with an external communications working group signals USAID’s desire to better organize and manage its own Congressional briefings and to improve its external outreach.

These structural changes may lead to some operational changes in the previously established responsibilities of GHC under the cooperative agreement.

- *Local-global forums.* These have been effective as mechanisms for bringing global health issues to the attention of local media and politicians. The new GHC criteria for selection of forum sites are strategic, but are now more oriented toward influencing the congressional agenda. Indicators of success, other than impact on local congressmen, have not yet been formally defined and routinely measured. Follow-up to these forums appears to be a minor concern and does not occur routinely.
- *Special events.* Most special events have been Washington based and their long-term impact is not clear. The Candlelight Memorial program, by contrast, appears to be well developed with good potential for expansion to meet broad program objectives.

Key Recommendations

1. *Congressional technical briefings and other contacts*

- Continue to assess the effectiveness of these briefings, especially through contacts with the target audience: congressional staffers. Place greater emphasis on staffers-only brown bag lunches, and on avoiding topics that might interest only a few staffers. In planning these briefings, however, GHC and USAID also need to consider their value to the PVO representatives and GHC members who often attend.
- The roles of the new communications officers in the Bureau for Global Health should be carefully defined within the context of a Bureau Communications strategy (now being developed). This strategy should delineate GHC and USAID responsibilities, especially in relation to technical congressional briefings. The strategy should carefully consider the proven advocacy strengths of GHC, its reputation as an independent voice, and its responsibilities in representing its broad membership.

2. *Local-global forums*

- Consider modifying selection criteria to supplement (not replace) the present objectives. The original USAID agreement objective of encouraging local community involvement in global health programs and issues should not be forgotten. GHC should consider linking their forums to ongoing local-global citizen programs (such as Sister Cities, Partners of the Americas state-to-state linkages, Asian-American associations, etc.). The Rotary Foundation's leadership on polio eradication demonstrates that not all global health leadership must emanate from Washington.

3. *Special events*

- GHC should move forward with staff proposals to use the Candlelight Memorial activities as an “anchor point” for other activities. The Candlelight model might be considered for other “Special Day” events, especially as a way to encourage more local

involvement in global health issues. Washington-based special events should be carefully evaluated to determine if they have any significant impact.

Building Global Alliances

Conclusions

- *Building global alliances.* The activities related to this objective are the least well known and understood of its three program objectives.
- *Database and database products.* Progress has been excellent. Most 5-year targets have already been met. The database has been aggressively used to increase GHC visibility and membership.
- The new *Global Partnerships Department* is a positive step toward providing a locus of responsibility and action within GHC, although all departments are involved in the objective of building alliances. The new department appears to be moving slowly with no approved strategy (and perhaps, no clear funding source) after almost a year in existence.
- *Regional forums and pilot affiliate.* These two activities seem to be intertwined. The initial regional forum in India may lead to the development of a regional alliance or a GHC affiliate (or perhaps both, eventually). Little progress has been made in meeting either objective. Some regional fora will be organized through the Global Partnerships program, while others will be organized by other departments, including Research and Analysis.
- *Specialty health networks.* The two networks fostered by GHC have been effective and are excellent models. GHC does not appear to have an organizational locus for fostering additional specialty networks.
- *Small Grants Fund.* This program was a logical addition to NCIH's successful HIV/AIDS partnership program. Unfortunately, the small grants program was cancelled due to political concerns prior to any formal evaluation of the program's impact. GHC does not plan to try to reinstitute a small grants program with USAID funds in the future due to its apparent political sensitivity.

Key Recommendations

1. Organizational priorities and responsibilities

- Clarify the organizational priorities and responsibilities for the regional forum, pilot affiliate, and specialty health network activities. The first two areas appear to fall under the Global Partnerships Department, but the third may be homeless.

2. Global Partnerships Department

- The GHC should consider moving the Global Partnerships Department to the GHC Washington office. Daily networking and close personal contacts with a wide range of health professionals are probably needed for program success.
- Place a higher priority on finalizing the Global Partnerships Department strategy and objectives. The new target of holding 10 regional forums over the next 2 years is optimistic. This period might best be used to test and evaluate models for regional forums, and assessing whether GHC has a long-term role in fostering such alliances.

3. *Establishing a pilot affiliate*

- GHC should carefully review the experiences of U.S.-based environmental PVOs that have had almost a decade of experience with affiliate or partner organizations in the developing world. GHC’s decision to go slow on any decision to establish a pilot affiliate seems appropriate, given the fledgling status of GHC itself.

4. *Specialty health networks*

- Clearly identify the GHC organizational focus for these activities. Over the next two years, determine GHC’s long-term roles in fostering specialty health networks in the United States or globally. Possible roles include: a) host organization; b) “good offices” facilitator but not a host; c) funding source for start-up; and d) technical resource base.
- Consider fostering health networks as a follow-up to annual conference themes, if needed (e.g., Health in Times of Crisis network, Environmental Health network).

5. *Small Grants Fund*

- USAID should decide if termination of the GHC Small Grants Fund leaves a gap that needs to be filled in its overall HIV/AIDS portfolio by another CA. One valuable and noncontroversial element of this program was the provision of funding to allow developing country NGO leaders to attend international and regional conferences. This is similar to USAID’s traditional “invitational travel grant” program. This program is normally viewed as a “participant training” rather than a “small grant” program and would appear to be appropriate for CA management in the future.

Communicating Best Practices

Conclusions

- *Publications and Web portal.* Excellent progress has been made in improving and expanding GHC’s traditional communication functions under this objective (HealthLink, AIDSLink, Web portal). Most five-year targets have been met or will be met by the end of the agreement.

- *Research and Analysis Department.* Establishment of new in-house technical capacity was delayed until the arrival of a qualified director in the summer of 2001. Since then, rapid progress has been made in meeting most agreement objectives. At this time, the Research and Analysis Department includes only one credentialed public health professional. The GHC decision to use the Cochrane Collaboration to do synthesis research seems to be an inspired choice, as it provides the Council with access to a talented research community and limits the need for the GHC to hire its own senior technical staff.
- *Advisory committees.* Two years ago, when membership interest in participating on advisory committees was low, GHC found an excellent alternative in the Cochrane Collaboration to produce synthesis research. The advisory committee approach illustrated in the GHC grant proposal to USAID in 1999 would probably have been difficult to implement, if it had been tested.
- *Annual conference.* GHC has done an outstanding job in improving the content and attendance at their annual conference. International participation has increased dramatically. GHC has successfully used topical themes to encourage attendance by individuals that have not previously considered attending (refugee organizations, mental health, etc.) while at the same time maintaining its traditional attendee base. GHC conference organization and planning has been extremely professional and effective.
- *Research publications.* The Evidence for Action series is off to a good start, but is not yet well known among senior global health professionals. The first GHC Technical Report shows promise, but may not be much different in content and style than publications already available from USAID CAs and international organizations.
- *Technical workshops.* The new GRIPP workshop series seems well targeted (and well named). No information is available on the impact of GHC's traditional technical workshops, based in Washington and co-sponsored by Management Sciences for Health (MSH) and Pan American Health Organization (PAHO).

Key Recommendations

1. *Research and Analysis Department*

- This department is producing valuable, high-quality reports with relevance to global health practitioners throughout the world. The next step is to make the department director and these publications better known throughout the global health community.

2. *Advisory committees*

- Now that GHC is well re-established as a membership organization, it should identify ways to involve its membership in council activities. Advisory committees are a traditional mode of membership participation. Membership participation encourages ownership and fealty, but more importantly, it expands the strength of an organization by providing volunteer talent and labor. Examples of involvement used by other membership

organizations include: 1) ad-hoc membership on board subcommittees (e.g., finance subcommittee, fundraising subcommittee); 2) program advisory committees to provide guidance on policy issues; 3) participation in evaluations of program components; and 4) regional program committees (e.g., the GHC branch of Northern California or Chicago could develop and host their own local functions).

3. *Research publications*

- GHC should place a high priority on “listening” to the reaction to its new publications over the next year. A variety of modes of obtaining feedback are desirable, but the key objective should be to calibrate the niche(s) for the Evidence for Action and Technical Reports series.

4. *Technical workshops*

- The GRIPP (Getting Research into Policy and Practice) workshops can be valuable only if they reach their targeted policy-maker audience and provide useable content for policy makers. GHC should review existing locations where members of their target audience — developing country health policy makers — already gather for training courses and workshops and should seek to add the GRIPP content to those venues. Examples are The World Bank Institute’s health policy training program and similar training programs run by USAID CAs, PAHO, and WHO. GHC. The GRIPP workshop materials might also be linked electronically to the Web sites of these well-known programs.

RELATIONSHIPS BETWEEN THE GHC AND USAID, AND THE MANAGEMENT OF THIS AGREEMENT BY BOTH PARTIES

Relationships

GHC and USAID believe that the two organizations share similar missions and issue focus, producing a strong synergy. Senior USAID officials, GHC board members, GHC leadership and staff, and knowledgeable informants all indicate their support for this continuing relationship. Senior USAID officials are pleased with the results of the past three years: clear, visible leadership at the Council helm; a prestigious and influential board of directors; stronger and more permanent staff; organizational reforms; and less financial dependence on any one funding source. Some observers say GHC is indispensable to the USAID mission.

However, some problems existed in the relationship during the agreement period, mainly due to congressional sensitivity and the nature of GHC’s advocacy functions. While some congressional office critics have argued that GHC has at times been too political, some PVOs and member organizations argue that GHC is “too politically correct”. Most observers, however, congratulate the Council, and especially its CEO, on being unusually sensitive to these concerns and navigating a non-partisan but activist course that has generally drawn praise from both sides.

Management of the Agreement

Although there are modest problems, in general this relatively small, but complex USAID grant has been well managed by both USAID and GHC. This report provides a few recommendations with an eye to obtaining some additional efficiencies.

I. INTRODUCTION

BACKGROUND

The objective of this midterm evaluation is to assess the accomplishments to date of the USAID cooperative agreement, HRN-A-00-99-00018-03, to the Global Health Council (GHC). The program has a five-year commitment from USAID, from August 1, 1999 to July 31, 2004. The review period is from August 1999 to August 2002.

The GHC, formerly the National Council for International Health (NCIH), is a 30-year-old not-for-profit membership organization. Through its multidisciplinary and cross-cultural board of directors, staff, and membership, the Council works with PVOs/NGOs, government agencies, and corporations, and individuals to engage national and international decision-makers on policies and practices that promote global health. The Council facilitates opportunities for members to establish linkages with organizations and individuals working in developing countries and in related fields, and offers programs to enhance their professional and scientific skills. The organization is a convener and an information clearinghouse on global health issues.

GHC activities are intended to increase public and private awareness of programs that address the Council's top policy priorities, and to improve the focus, effectiveness, and impact of these programs through shared application of best practices. The Council utilizes state-of-the-art communications technology as well as more traditional forums to provide members with ready access to usable technical information, shared experience, and tools for effective action central to improving global health.

The purpose of the USAID cooperative agreement is to support the overall objectives of the Global Health Council with specific support for information and capacity-building activities.

The Global Health Council promotes three key aspects of global health:

- Education and outreach for increased attention on health issues of global importance
- Building coalitions between members
- Communicating best practices in the fight against global health concerns

In its proposal to USAID in 1999, the Council outlined the following vision and objectives:

By 2004 the Council will become:

- An organization noted for its positive influence on global health and development policies, priorities, and resource allocations
- The principal networking organization for global health practitioners and activists
- A leading nongovernmental source of accurate and understandable information on key global health issues readily accessible to the public

- The first place practitioners turn for getting and sharing information on what works best for improving global health.

METHODOLOGY

A consultant was engaged to assess progress toward meeting the stated program objectives of the USAID cooperative agreement and GHC progress in achieving its organizational vision. The scope of work is found in Appendix A.

The consultant first conducted a thorough review of GHC and USAID documents and publications related to the three years of this program. A list of documents and publications is included in Appendix F. As background for in-depth interviews, GHC staff was asked to prepare written responses to each key question in the SOW and to list progress toward achieving program targets. These answers are provided as Appendix B. The consultant interviewed the USAID CTO, the USAID SO team leaders, and other knowledgeable USAID staff. In-depth interviews were then conducted with the GHC CEO and GHC staff located in the Washington office, followed by interviews with GHC/Vermont staff at their retreat site and the GHC main office in White River Junction, Vermont. Each interview took approximately 90 minutes and was organized around a list of questions prepared by the consultant.

Telephone interviews were conducted with four GHC board members and with a variety of knowledgeable public health professionals who work with international agencies, donor organizations, U.S.-based private volunteer agencies, and consulting firms. A list of questions was prepared for each telephone interview. Persons interviewed are listed in Appendix E.

The limited nature of this consultancy did not leave time for GHC members to provide feedback on their satisfaction with GHC activities and services. However, the consultant was able to glean information provided from responses to a questionnaire sent to a large sample of GHC members in February, 2002 by the Research and Analysis Department, as well as use the results of two focus groups meetings conducted May 29, 2001 at the GHC annual conference by GHC's polling firm, Lake, Snell and Perry.

A draft report was prepared and submitted to GHC and USAID for comments on August 15. Comments were provided in September and October and were carefully considered in finalizing this report in late October 2002.

This report is organized into three key parts. Section II assesses progress toward restructuring of the GHC organization, with a review of: 1) board structure and operations, 2) financial management and financial sustainability, and 3) staffing, administrative structure and controls.

Next, Section III reviews progress in achieving the specific "outcomes" of the USAID agreement. These outcomes include almost all GHC program activities (only a few GHC activities do not receive USAID support and are fully funded from foundation or other donor grants). A total of 13 program activities are assessed and discussed, organized under the three main program objectives (the "ABCs") of the GHC: Advocating for Global Health, Building Global Alliances and Communicating Best Practices.

The third major part, Section IV, reviews the relationship between the GHC and USAID and assesses both USAID and GHC management of the agreement.

Each section also presents conclusions and recommendations.

DESCRIPTION OF THE COOPERATIVE AGREEMENT

The USAID cooperative agreement with GHC, dated August 3, 1999, was the result of an unsolicited proposal submitted by the GHC in June of that year. The proposal was fully funded at a total of \$6,200,000 over five years. Of this, \$950,000 was obligated at the time the new agreement was signed. The level of “substantial involvement” by the USAID CTO consisted of: 1) approval of an annual work plan describing the specific activities to be carried out each year; 2) regular technical and policy consultation including GHC provision to the CTO of a brief synopsis or abstract of technical papers, including their policy recommendations, prior to their wider publication or distribution; and 3) approval of key personnel. GHC was not required to make a financial match to the USAID funding, but volunteered to contribute at least 25 percent of all membership and other fees collected during the agreement period to support USAID-funded activities. The “program description” in the agreement consisted of the GHC proposal. A full (midterm) evaluation of agreement activities was proposed after 24-30 months of operations.

The GHC proposal described the objectives of the newly constituted Global Health Council that had undergone a dramatic revitalization since June 1998. This revitalization flowed from the recommendations of a commission headed by Dr. C. Everett Koop in late 1997 and a critical USAID-sponsored midterm evaluation published in July 1997 of the previous USAID cooperative agreement with the National Council for International Health. As a result, the governance structure of the NCIH was disbanded, the name changed to GHC, a new CEO hired, a new smaller board of directors named, and a new and more efficient set of bylaws established. The Koop report, however, found the existing mission of the NCIH to have continuing validity and did not recommend a major change in most of the major program activities. The new GHC leadership and staff gradually built upon the traditional program structure (an annual conference, monthly newsletter, HIV/AIDS partner support program) and reorganized the GHC’s program objectives into three major components, the “ABCs” of the GHC: Advocating for Global Health, Building Global Alliances, and Communicating Best Practices. At the time of the agreement, USAID was the major financial contributor to the newly restructured organization and the USAID agreement provided approximately 80 percent of total GHC funds in the first year of the grant. Thus, USAID funds were needed to finance almost all GHC program activities. This proportion has been reduced dramatically over the first three years of the agreement as GHC has successfully solicited funding from other sources.

The objectives of the GHC proposal, as stated in the proposal, are the following: “to support the Global Health Council mission as summarized in the term *Promoting the ABCs of Global Health*:

- Advocating for global health
- Building global alliances
- Communicating best practices

Each of these elements is carried out in partnership with and in support of services for our members.”

The Council’s priorities mirror USAID’s strategic objectives, and aim to support efforts directed toward reducing the following:

- Child mortality and improving child health and nutrition
- Maternal mortality and improving women’s health and nutrition
- Unintended pregnancies
- The risk, spread, and consequences of HIV/AIDS and other sexually transmitted infections
- The risk and spread of infectious diseases

In addition, the Council advocates for programs directed toward emerging threats to global health.

The Council’s key areas of institutional focus are to inform and educate the American public, practitioners, and political and technical decision-makers engaged in delivering health and population programs around the world, and to serve as a leading forum for the exchange of information on best practices and access to technical training assistance and information.

The Council is the principal umbrella organization for a wide range of nongovernmental and private sector institutions and individuals engaged in the global delivery of essential health services. In this context, it plays a unique coordinating, facilitating, convening, and informational role. The Council’s advocacy and technical outreach is founded on our established strengths: creating public awareness through the media and highly visible events; and organizing and leveraging global health experts to provide education and programmatic information to policymakers.

As a membership association made up of thousands of individuals, institutions, organizations, and private companies working around the world in health promotion, disease prevention, health care services, research, and policy, the Council is in a position to magnify significantly its members’ impact in promoting better health for all.

The proposed activities, along with the Council’s dedication to expanding global participation and public/private partnerships, address a critical need to broaden the constituency for global health and population programs.

The GHC proposal included a description of program components, program activities, and program outcomes. Progress toward meeting these five-year outcomes (indicators of success) are discussed in the text of this report, and are also placed in their entirety in Appendix B.

Finally, the GHC proposal included a detailed discussion of the GHC’s new internal control system, including the functions of the newly appointed GHC financial director.

II. PROGRESS TOWARD ACHIEVING THE ORGANIZATIONAL VISION OF THE GHC

ORGANIZATIONAL VISION

This USAID cooperative agreement was signed in August 1999, less than one year after the Global Health Council had undertaken an organizational revolution with a major reorganization of its board structure and board membership, leadership, and operating structure, finally even moving its home office to a new region of the country. GHC's predecessor organization, the National Council on International Health (NCIH), was essentially dismantled and replaced by a new organization that resembled the NCIH only in portions of its vision and mandate. The Koop report that strongly recommended the organizational metamorphosis stated that the "overall goals and purpose" of NCIH were still valid. The Koop report recommended three major changes: 1) a new governance structure with a smaller board of directors and new bylaws; 2) a new mission statement; and 3) a complete overhaul of the operations of the organization to improve organization efficiency and effectiveness.

The USAID cooperative agreement strongly supported this major reorganization and included program management improvement objectives and targets. USAID shared the GHC goals of a vibrant, well-managed, and financially sustainable organization. Progress toward meeting these objectives has been exceptional during the first three years of the cooperative agreement; GHC has surpassed most benchmarks set for financial independence, improvements in staffing, and improvements in program efficiency.

BOARD STRUCTURE AND OPERATIONS

The last act of the old NCIH board to abolish itself. The NCIH board had been made up of an unwieldy 35 members who tended to represent specific interest groups. Following the recommendations of the Koop report, the new GHC board is limited to 12 members who are selected based on their personal attributes and their interest in supporting the objectives of the GHC. The new GHC chief executive officer convinced a prestigious group of senior public health leaders to join the new board (board members and their terms are found in Appendix H). A recently retired pharmaceutical company executive, with extensive board experience, agreed to become the first GHC board chairperson. Her energy, knowledge of how effective boards function, and skills in working with the CEO and board members were instrumental in quickly establishing what board members describe as unusually efficient board operations and an excellent working relationship with the CEO and the GHC senior staff.

The board meets formally four times per year and is represented between board meetings by an Executive Committee that handles urgent matters (e.g., approval of major capital purchases). The board members established an organizational vision for GHC working closely with the CEO and staff. The board approves the GHC annual program and the annual budget, approves major expenditures, plays a major role in fundraising, and assists in problem-solving when needed. The CEO, the new COO, and the board are all comfortable with the delegations of authority provided by the board to the GHC leadership. One example of board leadership was a recommendation in

2000 that an outside management review be carried out for the GHC. The recommendations of that review in August 2000 led to, inter alia, the establishment of new COO and grants manager positions. The GHC board members are volunteers and pay their own expenses when attending board meetings and functions.

The board has two subcommittees. The Finance subcommittee has not been activated but its functions have been carried out by the former treasurer and now vice president of the board. The board member selection subcommittee has been active. Because all 12 board members started together on the new board in 1999, they have now agreed to individually staggered terms so that board succession will be gradual and not precipitous. The bylaws state that members may serve for two consecutive three-year terms. At present the subcommittee and the CEO informally gather recommendations for new board members and then place a single slate (three recommendations for three positions) before the membership for their approving vote.

Board members and the CEO indicate that they are working toward a more varied board composition. They have discussed the need for more NGO representation on the board (possibly difficult due to the costs of attending meetings and the burden of fundraising); and more international representation (constrained by the costs of international travel to four board meetings each year).

FINANCIAL MANAGEMENT AND FINANCIAL SUSTAINABILITY

Revenue Base and Fundraising

At the time of the demise of NCIH and its replacement by the GHC, the organization's bank accounts were almost exhausted. GHC objectives were to make the organization both financially solvent and less financially dependent on any single donor.

Both of these objectives have been met in extraordinary fashion. The annual revenues of the GHC have now grown from approximately \$2.4 in 1999 to more than \$6.3 million in FY2001 and revenues are projected at \$7.7 million in FY2002. Approximately \$2 million in GHC assets are now kept in a contingency fund, earning additional interest. The sources of revenue from FY1997-2003 are detailed in Annex D-2.

At the time of the USAID agreement in 1999, USAID funds represented approximately 48 percent of total GHC revenues. Presently the USAID funding constitutes only about 16 percent of total projected 2002 revenues. One major change has been a dramatic increase in foundation grants to GHC. These grants have been provided by a wide variety of well-known foundations (Gates, Packard, Hewlett MacArthur, Rockefeller, Dreyfus, Soros Open Society Institute). Except for one large multiyear Gates grant for organizational support (\$4.8 million) and another multiyear Gates grant to fund the Gates Global Health Award, these foundation grants are programmatic in purpose and modest in size (8 under \$750,000). Other recent sources of funding are annual CDC funding for annual conference scholarships and a small PAHO grant.

Another welcome source of increased GHC funding has been from membership dues, conference revenues, and the sales of GHC publications. These revenues have increased about 400 percent

since FY98 to approximately \$1.3 million in FY01 and now constitute approximately 15 percent of the vastly increased GHC annual budget — a laudable improvement.

GHC does not have a fundraising plan, unlike some NGOs, but has obviously been unusually successful in soliciting support. A new director of philanthropy and marketing, starting work in September 2002, will be responsible for developing a longer-term fundraising plan that will be needed to even out the peaks and valleys of the present revenue flows.

FINANCIAL MANAGEMENT AND CONTROLS

The GHC grant proposal to USAID in 1999 detailed the objectives of a strengthened GHC internal control system and the responsibilities of a new business manager/controller. These objectives are being met. Financial records and reports are available to document expenditures under the USAID-funded program. Excellent financial internal controls have been established for the GHC with the advice of the board treasurer. The director of finance works with four staff. A procurement policy has been established with multiple bids required for any purchases over \$5,000. An appropriate expenditure approval system is used, with two signatures required for all purchases over \$15,000. Outside audits carried out annually by Goodman and Company have issued no qualifying opinions, nor found any material weaknesses. GHC is categorized as a “low-risk audit” organization.

BUDGETING

GHC is moving to a new Activity-Based Budgeting system for FY03 using the principles of Strategic Activity Costing. In addition, new project accounts software (with a Grants Management Module) should become operational in both offices in the next few months. GHC staff charge their time to various sources of funding based on budget estimates developed by the financial manager. They do not presently record their time based on actual time; a staffer works on each grant.

The GHC overhead rate has increased from 34 percent at the time of the grant to 39 percent in FY02. Increased overhead costs are largely due to large staff increases (from 8 staff in 1998 to 44 in August 2002). GHC believes that the costs of maintaining two offices (in White River Junction, Vermont and in Washington, D.C.) have not raised organizational costs, due to lower office space costs in Vermont (GHC office space rents in Vermont for 30 percent of the square footage rate for their modest office in Washington, D.C.) and due to lower salary costs in Vermont.

STAFFING, ADMINISTRATIVE STRUCTURE, AND CONTROLS

A major objective of the Koop report and the USAID agreement was to “professionalize” the GHC staff and to reduce the rapid staff turnover that characterized the NCIH.

Progress has been made in establishing a professional cadre at GHC. The CEO is a well-known, highly respected MD/MPH and public health professional whose technical knowledge and professional balance have been instrumental in rapidly improving the reputation of the GHC.

However, the number of additional professional staff with public health credentials is still limited. The new director of research and analysis is highly credentialed (see below). Of other key staff, only the directors of the Global Partnership and Government Relations departments hold public health (MPH) degrees. The new COO has worked as the director of planning for a major medical school and holds a MBA degree.

The new Research and Analysis Department, meant to be the locus of GHC's technical staff, was established only in July 2001, with the delayed arrival of its new director, a public health research specialist from South Africa who holds MD, MPH, PhD degrees. The R&A Department presently also includes a senior analyst and two project associates and is recruiting for a policy analyst. At present, none of these staff holds public health degrees, although the senior analyst has a great deal of practical experience with the GHC and an excellent reputation with professional counterparts. Because of its collaboration with the Cochrane Collaboration (see Section III, Establishment of a Technical Department), the R&A Department may not need to hire a stable of senior health professionals to prepare the technical summaries and "lessons learned" documents outlined in the USAID agreement. GHC may also be able to make increased use of membership talent and skills to help achieve the department's objectives.

GHC has made major advances in professionalizing its overall approach to staff hiring and retention. In February 2002, a human resources director was hired. Formalized recruitment and hiring practices have been established. Salary levels are based on wage surveys carried out periodically in both GHC locations and are viewed as competitive but not overly generous. New hire orientation programs and staff training programs are in place. GHC has adopted the "Society for Organizational Learning" management philosophy, with support provided by the Society with Packard Foundation funding.

Staff retention has been good, although one experienced staff departed from GHC's Washington office within the past 18 months. The well-known director of public policy was replaced by her deputy. The equally well-known senior HIV/AIDS program officer departed at the end of CY 2000 and, after an international search, will be replaced in September 2002. The Vermont office staff has been stable. GHC's major effort to find excellent candidates for the expanding organization is now coming to completion with the hiring of a senior HIV/AIDS policy advisor and the director for philanthropy and marketing in September 2002, the hiring of the COO, and R&A director in 2001, and recent internal promotions of existing staff to be directors of the Government Relations and Global Partnerships Initiatives departments.

CONCLUSION AND RECOMMENDATIONS

Progress in restructuring the GHC's staff, budget, financial management, and organizational procedures has been so rapid, and so well done that few major recommendations are needed.

1. Give members some choice in selecting new board members

The present system of replacing board members via a “set slate” with no options is unusual for a membership organization. There was good reason for the new CEO to carefully solicit prestigious board members for the new organization in 1997. The initial GHC board was well chosen and has been active in supporting the new organization with their knowledge, volunteer time, and fundraising skills. However, some members state that the present system smacks of an “old boy” system. Specialists in board operations and management would not recommend returning to the old NICH representation model of board selection. However, it seems appropriate for the board to consider giving the membership some choice in the selection of new board members, perhaps by presenting a slate of four or five choices to fill the three positions that need to be replaced annually.

2. Focus on overhead management for the long-term

GHC has increased staff size threefold (NCIH staff size normally numbered about 15 prior to budget cutbacks that reduced it to 8 in 1997) and budget expenditures almost fivefold over the past four years. Audited overhead rates have increased from 34 percent to 39 percent, even though most new positions have been “program funded.” While each new staff position appears to be needed to further strengthen. GHC’s program and management capabilities, it seems likely that GHC’s core staff has reached its cruising altitude, at least for the foreseeable future. Many new positions are funded from the Gates three-year organizational support grant with a completion date of August, 2003. Foundation funding is notoriously ephemeral and revenue levels may be difficult to sustain or increase over a five-year or 10-year planning horizon.

GHC should carefully consider finding ways to assure the “core costs” of its operations over the long-term. Options include: a) optimizing annual revenues from membership, conference fees, and publication sales; b) maintaining USAID multiyear support that includes significant funding for core costs; c) soliciting similar multiyear support from other donors; and d) establishing an endowment whose investment returns would provide, along with (a) above, funding to cover GHC core costs annually.

III. PROGRESS TOWARD MEETING THE MAJOR OUTCOMES OF THE AGREEMENT

The USAID agreement provides support for GHC's three primary objectives:

1. Advocating for global health
2. Building global alliances
3. Communicating best practices

Many activities under these objectives are supported with funding from other donors and, when needed, with non-restricted funding provided from GHC membership and conference revenues. USAID support ranges from 25 percent to 100 percent of the total cost of these objectives. The percentage of USAID funding in 2002 for each program activity varies from 98.7 percent for the AIDSLINK periodical to less than 1 percent for the Evidence for Action reports and 0 percent for GHC Web site operations (see Annex C for all USAID funding percentages). Each year of the cooperative agreement, a detailed work plan has been developed by GHC, the USAID CTO and the five SO team leaders whose SOs contribute funding to the agreement. The work plan includes funding for "core costs" needed for essential GHC functions and for specific activities for the year (e.g., series of briefings concerning the World Summit for Children, local-global health forum on Infectious Diseases in New York, regional forum on HIV/AIDS in Thailand, technical report on HIV/AIDS and TB, etc.).

ADVOCATING FOR GLOBAL HEALTH

This strategic topic includes three major programs: a) congressional education/technical briefings; b) local-global health forums and c) special events. The GHC proposal stated that a global approach is needed to erase the borders between national and international health. For GHC, advocacy "entails winning the support of key policy-makers in order to influence policies and funding, and to bring about social change. The Council believes that its strength as an effective advocate lies in its ability to reach influential policy makers through its member coalition partnership, grassroots network, the media and individual member experts."

Congressional Education/Technical Briefings

During its first three years the new GHC placed a high priority on educating congressional members and staffers on the need for increasing funding for global health as a whole as well as funding for a variety of global health needs. USAID and other Washington-area sources report that the GHC has been highly visible in successfully encouraging a doubling of USG funding for global health (a GHC target), and in expanding opportunities for discussing these issues in Congress. Thirty-five congressional briefings have been completed with three more planned during FY02 (the 5-year agreement target is 30). While it is difficult to attribute the increased USG funding for global health to the work of the Council or to a specific influence, knowledgeable informants believe there is now a much better understanding of global health on both sides of the congressional aisle, members and staff are "better educated," and "sniping" is being reduced.

A typical 90-minute lunchtime briefing is held in a congressional meeting room. The briefing is attended by 10-20 congressional staff. NGO representatives and USAID staff are invited and their presence often raises total attendance to 60-80 people. Education/technical briefings that have been funded by USAID (normally 50 percent of donor support) are listed in the box below .

USAID Congressional Educational/Technical Briefings

1999 Congressional Technical Briefings

Mar 24	HIV/AIDS and China
Apr 22	A Continent in Crisis: AIDS in Africa
May 12	The AIDS Pandemic: A Global Update
Jul 20	Americans' Attitudes Toward Infectious Disease
Aug 3	Americans' Attitudes Toward Infectious Disease
Aug 13	Border Health Issues
Nov 3	The Fight Against AIDS in Africa: Regional Perspectives
Nov 16	WHO's "Roll Back Malaria" Campaign

2000 Congressional Technical Briefings

April 6	Why Family Planning Matters: Promoting Women's Roles, Saving Women's Lives
April 12	Polio Eradication: The Opportunity of a Lifetime
May 3	Infectious Disease and National Security: Making the Case for Global Health Research
May 24	Trafficking: Health and Human Rights
June 7	The Impact of AIDS on India
June 12	White Ribbon Alliance: Highlights from an Awareness Campaign
July 26	Confronting the AIDS Crisis: Moving Forward from Durban 2000
Aug 23	Nations in Crisis: Women's Reproductive Health Suffers
Sept 12	Generations in Peril: Children Affected by AIDS
Nov 16	Female Genital Mutilation: a Woman's Choice?

2001 Congressional Briefings

Feb 27	How US Development Programs Work
March 8	Family Planning and HIV/AIDS: Interventions That Work
March 21	The Forgotten Killers of Children – Global Infectious Diseases
April 25	Fortifying Our Children
May 23	Safe Motherhood: Helping Mothers Survive Childbirth
June 14	Protecting the Next Generation: Saving the Lives of Newborns
June 19	HIV/AIDS in the Caribbean
July 11	Feeding the World's Children
Sept 26	Leading the Way: USAID Responds to HIV/AIDS
Nov 8	The State of Humanitarian Aid in Afghanistan: Stories from the Frontlines

2002 Congressional Briefings

Jan 30	Health As a Bridge to Peace
Feb 26	The Faith-Based Community Responds to HIV/AIDS
March 5	Brown Bag: The Economic Impact of AIDS on Africa
March 6	Global Women's Health: What Works? What is on the Horizon?
April 11	A Healthy Start in Life: Looking Forward to the UN Special Session on Children
April 18	Brown Bag: Children Affected by AIDS. What Must be Done?
May 8	Responding to Children Affected by AIDS
May 13	Malaria's Attack on Mothers and Children
May 24	Brown Bag: Safe Motherhood in Afghanistan
June 4	Brown Bag: What is HIV/AIDS Care? How is USAID Supporting Care and Treatment Programs?
June 13	The Emerging Threat: HIV/AIDS and TB in Russia and Central Asia
June 19	HIV/AIDS in Latin and Central America
June 24	The United Nations Special Session on Children: What Progress Will We Make in the Coming Decade?
July 17	Brown Bag: The Faith-Based Community and Family Planning
July 24	Confronting AIDS in 2002: Moving Forward from the XIV International AIDS Conference
July 29	Public Health without Information: Why Bother?
Sept 5	Improving Children's Health: The Role of U.S. Research
Sept 10	Securing the Future for Adolescents and Youth

USAID-funded topics are identified each year in the annual work plan process. The GHC tries to maintain a balance in the variety of topics it covers and to reach across potentially divisive issues, for example, linking child health and the health of mothers, family planning, and child survival, reproductive health, and HIV/AIDS. Speakers are normally chosen by GHC and the sponsoring SO team leader, and they have often included senior USAID technical specialists.

Firm indicators of success to identify and measure are difficult for educational events such as these and opinions are mixed. Senior USAID staff have been pleased with the sessions they have attended, but SO team members report that some briefings have been sparsely attended and congressional staffers don't remain throughout the briefings.

GHC carefully monitors congressional reaction to these briefings. In response to comments by USAID and congressional staff, GHC has recently developed a second format for briefings — brownbag luncheon briefings for congressional staff only. These staff-only briefings have been successful in attracting larger numbers of staffers and in providing a forum where staff are more willing to discuss the issues presented since they feel they may not be heard and quoted by outside attendees.

Overall, senior public health professionals agree that GHC is increasingly seen as a source of reliable and accessible information on global health issues. GHC reports that it is increasingly contacted by congressional offices and the media to provide information on global health issues. Readers of mainline press (NY Times, Washington Post, Los Angeles Times) have come to expect a quote from GHC CEO Nils Daulaire in any breaking article on global health policy and funding.

USAID has recently hired communications officers for three offices in the Bureau for Global Health (HIV/AIDS, Population and Health) and their responsibilities include organizing briefings and providing technical information to the Congress. A recent Bureau effort to develop a cross-cutting communication strategy is timely and should clearly include a clear division of responsibilities between USAID and the GHC for congressional technical briefings.

Local-Global Health Forums

These forums were initiated in 1999 as a new element of the Council's advocacy strategy. Initially they were meant to be conducted in strategically selected locations around the United States with the objective of significantly expanding the engagement of the public and influential members of their communities in global health issues. The forums were meant "to educate and engage a new generation of global health constituencies, ranging from local community activists to academic institutions and youth groups, business organizations and the media". These multi-disciplinary education seminars focus on key global health issues and interventions at the local and global levels and increase awareness of the interconnectedness of the local and global issues.

To date the GHC has conducted eight Local-Global Forums. USAID funding has been used for four of these events constituting 25 percent of donor support. Other sponsors include the Gates Foundation, Robert Wood Johnson Foundation, and Rockefeller Foundation. The USAID-funded fora were conducted in the first year of the agreement in New York, Massachusetts, California

Local-Global Selection Criteria

1. Is there a public health problem local communities can relate to?
2. Would a presence in the area help to further the Council's education and outreach efforts among key policy makers?
3. Is there potential for gaining media attention/is the media market large enough to garner significant audience?
4. Does our database reveal a good proportion of prospective attendees and participants?
5. Do we have high-profile individual or organizational members with whom we can partner to organize an event of the highest quality and visibility?
6. Is there potential for building strong alliances based on the Council's current education and outreach agenda?

and Washington, D.C ; all focused on infectious diseases/HIV or maternal/child health. GHC then reassessed the site selection process and, using new selection criteria (see box at left) has held four additional forums in Illinois, Arizona Washington (Seattle) and Florida. A ninth forum will be held in Portland, Oregon in August, 2002 (see box below).

Although most fora have been half-day or day-long events, a new model of a luncheon forum setting will be tested in Oregon. Each forum is carried out in partnership with local co-sponsors from the public, private, or NGO sectors. For example, the Oregon forum "Building Strategic Alliances for Better Health: Public Private Partnerships At Work in Your Community" will address child immunization, in partnership with the Oregon Partnership to Immunize Children. Another example of local partnerships was the Arizona forum where the Intertribal Council of Arizona, Johns Hopkins Center for American Native and Alaskan Native Health, the U.N. Association of Southern Arizona and the US Coalition for Child Survival were co-sponsors along with GHC and its funding entities.

Local-Global Health Forums

- March 3, 2000, San Diego, CA*
U.S. & Mexico: Together Against TB in the 21st Century (USAID funded)
- May 11, 2000, Washington, DC*
Mothers Matter: Maternal and Newborn Health Challenges Across Borders (USAID funded)
- October 24, 2000, New York City, NY*
Our Shrinking World: Global Infectious Diseases in Our Neighborhood (USAID funded)
- November 30, 2000, Boston, MA*
World AIDS Day 2000: Turn Awareness Into Action (USAID Funded)
- October 18, 2000, Chicago, IL*
Building Strategic Alliances for Better Health
- December 4, 2001, Tucson, AZ*
American Indian and Alaskan Native Contributions to the Control of Global Infectious Diseases: Past, Present and Future
- March 18, 2002, Miami, FL*
When HIV and TB Collide (USAID funded)
- August 14, 2002, Portland, OR*
Building Strategic Alliances for Better Health: Private-Public Partnerships at Work in Your Community

A key selection criterion now is: "would a presence in the area help to further the Council's education and outreach efforts among key policy makers." The new selection criteria appear to tilt the original Forum objectives more toward influencing congressional members, with less emphasis on "educating and engaging a new generation of global health constituencies." Recent sites for forums have focused on "key congressional districts" where the council has "been able to engage a small but influential number of members

in the global health issues that the forums were designed to address." Thus, the forums run the risk of becoming simply an adjunct activity to the Council's Washington-based attempts to educate members of Congress. The Council indicates that its measures of success for a forum

include the size of the turnout, the degree of local media coverage, and whether a participating congressional member has attended, heard the message and “is happy.”

Follow-up: At the time the agreement was signed both USAID and GHC were searching for ways to provide follow-up to what appeared to be “one off” forum events. The GHC proposal stated that electronic “state of the art communications technology” would be utilized to encourage attendees to continue a dialogue and gain further information on the global health issue discussed at the forum (perhaps via a list serve of attendees). GHC has not found a feasible way to implement this concept. GHC states that each local setting requires a specific approach to follow-up and has explored alternatives. For example, GHC returned to San Diego one year after a forum on TB and sponsored a study tour of TB clinics in San Diego and Tijuana, Mexico for bipartisan members of the local city council and the district’s U.S. Congressperson. Soon afterward, the local council increased funding for cross-border TB programs and local interest remains high on this subject.

Special Events

The USAID agreement provides funding for 20 special events, especially on important global health dates such as World Population Day, World Health Day, International Women’s Day, World AIDS Day, World TB Day, and the annual AIDS Candlelight Memorial. USAID provides 50 percent of support for these events. Many of these special events use the structure for congressional briefings or local-global forums, but focus the activity on a special day. For example, “When HIV and TB Collide: A World TB Day Event” was held in Miami on March, 18, 2002. This special event used the forum structure and was developed in partnership with the American Lung Association of South Florida, the Florida state office on TB and Refugee Health, and a local NGO, among others. Most other special events cited in the GHC quarterly reports have been held in Washington and often bring together congressional members and staff, administration officials, and GHC members. GHC has held six congressional briefings to coincide with the annual “Days,” but believes that it may be more effective in educating congressional staffers and members by providing, for example, “International Women’s Day” email fact sheets.

One special event, the AIDS Candlelight Memorial, has been managed differently with a focus across multiple sites on a single day. This event appears to be the main special event that encourages grassroots involvement and participation, attempts “to educate the American public on major global health issues, and to encourage their involvement in local and global health activities.” The GHC serves as the international coordinator of this event that takes place in 500 communities around the world. The Memorial brings together individuals and groups and provides an incentive for the creation and support for networks and alliances. GHC hosts meetings of local coordinators at the regional and international HIV/AIDS conferences each year where information, best practices, and lessons learned are discussed.. The energetic manager of this GHC program is considering options on how to build on this special day “as an anchor point.” Possibilities include training local candlelight coordinators to organize technical training sessions and conduct awareness campaigns, in co-sponsorship with other sponsors. Because of the increasing focus on the alliance nature of this “special event,” in FY2002, the Candlelight Memorial activities were budgeted under the “Building Alliances” segment of USAID funding.

Non-USAID funded services: The GHC Government Relations Department also provides its members with periodic email Public Policy updates on the status of global health-related legislation and appropriations. GHC also encourages local advocacy via its “Power of Ten” Web site system and has conducted visits for congressional members and staffers to locations such as Guatemala/Honduras and West Africa.

Special Events

1999

Reception, “Global Health, Poverty and Development,” June 23, 1999.

2000

World Health Day, Congressional forum on “Why Family Planning Matters: Promoting Women’s Roles, Saving Women’s Lives,” April 6, 2000.

“Polio Eradication — the Opportunity of a Lifetime,” April 12, 2000.

US Conference on HIV/AIDS, Atlanta, GA ; October 1-4, 2000.

- The Council coordinated three panel sessions: Advocacy: Making it Happen Locally and Globally; HIV/AIDS and Human Rights; and The Politics of Drug Access and Affordability. A half-day institute entitled “Building US/Global Linkages” was also coordinated by the Council.
- Rally for World AIDS Day, Washington, D.C., December 1, 2000.

2001

National HIV/AIDS Update Conference (NAUC), March 20-22, 2001.

- The Council played a role in expanding the program by facilitating the integration of conference to international issues in the program. The Council’s AIDS Program Manager moderated a session on Global AIDS Advocacy and delivered a presentation on the UN General Assembly Special Session on HIV/AIDS. The Grassroots Manager for the Council gave a presentation on Grassroots Advocacy and the Power of Ten Network.

Congressional Study Tour: “Tackling Tuberculosis: A Bi-national Success,” March 23, 2001.

Congressional Study Tour to Guatemala and Honduras, August 18-26, 2001.

Congressional Networking Reception – “A Celebration of Partnerships,” November 28, 2001

“UN Special Session on Children Celebration,” September 6, 2001.

Congressional Networking Reception “A Celebration of Partnerships,” November 28, 2001.

- Getting Research into Policy and Practice (GRIPP) Workshops in 2001.

2002

Congressional Study – Congressional Delegation to Côte d’Ivoire and Burkina Faso, January 6-14, 2002.

Maternal and Child Health Reception, 6/27/02.

Tuberculosis and HIV: The Critical but Ignored Linkage.

Care in the African Community: Coordinating the Response to AIDS.

Community Efforts for Improving Health-Care Access.

Conclusions

- *GHC’s educational/technical briefings and other contacts.* The briefings and contacts with Washington-based decision makers are viewed as valuable and effective. However, both GHC and USAID recognize that improvements can be made to better target issues and more efficiently use the limited time of congressional staffers. Public policy updates held on Capitol Hill are opportunities for member organizations to meet policy makers and these sessions are well-used and appreciated by GHC member organizations and individuals. The recent establishment of three new communications officer positions in the Global Health Bureau and USAID’s desire to organize and manage its own congressional

briefings for specific purposes are welcome changes but they complicate the previously established responsibilities of GHC under the cooperative agreement

- *Local-global forums.* Local-global forums have been effective as mechanisms for bringing global health issues to the attention of local media and politicians. The new GHC criteria for selection of forum sites are strategic, but also oriented toward influencing the congressional agenda. Indicators of success, other than impact on local congressmen, have not yet been formally defined and routinely measured. Follow-up to these forums appears to be a minor concern and does not appear to occur routinely.
- *Special events.* Most of these events have been Washington based and their long-term impact is not clear. The Candlelight Memorial program, by contrast, appears to be well developed with good potential for expansion to meet broad program objectives.

Recommendations

1. Congressional briefings and other contacts

- Continue to assess the effectiveness of these briefings, especially via contacts with the target audience, congressional staffers. Place greater attention on staffers-only brown bag lunches, and on avoiding narrow topics that might be of interest to only a few staffers. In planning these briefings, however, GHC and USAID also need to consider their value to the PVO representatives and GHC members who often attend.
- The roles of the new communications officers in the Bureau for Global Health should be carefully defined with the context of a Bureau Communications strategy (now being developed). This strategy should delineate the responsibilities of GHC and USAID, especially in relation to technical congressional briefings. The strategy should take into careful consideration the proven advocacy strengths of GHC, its reputation as an independent voice, and its responsibilities in representing its broad membership.

2. Local-global forums

- Consider modifying selection criteria to supplement (not replace) the present objectives. The original USAID agreement objective of encouraging local community involvement in global health programs and issues should not be forgotten. GHC should consider linking their forums to ongoing local-global citizen programs (such as Sister Cities, Partners of the Americas state-to-state linkages, Asian-American associations, etc.). The Rotary Foundation's leadership on polio eradication demonstrates that not all global health leadership must emanate from Washington.

3. Special events

- GHC should move forward with staff proposals to use the Candlelight Memorial activities as an “anchor point” for other activities. The Candlelight model might be considered for other “Special Day” events, especially as a way to encourage more local

involvement in global health issues. Washington-based special events should be carefully evaluated to determine if they have any significant impact.

4. Educational and advocacy techniques and skills

- GHC has developed excellent educational and advocacy techniques and skills. In the future it should consider transferring these skills to local or regional health organizations with similar objectives.

BUILDING GLOBAL ALLIANCES

The Global Health Council is an alliance or a network of partners. As stated in the GHC proposal to USAID, the network includes “collaborative partnerships and regular contact and communication with non-governmental organizations in the developing world, multilateral agencies, US government leaders and a wide array of international health and development organizations and individuals. Networking and assuring ongoing contact between those actively involved in global health issues is a dynamic process ... and is the essence of what makes the council a trusted, respected member of the international community.... This networking is enhanced through several Council activities: the Council database, partnering with counterpart networks, providing financial support for conferences, meetings and workshops, and promoting domestic linkages.”

USAID funding was envisaged for five activities under objective “B:” a) the GHC database and products from the database; b) regional forums; c) a small grant fund; d) establishing a pilot GHC affiliate; and e) support for specialty health networks. Progress in achieving agreement targets has been slowest to date under this objective, with the exception of the database. Focus groups have indicated that building alliances is one of GHC’s most valuable functions. However, USAID counterparts, knowledgeable health practitioners, and even some GHC board members have difficulty describing what the “B” in the ABC objectives stands for and how the GHC is building global alliances. Acknowledging the previous lack of organizational focus on this objective, in September 2001 the GHC established a new Global Partnerships Department under the leadership of an experienced GHC staff member. Goals, objectives, and outcomes for the new department are still in draft format. A major setback to the building alliances objective occurred in December 2001 when issues with the program raised by a Senate office led to the termination of the visible Small Grant Fund, which encouraged global alliance building.

GHC Database and Database Products

The new GHC inherited a database with inadequate hardware and computer support and data that was reportedly poorly organized and often out of date. Success in building the database and products from the database has been exceptional. Presently 6,500 organizations and individuals are included in this rapidly growing database, managed from the Vermont office. The database is used to generate targeted emails, mailing lists, and directory information. Global Health and HIV/AIDS Directories are published in alternate years. Online versions of each directory should be available within the next year. The directories include information on GHC individual members that have grown from 399 in October 1999 to 1,760 and organizational memberships

that have grown from 87 to 431. Non-U.S. organization memberships have expanded from 23 in 1999 to 282, far beyond the 100 percent increase targeted in the USAID agreement. Total international memberships now total 458. USAID provides about 40 percent of all funding for the database and directories and USAID funds are used specifically to cover database labor costs and the costs for production of the two directories.

The GHC Membership Department has continued to aggressively market the organization and its services. For example, in 2002 GHC and APHA exchanged mailing lists and GHC sent mass mailings to all APHA members. The resulting membership conversion rate has been an acceptable 25 percent to date. Some foundations have agreed to provide initial two-year memberships along with funds for annual conference attendance. For example, the Soros Open Society Initiative sponsored 250 organizational memberships for health organizations from NIS/CEE countries. GHC provides a free three-month trial membership to non-members who attend the annual conference. The GHC member retention rate is over 90 percent, indicating that members feel they are receiving good value for their money. Annual membership fees for a professional in a developing country are 10 percent of the \$120 rate for other “professional” members and clearly encourage wider developing country participation in the GHC. Special organization membership categories have also been established for NGO/PVOs, smaller or “associate” NGO/PVOs, academic departments or schools, government organizations, and developing country institutions.

Regional Forums

The USAID agreement targeted “at least 14 regional forums” held outside the United States to help reach increased consensus on specific globally health issues, policies, and programs. They were envisaged as a means to stimulate organizational and individual partnerships between U.S. and overseas organizations on global health issues. The regional forums were to be often linked to the council’s annual conference theme and to USAID’s strategic objectives. USAID planned to provide 25 percent of all donor support for these activities.

Only one regional forum has been carried out to date with USAID funding. A meeting was held in India in 2001 with 25 NGOs attending to discuss an initial structure for an India-based partnership organization focusing on the right to comprehensive health care in India. The new Global Partnerships Department has held initial discussions that might lead to regional partnerships in Africa (African Council on Sustainable Health and Development in Nigeria), in the NIS/CEE region (five organizations in dialogue), and in Guatemala (FESIRGUA). These organizations all either lead networks or have strong regional affiliations. Ten additional regional forums are planned during the remainder of the USAID grant period, and these will be carried out through collaborative work between the Partnerships, the Government Relations, and the Research & Analysis Departments, which hope that these will be stepping stones to long-term partnership relationships with GHC.

Small Grants Fund

A key element of the partnership objective was the establishment of a Small Grants Fund. Ninety-five grants were anticipated over the five years of the USAID agreement with USAID

Small Grants Awarded

FY1999

\$10,250	South American Regional Network of People Living with HIV/AIDS; Brazil and Venezuela
\$10,015	Global Network of People Living with HIV/AIDS (GNP+); Warsaw, Poland
\$7,615	International Community of Women Living with HIV/AIDS, (ICW); London, UK
\$5,015	International Gay and Lesbian Human rights Commission; San Francisco, CA
\$8,415	NAZ Foundation; India
\$10,015	PROMETRA – The Association for the Promotion of Traditional Medicine; Dakar, Senegal
\$5,015	Thailand Business Coalition on AIDS; Bangkok, Thailand
\$10,015	Visions Worldwide
\$11,545	Homa Bay Rural Development Project

FY2000

\$7,187	Orissa State Volunteers and Social Workers Association; Orissa, India
\$9,445	Asia Pacific Network; Singapore
\$10,045	SourceNet 2000 Plus; Nairobi, Kenya
\$10,015	Gender and Development Action; Cross River State, Nigeria
\$5,000	American Association for World Health – USAID Support for World AIDS Day; Washington, DC
\$5,045	Future Forests Project – Kenya; Oyugis, Kenya

FY2001

\$5,000	Visions Pakistan; Lahore, Pakistan
\$5,000	Volver a Nacer Association of People Living with AIDS; Callao, Peru
\$5,000	Society for Women Against AIDS in Africa; Johannesburg, South Africa
\$5,000	Yayasan Peduli Sesma; Jawa Timur, Indonesia
\$5,000	KENWA; Nairobi, Kenya
\$5,000	IFRO; Nairobi, Kenya
\$5,000	Association “DRUGS;” Moscow, Russia
\$5,000	Ubumbano LoMama; Orlando, Florida
\$5,000	Friends of the Nation; Takoradi, Ghana
\$5,000	Center for Counseling – COUNSENUTH; Dar Es Salaam, Tanzania

FY 2002 (prior to December, 2001)

\$5,000	Fantsuam Foundation; Leeds, UK
\$5,000	Society for Women and AIDS in Kenya; Nairobi, Kenya
\$5,000	Public Movement “Faith, Hope, Love;” Ukraine
\$5,000	Copper Belt University Health Services; Kitwe, Zambia
\$5,000	Nile Youth Development; Kabale, Uganda
\$5,000	Red Mexicana dePersonas; Mexico
\$5,000	Health and Social Development Foundation; Sofia, Bulgaria
\$5,000	Women’s Health and Action Research Center; Sofia, Bulgaria

earmarked USAID funds were transferred to other GHC programs.

No evaluation of the impact of the 32 grants has been conducted, so it is difficult to measure the program’s early success or the effect of the program termination on the target NGO

contributing 100 percent of the monies for this program. GHC set up a grants solicitation and review process in the first year. Thirty-two grants were awarded by December 2001 (see box at left) with USAID participation on the grants advisory panel.

Grants helped sponsor NGO attendance at international or regional workshops, meetings and conferences, and assisted members and partners to hold meetings and workshops on their own. The GHC Small Grants Fund built upon partnerships and alliances developed by the NCIH Global HIV/AIDS Program, but widened participation beyond that problem area. The small grants program gave GHC credibility and allowed them to provide tangible support to nascent, developing country NGOs at critical times.

In late 2001, concerns by a key member of Congress about the appropriateness of some grants resulted in senior-level political discussions between the Hill, USAID, the State Department, and GHC. As a result, the small grants program was terminated in December 2001. Eighty thousand dollars in

organizations. GHC does not plan to try to reinstitute a small grants program with USAID funds in the future. At this point, there appears to be no strong pressure from USAID to attempt to reconstitute the GHC small grants program, in part because it has a somewhat similar program another USAID grantee.

Establishing a Pilot GHC Affiliate

The GHC proposal to USAID envisaged the development of “affiliated networks...that will encompass organizations engaged in the range of priority health issues and will draw together single-issue networks...” During the five-year grant period, GHC would take the first step in this process, by setting up a pilot affiliate. This affiliate might be a “virtual” organization that would primarily serve a convening and coordinating function.

GHC was a totally new organization itself when the USAID agreement was signed in 1999. Given the major institution strengthening issues faced by the GHC itself, it is not surprising that establishing an affiliate has received little priority attention to date. GHC plans to continue to work slowly towards this objective, and plans to have only “determined the feasibility” of an affiliate (rather than having “established” an affiliate) by the end of this agreement. The new Global Partnerships Department is now taking the lead, and has thus far interviewed 150 organizations. Two possible partner organizations have been identified and concept papers have been generated. No USAID funds for supporting this activity have been included in the FY01 and FY02 budgets. Foundation funding sources were found for this activity in FY02.

Support for Specialty Health Networks

The USAID agreement envisaged the development of both broad based international health alliances/partnerships (e.g. affiliates), but also targeted the establishment of “specialty health networks, such as Cairo+5 and GNP+”. Ten such networks were envisaged.

Once again, progress has been slow in building this concept. Only two networks have been established and supported to date. First, a U.S.-based US Coalition for Child Survival found a welcome home at GHC where a three-person secretariat worked to encourage the review of technical issues and NGO participation in the run-up to the UN Special Session on Children in May 2002. USAID continues to fund the maintenance and media outreach activities of this coalition, facilitating subcommittee meetings and contacting the media regarding child survival events and issues. Secondly, the GHC has supported the development and growth of the White Ribbon Alliance for Safe Motherhood. The GHC has supported the alliance steering committee and has also managed the Global White Ribbon Contest for three years, rewarding community organizations by sponsoring their attendance at the annual GHC conference, where they can increase their knowledge base and develop program linkages with similar organizations.

Finally, the International Candlelight Memorial (discussed above) essentially fits the criteria for an international specialty network; and is now legitimately counted by GHC as a third such network receiving GHC support.

Conclusions

- *GHC Building Alliances program.* The activities related to this objective are the least well known and understood of its three program objectives.
- *Database and database products.* Progress has been excellent. Most 5-year targets have already been met. The database has been aggressively used to increase GHC visibility and membership.
- The new *Global Partnerships Department* is a positive step toward providing a locus of responsibility and action within GHC. However, the new department appears to be moving slowly with no approved strategy (and perhaps, no clear funding source) after almost a year in existence.
- *Regional forums and pilot affiliate.* These two activities appear to be intertwined. The initial regional forum in India may lead to either the development of a regional alliance or a GHC affiliate (or perhaps both eventually). Little progress has been made to meet either objective to date. GHC's decision to go slow on any decision to establish a pilot affiliate seems appropriate, given the young age of GHC itself.
- *Specialty health networks.* The three networks that GHC has fostered have been effective and excellent models. GHC does not appear to have an organizational locus to foster additional specialty networks.
- *Small grants fund.* This program was a logical addition to NCIH's successful HIV/AIDS partnership program. Unfortunately, the program was cancelled due to political concerns prior to any formal evaluation of the program's impact. GHC does not plan to try to reinstitute a small grants program with USAID funds in the future. At this point, there appears to be no strong pressure from USAID to attempt to reconstitute the GHC small grants program.

Recommendations

1. *Organizational priorities and responsibilities*

- Review the continued validity of GHC's strategic vision for the building alliances component of its program. Clarify the organizational priorities and responsibilities for the regional forum, pilot affiliate, and specialty health network activities. The first two appear to fall within the responsibilities of the Global Partnerships Department, but the third may be homeless.

2. *Global Partnerships Department*

- The GHC should consider moving the Global Partnerships Department to the GHC Washington office. Daily networking and close personal contacts with a wide range of health professionals are probably needed for program success.

- Place a higher priority on finalizing the Global Partnership Department strategy and objectives. The new target of holding 10 regional forums over the next 2 years appears optimistic. This period might best be used to test and evaluate models for regional forums, and to assess whether GHC has a long-term role in fostering such alliances.

3. *Establishing a pilot affiliate*

- GHC should carefully review the experiences of U.S.-based environmental PVOs, such as World Wildlife Fund, The Nature Conservancy, and Conservation International that have had almost a decade of experience with affiliate or partner organizations in the developing world.

4. *Specialty health networks*

- Clearly identify the GHC organizational focus for these activities. Over the next two years, determine what GHC’s long-term roles should be in fostering specialty health networks in the U.S. or globally. Possible roles include: a) host organization; b) “good offices” facilitator but not host; c) funding source for start up; d) technical resource base.
- Consider fostering health networks as a follow-up to annual conference themes, if needed (e.g., Health in Times of Crisis network, Environmental Health network).

5. *Small Grants Fund*

- USAID should decide if the termination of the GHC Small Grants Fund leaves a gap that needs to be filled by another Cooperating Agency. One valuable and noncontroversial element of the Small Grants Fund was the provision of funding to allow developing country NGO leaders to attend international and regional conferences. This is similar to USAID’s traditional “invitational travel grant” program. This program is normally viewed as a “participant training” rather than a “small grant” program and would be appropriate for incorporation into the responsibilities of another HIV/AIDS Office-funded CA in the future.

COMMUNICATING BEST PRACTICES

Over most of the years of NCIH/GHC, USAID has provided core support for the organization’s most visible annual activity — the annual conference — and for its primary publication for its membership, HealthLink. USAID was also the sole funder of AIDSLink when it was initiated in 1997 and began to support NCIH’s Web-based communications about the same time. The 1999 USAID agreement continued funding for these core GHC activities, but also encouraged GHC to move into a major program area: the establishment of an in-house technical capacity and the preparation of technical synthesis papers for the use of members. This technical role was aimed at filling a perceived void — the absence of carefully researched, unbiased, technical summaries of best practices that could be easily used by global health practitioners. These technical analyses would be communicated in formats appropriate for both a professional audience and a non-technical, non-professional audience.

Following are the major activities supported by the USAID in support of GHC's "C" objective:

- GHC Publications and the Web Portal.
- Annual conference.
- Establishment of a technical department with approximately 4 qualified staff that would publish technical synthesis papers (29) and convene technical workshops (44).
- Establishment of expert advisory committees (6) made up of volunteers from the GHC membership. These committees would help determine "best practices" and would provide policy recommendations to the GHC.

GHC Publications and the Web Portal

Global HealthLink and Global AIDSLink are published bimonthly and are meant to provide a forum for donors, policymakers, PVO/NGO representatives, and advocates to share experiences, resources, and pertinent information. A new director of publications in the Vermont office has revamped and expanded the size of both publications and both now have attractive, but different formats. HealthLink is oriented toward a wide global health readership and is published in magazine format with an attractive color cover. AIDSLink has been structured to be attractive to field-based practitioners and is published in a newspaper tabloid format. The readership of both publications has increased from 2,500 copies per issue to more than 4,000 copies. GHC anticipates that it will meet the goal of increasing readership by 100 percent (to 5,000 copies) by the end of this agreement.

Copies of both publications are now sent free of charge to all congressional offices and will soon also be sent to a select list of journalists.

GHC members, USAID staff, and other knowledgeable health professionals are quite familiar with these publications and speak highly of them. A recent survey by the Research and Analysis Department solicited member recommendations on what members appreciated most (and least) about the publications and asked about the format and content additional technical information that might be provided in the future. USAID funds 33 percent of all donor support for HealthLink and is used by the GHC to cover the costs of producing specific sections (Calendar, Policy Maker, Outbreaks, On the Move, Technical Update, Best Practices and Global Health News). USAID finances 80 percent of the donor costs of AIDSLink. GHC has not decided to produce additional technically oriented publications, such as IDLink (Infectious Disease) or MCHLink (Maternal Child Health) that were mentioned in their proposal as possibilities.

The GHC Web Portal has been virtually revolutionized during the three years of this agreement. The site is now attractive and quite user friendly. All GHC publications are available via the Web site, except for the lengthy member directories. GHC organizational members are listed on the Web site, with a hot link to all of them. The Web site provides a job search service for members, Career Connections, which is the most heavily used section of the Web site. GHC technical reports from the Evidence for Action series and the GRIPP series are available to download from their Web site.

GHC data indicates that “hits” on their Web site have increased 700 percent from 65,000 in October 2001 to 460,000 in July 2002. The heaviest usage month to date was May 2002 (conference month) when 803,000 hits were recorded. Page requests for downloaded materials have also grown rapidly, from 7,300 in October 2002 to 31,000 in July 2002. Once again, the highest month recorded is May 2002 with 46,000 page requests.

Many global health specialists are not yet familiar with the GHC Web site, nor would they use it to get technical information. To encourage new users, GHC plans to send monthly emails to all members alerting them to what has been added to the Web site each month.

Annual GHC Conference

Over the past few years, the GHC annual conference has been revitalized (the box at right and on the next page lists sessions funded by USAID. This conference is now the largest conference in the world dedicated to global health issues and practices. It is an important vehicle for sharing best practices and establishing and deepening relationships among participants and policymakers involved in global health and development issues. All available indicators are positive. Conference attendance has increased 80 percent since 1999 and GHC anticipates it will meet the USAID agreement target of 100 percent increase by 2003. Developing country attendance of 231 in 2002 has already surpassed the agreement target of a 200 percent increase. A growing number of these participants are sponsored by Foundations. The GHC hopes to attract private sector funds to ensure even broader international participation with an overall goal of one-third of all conference attendees. The conference exhibition section has doubled in size. More auxiliary events (book launchings, lunches to discuss new reports, etc.) link themselves to the GHC conference. The abstract review process has been revamped and the quality of abstracts (and presentations) is gradually becoming more professional. GHC uses

2001 USAID-Funded Sessions
<p>The May 29-June 1, 2001 GHC Annual Conference was entitled <i>Healthy Women; Healthy World, Challenges for the Future.</i> USAID is helped to support the following technical sessions at this conference:</p> <ul style="list-style-type: none"> • Unbroken Circle: The Health of a Woman and the Health of The World • Building New Traditions • The Path Ahead for Women’s Health • Survey Designs in Complex Humanitarian Emergencies • Female Genital Mutilation: Integrated Community Based Models • US Government Priorities in Global Health • Building Partnerships for Reducing Maternal Mortality • Mobilization for HIV Awareness • Vertical Transmission of HIV • Getting to Good Breastfeeding Practices • Community Based initiatives • Healthy Women: Who Will Pay? • Influencing Women’s Health through Leadership Development • Cervical Cancer Knowledge and Prevention • Women and Infectious Disease • Women and AIDS • Reducing Delays in Seeking Care through Birth Preparedness • Non-health Determinants of Women’s Health Outcomes • Healthy mothers, Healthy Babies: Innovations in Post-partum Care • Gender-Based Violence • Implementing Guidelines for Improving Maternal and Neonatal health • NGO Reproductive Health Networks: Impacts and lessons learned • Human Trafficking: Enacting Laws, Linking Activists, Mitigating Harm • Assessing, Assuring and Improving Quality of Obstetric Care • Successful Maternal and Infant Nutrition: Lessons from India • Microbicides: New Hope for Saving Women’s Lives • Process Indicators for Maternal Mortality Reduction • Should Infant Formula be resurrected? • Performance Measurement in Women’s Health Programs • Contraceptive Technology Update (SO 1,2,3,4,5)

2002 USAID-Funded Sessions

The 2002 GHC Annual Conference (May 28-June 1) was entitled *Global Health in Times of Crisis*. USAID is helped to support the following technical sessions at this year's conference:

- MTCT-PLUS: Linking Efforts to Prevent Mother-to-Child HIV Transmission
- Assessing Health and Family Planning Needs of Refugees and Displaced Persons
- Human Trafficking: Raising Awareness Among Vulnerable Populations
- The Impact of Economic Transition on Health in Central and Eastern Europe Building it to Last: Developing and Assessing Sustainability
- Improving Child Health in Conflict-Affected Areas
- Understanding AIDS among Refugees and the Displaced
- Rolling Back Malaria (Part 2): Interventions in Complex Emergency Settings
- Maternal Mortality: A Human Rights Perspective
- Coloring Outside the Lines: Partnerships among NGOs
- Challenges in Monitoring and Evaluation in Conflict Settings
- Health Sector Reform in Latin America and the Caribbean
- Roots and Repercussions: Examining Crisis and the Role of Public Health
- AIDS Treatment: Pricing and Care
- Strategies to Contain Anti-Microbial Resistance in Poor Countries
- Mobilizing for Maternal Health in Times of Crisis
- Tobacco's Global Reach: The Preventable Crisis
- Diarrhea, Dysentery and Disaster
- Saving the Next Generation: Increasing AIDS Awareness among Youth
- Reproductive Health Programs: Ensuring Human Rights during Crisis
- Multi-Site Youth Studies: Methodological Advance or Management Nightmare?
- Approaches to Rebuild Trust in the Health-Care System
- Monitoring Nutrition in Conflict-Affected Populations
- Interventions for Educating Sex Workers and Garment Workers
- Water in Crisis: Supply, Sanitation and Environmental Hazards
- Tuberculosis and HIV: The Critical but Ignored Linkage
- Care in the African Community: Coordinating the Response to AIDS
- Community Efforts for Improving Health-Care Access (SO – 1,2,3,4,5)

the conference to announce the winner of the prestigious Gates Global Health Award and the Gates Foundation funds are used to provide attendees with the opportunity to attend a glittery evening of dinner and speeches by esteemed health specialists and policy makers.

GHC has attracted foundation funding for the conference and the USAID contribution has decreased by \$100,000 since 1999 and now constitutes only 25 percent of total conference costs and funds 100 percent of a set of plenary sessions, workshops and panel sessions identified each year.

Themes of the conference have varied significantly since 1999, and the special themes have been successful in attracting new groups to the conference (e.g. relief organization personnel for the 2002 conference entitled

Global Health in Times of Crisis). Thus far, the GHC has succeeded in stretching the conventional definition of global health while maintaining an attractive and informative set of seminar topics that keep members attending each year. GHC conference organizers have varied the format for some sessions, especially for topical issues and a 'crossfire' format has been successfully used for the past two years.

Conference organizers have increased the involvement of GHC members in conference planning, especially in the abstract review process. Evaluation forms are ubiquitous at each conference panel session, providing attendees an opportunity to give feedback on each session they attend.

Establishment of a Technical Department

The new GHC Research and Analysis Department became operational with the arrival from South Africa of a highly qualified director in the summer of 2001. The department presently

consists of four staff members, and one additional staff member is being recruited. The new department's goal is to disseminate rigorously assessed evidence on the effects of health care interventions to professionals in need of such information. This information is provided in a variety of formats.

The major output of the department is a new series entitled Evidence for Action, which summarizes the result of major systematic reviews of health interventions. These reviews are secondary research analyses, which critically evaluate primary research conducted on action-oriented health interventions. The reviews are written in collaboration with the Cochrane Collaboration, based on detailed research protocols drafted by the R&A Department. Five Evidence for Action reports have been completed to date (see box at below). Twenty more are expected to be produced during the agreement period. The reports are presented in one-page summaries in HealthLink and the full 20-page reports can be downloaded from the GHC Web site or from the Cochrane Library. They can also be requested in hardcopy form from GHC. The topics have been chosen thus far by the GHC leadership sometimes using suggestions from the board and GHC members. The initial analyses have been biomedical in nature, but the department plans to also request analyses on behavioral interventions.

GHC published its first in a series of technical reports, "Making Childbirth Safer," in May 2002, in collaboration with JHPIEGO. This report was not funded via the USAID CA. This 20-page document consisted of six short articles that touched on key childbirth safety issues, described the GHC's evidence-based approach to decision making, and highlighted sources of additional information (the WHO Reproductive Health Library). Three additional GHC technical reports and five systematic reviews are scheduled during the remainder of the USAID agreement period. USAID funds represent one-third of all donor funding for the R&A Department.

Evidence for Action Report Titles
<ul style="list-style-type: none">• Fewer antenatal visits as effective as standard antenatal-visits model• Melatonin effective for preventing or reducing jet lag from air travel• Condoms reduce, but do not eliminate, risk of heterosexual HIV transmission• Lack of evidence that directly observed therapy (DOT) improves cure or treatment completion rates in patients with tuberculosis• Reduced osmolarity oral rehydration solution (ORS) more effective than standard WHO solution for treating acute diarrhea in children.

Two key questions revolve around the approach chosen by the GHC to analyze and publish "best practices" information. First, will the *quality* of the analyses be acceptable? Many USAID CAs produce "best practices" documents based on their own organizational experience. WHO and other UN organizations (UNAIDS) have played a traditional role in providing non-biased recommendations for health interventions. GHC hopes to provide a neutral source of high-quality analysis that health practitioners are not now receiving.

The GHC has chosen to use the Cochrane Collaboration to conduct the analyses, rather than using GHC advisory committees discussed in the 1999 GHC proposal. The new R&A director is a long-time collaborator with the Cochrane group and is familiar with their procedures. The Cochrane Collaboration, located in the U.K., is not well known to many GHC members, but is reputed to be an equivalent body to NIH technical review panels that are more common in the United States. Some of the initial analyses have been modestly controversial, eliciting critical emails and letters from members. In fact, GHC has deliberately chosen controversial topics for

most of their initial reports (e.g., The effectiveness of DOTS therapy, Do Condoms Work to prevent HIV/AIDS). GHC encourages debate and discussion on these topics (and has showcased some in “crossfire debates” at GHC annual meetings). Laudably, GHC has printed the comments and GHC responses in HealthLink and has added them to the relevant report on their Web site.

The alternative of engaging volunteer council members on advisory committees that would compile “lessons learned” was explored at the initiation of this agreement, but was shelved due to lack of interest. GHC plans to revisit the possible establishment of advisory committees in the near future. However, if established, GHC envisages the role of the advisory committees to identify issues not being addressed, refining the GHC’s education and outreach agenda and advising on new methods of identifying and disseminating best practices. The advisory committees, if established, would not replace the Cochrane Collaboration in conducting “Evidence for Action” analyses. USAID CTO team leaders also can play a valuable role in selecting topics for future issues and in ensuring that there is no duplication with other USAID-funded activities.

The second major question is whether there is a *market* for the Evidence for Action series and for other technical reports that GHC plans to produce. Will there be enough readers to justify the costs of adding these reports to the inboxes of health professionals who often state that they are saturated with information? A thorough GHC member survey completed in May 2002 seems to indicate that a market exists. A high proportion of respondents want the GHC to provide them with research information “to stay abreast of cutting edge information in my field” and “for my general knowledge”. They requested research information concerning program evaluations, demographic and epidemiological status, behavioral change interventions, and education interventions. The highest areas of technical demand were HIV/AIDS, emerging global health threats, and other infectious diseases. Respondents indicated that one-page summaries of intervention research and electronic compilation of full research were the most important ways to disseminate this information.

The Evidence for Action series and GHC technical reports series are less than a year old. Not surprisingly, a sampling of GHC members (senior health professionals) indicated that almost none were familiar with either series. More surprisingly, several senior USAID health professionals, including SO team leaders, did not know the two series existed and were not familiar with the Cochrane Collaboration. By contrast, documents from these series are beginning to be downloaded from the GHC Web site with 1,000 downloads reported in the past 8 months.

Technical Workshops

The USAID agreement anticipated that GHC would conduct 44 monthly technical workshops to develop consensus on global health challenges and focusing on specific health issues in line with USAID’s strategic objectives and major programmatic emphases. Thus far, GHC has conducted 24 workshops at the Washington, D.C. National Press Club in partnership with Management Sciences for Health and the Pan American Health Organization.

A new format for technical workshops, GRIPP (Getting Research into Policy and Practice) has been initiated by the R&A Department. Two workshops, in Egypt and Washington, D.C., have been carried out with the goal of promoting better understanding between researchers, policy makers and practitioners and encouraging the use of research evidence in decisions about healthcare. These workshops were not funded via the USAID CA. GHC reports that these workshops were rated highly in participant evaluations. Six additional GRIPP workshops around the world are anticipated by GHC during the remainder of the agreement period.

In an attempt to encourage the use of research evidence in decisions about health care, the department plans to conduct three GRIPP workshops in both the United States and in low-income countries during the next 12 months. These interactive workshops will target policy makers, healthcare practitioners, and researchers with the goal of exploring these issues in more depth and bridging the gap between these groups.

Conclusions

- *Publications and Web portal.* Excellent progress has been made in improving and expanding GHC's traditional communication functions under this objective (HealthLink, AIDSLink web portal) and most five-year targets have already been met or will be met by the end of the agreement.
- *Research and Analysis Department.* Establishment of the new in-house technical capacity was delayed until the arrival of a highly qualified director in the summer of 2001. Rapid progress has been made in meeting most agreement objectives since his arrival. At this time, the Research and Analysis Department includes only one credentialed public health professional. The GHC decision to use the Cochrane Collaboration to actually do the synthesis research seems to be an inspired choice. It provides the Council with access to a talented research community and limits the need for the GHC to hire its own senior technical staff.
- *Advisory committees.* Membership interest in participating on advisory committees was low two years ago, and the GHC found an excellent alternative to produce synthesis research. The advisory committee approach illustrated in the GHC proposal would probably have been difficult to implement.
- *Annual conference.* GHC has done an outstanding job in improving the content and attendance at their annual conference. International participation has increased dramatically. GHC has successfully used topical themes to encourage attendance by individuals that have not previously considered attending (refugee organizations, mental health, etc.) while at the same time maintaining its traditional attendee base. GHC conference organization and planning has been extremely professional and effective.
- *Research publications.* The Evidence for Action series is off to a good start, but is not yet well known among senior global health professionals. The first GHC technical report shows promise, but may not be different in content and style than publications already available from USAID CAs and international organizations. USAID CTO team leaders

can play a useful role in identifying future topics and ensuring that there is no duplication with other USAID-funded “best practice” research efforts.

- *Technical Workshops.* The new GRIPP workshop series seems well targeted (and well named). No information is available on the impact of GHC’s traditional technical workshops, based in Washington and co-sponsored by MSH and PAHO.

Recommendations

1. Research and Analysis Department

- This department already is producing valuable, high-quality reports with relevance to global health practitioners throughout the world. The next step is to make the department director and these publications better known throughout the global health community.

2. Advisory Committees

- Now that GHC is well re-established as a membership organization, it should find multiple ways to involve its membership in council activities. Advisory committees are a traditional mode of doing so. Membership participation encourages ownership and fealty, but more importantly, it expands the strength of the organization by providing volunteer talent and labor. Some examples of membership involvement that other membership organizations utilize include: a) ad-hoc membership in board subcommittees (e.g., finance subcommittee; fundraising subcommittee); b) program advisory committees to provide guidance on policy issues; c) participation in evaluations of program components; and d) regional program committees (e.g., the GHC branch of Northern California or Chicago could develop and host their own local functions).

3. Annual conference

- No major recommendations. GHC might consider more formal conference follow-up activities, such as developing a list-serve and online conferencing capacity for members who want to continue communicating on the theme or themes of the annual conference.

4. Research publications

- GHC should place a high priority on listening to the reaction to its new publications over the next year. A variety of modes of obtaining feedback are desirable, but the key objective should be to calibrate the niche(s) for the Evidence for Action and technical reports series. Senior USAID technical officers should be given an opportunity to provide their views on future research topics, especially in light of the best practices research that other USAID CAs may be carrying out.

5. *Technical workshops*

- The GRIPP workshops can be valuable only if they reach their targeted policy-maker audience and provide useable content. GHC should review existing locations where members of their target audience (developing country health policy makers) already gather and should attempt to add the GRIPP content to those courses and workshops. Some examples are The World Bank's health policy training program and similar training programs run by USAID CAs, PAHO, and WHO. GHC should also attempt to make their GRIPP materials broadly available by establishing electronic linkages to the training and workshop Web sites.

IV. RELATIONSHIPS BETWEEN USAID AND THE GHC

CONGRUITY OF MISSIONS

USAID has provided support to the NCIH and the GHC since the former was created in 1971. NCIH/GHC, like many USAID-funded CAs, has carried out important programs that are complementary to and supportive of USAID's overall strategy. When a USAID-sponsored evaluation in 1999 recommended major changes in NCIH governance and leadership, and the Koop Committee report recommended similar reforms, neither critical document urged major changes in the programmatic focus and activities of the organization. USAID should be commended for strongly supporting the new GHC in 1999, early in the new organization's life, by approving a major grant whose five-year duration signaled that USAID planned to support the organizational development and program of the new GHC for the long-term.

GHC and USAID both believe that they share similar missions and similar issue focus, and the resulting synergy of the two organizations is strong. The GHC program goal is to improve health for all, especially the underserved; the GHC program objectives focus on areas where the Council has developed a comparative advantage and a proven track record: advocating for global health, building global alliances, and communicating best practices. USAID goals and program objectives are stated differently, but are seen to be fundamentally in agreement with the GHC mission and program objectives.

Senior USAID officials, GHC board members, GHC leadership and staff, and knowledgeable informants indicate their support for this continuing relationship. In recent years, they believe this relationship has improved largely primarily because of GHC's increasing lack of dependence on USAID funding. The USAID agreement strongly supported this increasing organizational independence. The key indicators of success in the agreement included gradually increasing non-USAID funding for the annual conference and for other program activities.

Senior USAID officials are pleased with the results of the past three years: clear, visible leadership at the helm of the Council; a prestigious and influential board of directors; more experienced and more permanent staff; organizational reforms; and less financial dependence on any one source of funding. Some observers say that GHC is indispensable to the USAID mission.

However, there have been problems in the relationship during the agreement period, primarily due to the highly political nature of GHC's advocacy functions and congressional sensitivity. As a result of political and legal concerns, GHC terminated the small grants program in December 2001, temporarily stopped using USAID funds for Local-Global Health Forums, and indicated that USAID funds would be used only to support non-controversial elements of the annual conference and GHC publications. These political landmines are perhaps inevitable. While some congressional office critics have argued that GHC has sometimes been too political, some PVOs and member organizations argue that GHC is "too politically correct". Most observers, however, congratulate the Council, and especially its CEO, on being unusually sensitive to these concerns

and navigating a middle, non-partisan but activist course that has generally drawn praise from both sides.

GHC MANAGEMENT STRUCTURE FOR THE USAID AGREEMENT AND MANAGEMENT ISSUES

GHC responsibility for managing the USAID cooperative agreement has been assigned to the director of public policy since the agreement was signed in 1999. The incumbent met periodically with the USAID CTO, drafted quarterly reports, ensured the support of other GHC staff in meeting agreement objectives, and reported directly to the CEO. Faced with a wide variety of responsibilities at GHC, this person was reportedly not interested in establishing planned monthly meetings with the CTO and no quarterly reports were prepared for USAID until December 2000. This project leader was the primary, and sometimes only, GHC contact with USAID for the development of the annual work plan.

The GHC financial director took an active role in structuring an appropriate accounting system for the USAID grant and preparing quarterly financial reports.

Organizational changes over the past year have increased the involvement of new GHC personnel: the new COO participates in the work plan meetings and often joins meetings with the CTO; the COO and the senior associate for development and communication participate in drafting and reviewing quarterly reports; and the COO has established a new semiannual review procedure within GHC to review the progress of the USAID grant and all other GHC grants. The new director of government relations plans to encourage much broader GHC staff participation in the FY03 work plan planning sessions scheduled for August 2002.

GHC does not report any significant technical issues regarding the implementation of this agreement, and GHC is particularly complimentary about the helpfulness and availability of the USAID CTO. GHC has never received feedback from USAID concerning any of its quarterly technical or financial reports and is not certain how widely its quarterly technical reports are circulated within USAID by the CTO.

GHC has been somewhat frustrated with the length of the annual USAID work plan process. The FY02 work plan, for example, was not completed until June 2002 (nine months through the fiscal year). Because GHC receives funding under five separate USAID/W strategic objectives (and a small amount from the Africa Bureau), GHC must communicate with and satisfy not only its CTO, but also five other USAID officers, normally SO team leaders. Bringing everyone together for a focused discussion on the GHC work plan has not been easy; at least one SO team representative prefers to meet separately with GHC. Delays in completing the work plan have led to cancellation of at least one partially planned event and to more last-minute planning than desirable. This lengthy process contrasts with almost all other GHC sources of funding (foundations that do not require lengthy annual planning, and non-restrictive funds raised by GHC). Once the work plan is completed, or at a minimum an event is agreed upon with a SO team leader, GHC dialogues directly with that team leader to plan the details of the event (speakers, specific timing, location). This interaction has normally worked very well, according to both parties to the agreement.

USAID GRANT MANAGEMENT STRUCTURE AND MANAGEMENT ISSUES

The GHC agreement has been managed by an experienced CTO in the Health Policy and Sector Reform Division of USAID's Office of Health. The CTO convenes the USAID SO team leaders for the annual planning process and is the point person for resolving any issues or problems concerning the agreement. Appropriately, she leaves the detailed planning of 30-40 specific events in each work plan to the relevant SO team leader in direct contact with GHC staff. The major problems faced by the CTO to date have been: a) congressional complaints concerning the Small Grant Program; b) uncertainty whether USAID funds could be used to fund Local-Global Health forums (if these forums engage in "advocacy"); and c) developing the annual work plan and budget on a reasonable schedule.

The CTO is responsible for soliciting funds from the SO teams for the GHC annual budget, a process she describes as "going cup in hand" to each. She requests funding for a "core GHC budget" (the annual conference, HealthLink and the Web portal, database maintenance, etc.) and additional SO funding for special activities they identify or agreed to fund (specific congressional educational briefings, specific Local-Global Health Forums, etc.).

The CTO and almost all SO team leaders indicate that they increasingly value the activities of the Council and often participate in these events as speakers or attendees. The HIV-AIDS SO team member, however, is not yet convinced that the GHC provides significant value-added to the HIV-AIDS office's portfolio, especially given the recent major expansion of that USAID office's staff and program. The recent arrival in September 2002 of the new senior GHC HIV-AIDS specialist should provide an opportunity for GHC and USAID to jointly review HIV-AIDS program options for the remainder of the grant period.

As GHC's reputation has been rejuvenated over the past three years and GHC program capacity has improved, SO funding levels have increased. Nevertheless, SO funding decisions appear to be contingent upon the views of one person in each SO. Also, when SO budgets are tight, SO team leaders tend to fund activities in their SO before they allocate funding to activities managed outside their SO. Thus, GHC approaches each fiscal year with more uncertainty about the overall level and composition of their next USAID budget than most USAID CAs.

RECOMMENDATIONS

Although there are modest problems, this relatively small, but complex USAID grant has been well managed by both USAID and GHC. A few recommendations are provided, however, in the hope that some additional efficiencies can be obtained.

GHC

1. Broaden GHC staff involvement (and visibility) in the work plan planning process.
2. Provide training on USAID procedures for the Director of Government Relations and perhaps others (e.g., attend the CEDPA one-week training course for new TAACS and Fellows or a similar course).

3. Ensure that the USAID CTO, SO team leaders, and all senior USAID health officials are aware of the breadth of GHC activities, and that they are particularly familiar with the new R&A Department leadership and the Evidence for Action series.
4. Establish a GHC HIV/AIDS working group to ensure inter-GHC coordination on HIV/AIDS activities and effective liaison with USAID's new HIV/AIDS Office.
5. Prepare quarterly reports that are more aggregative in nature and more results-oriented. Presently these reports provide activity lists of the events of the previous month and repeat text about ongoing GHC functions. For example, the description of the database (presently an example of repeated verbiage copied from the GHC proposal) could provide updated information on the increasing size of the database and how the database is being used.

USAID

1. Broaden USAID SO team member participation in the annual work plan process, especially in the brainstorming phase. This should add ideas to the brainstorming mix and make USAID officers more aware of the potential for utilizing GHC services.
2. The CTO should find ways to make the GHC program and its products more visible to a wider number of USAID technical and program staff. At present, much of the newer work of the GHC is not widely known.
3. The CTO should set and keep a deadline for completion of the annual work-plan (ideally by October 1). Make amendments to the work plan on a quarterly basis, as needed.
4. Review the (short) GHC pipeline and consider providing initial FY03 funding by the second quarter.
5. If warranted by a full pipeline review, amend the cooperative agreement to provide funding at the present level (approximately \$1,385,000) for the final year of the agreement.
6. Ensure that the relatively new USAID communications officers in the offices of HIV/AIDS, Health and Population have a clear vision of how traditional GHC and the new USAID office media activities can complement and not duplicate each other.

APPENDICES

- A. SCOPE OF WORK**
- B. GHC RESPONSES TO SPECIFIC SOW QUESTIONS**
- C. FUNDING TABLES**
- D. GHC FINANCIAL TABLES AND CHARTS**
- E. LIST OF PERSONS INTERVIEWED**
- F. LIST OF DOCUMENTS REVIEWED**
- G. GHC ORGANIZATION CHART**
- H. LIST OF GHC BOARD MEMBERS AND THEIR TERMS OF OFFICE**

APPENDIX A
SCOPE OF WORK

A. SCOPE OF WORK

GLOBAL HEALTH COUNCIL

EVALUATION CONSULTANCY – USAID COOPERATIVE AGREEMENT SCOPE OF WORK

July 17–September 7, 2002

I. ACTIVITY TO BE EVALUATED

Project Name: Global Health Council
Contractor: Global Health Council
Cooperative Agreement Number: HRN-A-00-99-00018-03
Expected Life of Project Cost: \$6,200,00.00
Cumulative Obligations 8/1999 – 7/2002: \$4,699,000
Cumulative Expenditures 8/1999 – 7/2002: \$4,045,000.

II. PURPOSE OF EVALUATION

The objective of this midterm evaluation is to assess the accomplishments to date of the USAID cooperative agreement #HRN-A-00-99-00018-03 to the Global Health Council. The period of this review is from August 1999 to present. An outside evaluator shall be commissioned to review program objectives and outcomes, program management, and sustainability and to make recommendations for program continuation. The program has a five-year commitment from USAID, from August 1, 1999 to July 31, 2004.

III. TIMEFRAME

It is anticipated that the consultant will be able to complete all aspects of the evaluation, including the final report, in a three-week period. Currently the evaluation is planned for July 17 – September 7, 2002.

IV. PROGRAM BACKGROUND

The Global Health Council, formerly the National Council for International Health, is a 30-year old not-for-profit membership organization. Through its multi-disciplinary and cross-cultural board of directors, staff and membership, the Council works with PVOs/NGOs, government agencies, and corporations, as well as with individuals, to engage national and international decision-makers on policies and practices that promote global health. The Council also facilitates opportunities for its members to establish linkages with organizations and individuals working in developing countries and in related fields, and offers programs designed to enhance their professional and scientific skills. The organization serves as a convener and an information clearinghouse on global health issues.

The results of the Council's activities are intended to increase public and private awareness of programs that address the Council's top policy priorities, and to improve the focus, effectiveness

and impact of these programs through shared application of best practices. The Council utilizes state-of-the-art communications technology as well as more traditional forums to provide members with ready access to usable technical information, shared experience and tools for effective action central to improving global health.

The purpose of this cooperative agreement is to support the overall objectives of the Global Health Council with specific support for information and capacity building activities.

The Global Health Council promotes three key aspects of Global Health:

- Education and outreach for increased attention on health issues of global importance
- Building coalitions between members
- Communicating best practices in the fight against global health concerns

In its proposal to USAID in 1999, the Council outlined the following vision and objectives:

Organizational Vision

By 2004 the Council will become:

- an organization noted for its positive influence on global health and development policies, priorities, and resource allocations;
- the principal networking organization for global health practitioners and activists;
- a leading non-governmental source of accurate and understandable information on key global health issues readily accessible to the public;
- the first place practitioners turn for getting and sharing information on what works best for improving global health.

Program Objectives

The Council's priorities mirror USAID's Strategic Objectives, and aim to support efforts to reduce:

- child mortality and improve child health and nutrition
- maternal mortality and improve women's health and nutrition
- unintended pregnancies
- the risk, spread and consequences of HIV/AIDS and other STDs
- the risk and spread of infectious diseases.

V. STATEMENT OF WORK

The following lists of questions regarding the project are meant to be a guide for the evaluator. The main focus of this evaluation shall be an assessment of a) the stated outcomes and b) progress in achieving the organizational vision.

A. Review and results of relevant recommendations from NCIH end-of-project evaluation, dated 1997:

1. Given USAID budget constraints, NCIH has no choice but to strive aggressively towards increasing financial self-sufficiency for certain of the services they provide – especially AIDSLINK and the Network Directory. To encourage more active fundraising, USAID might consider requiring NCIH to cover a percentage of overall AIDS program costs from outside fundraising.
2. Prior to approving a new long-term grant to NCIH, USAID should be assured that the NCIH board and executive leadership have developed an organizational strategy that includes the AIDS program as an integral part of NCIH goals, makes full and efficient use of NCIH staff skills for all NCIH programs, and attracts/retains more experienced staff.
3. Two options for USAID funding might be considered:
 - a) Funding for the basic NCIH/AIDS functions, as described above, plus “extended network support” (not “capacity building”) to selected NGO networks. This would probably require funding for three full time staff, including a senior program director, two of whom would be funded by USAID. The third position, AIDSLINK editor, should eventually be funded from AIDSLINK revenues and from matching funds.
 - b) Funding for (a) above plus some or all of the following “stretch” functions:
 - An expanded public education effort underlining the linkages between the worldwide HIV/AIDS epidemic and AIDS in the United States. This effort might also strive to make the public and policy makers aware of the need for a truly global response to the global HIV/AIDS epidemic, a response which would help alleviate the growing disparity between prevention and treatment available in the first world and the third world and which would provide mutual benefits.
 - Becoming a true intermediary for NGO network capacity building, organizing and directing needs assessments and financing (rather than implementing) more traditional capacity building activities with NGO networks.
4. During any future grant period, NCIH/AIDS needs to demonstrate greater knowledge of how USAID functions (e.g. to avoid APCASO-like problems) and increased capacity to work in continuing, close cooperation with the HIV/AIDS Division leadership and other ATSP III partners.

B. Key questions:

The evaluator will assess the extent to which the Council has worked toward achieving program outcomes as stated in the cooperative agreement.

- How has the Council evolved since the reorganization as outlined in the Koop report?
- Is the Council fulfilling its current mission? If not, what additional activities could be undertaken?
- Does the current mission of the Council complement the mission of USAID?

The evaluator will assess the extent to which the Council has worked toward achieving program outcomes as stated in the cooperative agreement.

1. Advocating for Global Health

- Have the local-global forums increased the engagement of the public and influential members of their communities in global health issues?
- Have electronic methods of communication been established to facilitate dialogue among forum participants?
- Has the Council partnered with others to support and publicize key events?
- Is the Council recognized by Congress as a source of non-partisan, unbiased and high quality information on global health issues? Are the Congressional Educational Briefings well-attended by congressional staff?
- Has the overall attention and knowledge of global health issues increased on Capitol Hill and among the general public?

2. Building Global Alliances

- What evidence is there that the Council's activities and resources have enhanced networking among its members?
- Has the Council diversified its membership to include developing country members as well as a more diverse representation from the United States?
- Have the regional forums been effective in increasing consensus on global health issues outside the U.S.?
- Have specialty health networks been identified and supported?
- Are there plans to establish one model Council affiliate?
- Are non-US organizations actively using Council services?
- Have the activities of the Council had an influence in expanding the network of organizations and individuals working on global health issues?

3. Communicating Best Practices

- Has the Council expanded its staff to include experts who are able to synthesize research findings for its members?
- Are Technical Synthesis Papers adequately disseminated and used?
- Have technical workshops brought together global health experts to encourage timely consensus on key issues?
- Has readership of HealthLink and AIDSlink expanded?
- Has the Web site been a successful vehicle for reporting findings and results of USAID-funded projects?
- Does the Annual Conference continue to serve as a leading mechanism for dissemination of information on global health issues?
- Have major sponsors begun to financially support the annual conference thereby reducing Council dependence on USAID support?

- Has conference participation increased? Has the quality of presentations improved at the annual conference?

4. Staff and Financial Management

- Is the staff adequately qualified, trained and supported to complete their scope of work?
- Does the executive director give proper support and guidance to the USAID program?
- What steps have been taken to improve the overall management of the program?
- What steps have been taken to improve the overall financial management of the program? Has the Council been able to diversify its funding base and what proportion of the budget is from private and public funds?

5. USAID management issues

- Has there been proper technical oversight on the part of USAID?
- Has USAID offered proper assistance in the development of their program?
- Does USAID provide assistance in proper and timely fashion?
- Has USAID supported the Council in reaching their program outputs?
- How could USAID improve their management of the program?

VI. METHODS AND PROCEDURES

A review of documents and a series of interviews will be conducted to address the evaluation framework.

VII. DOCUMENTS AND PUBLICATIONS

- Cooperative Agreements and Amendments
- Work plans
- Evaluation Reports

VIII. SUPPORT PROVIDED BY THE COUNCIL

The Global Health Council will provide the evaluator with access to all quarterly reports submitted to USAID, as well as any statistical information available through the GHC membership database or any other GHC analysis of membership (surveys, focus group findings, etc.) currently available. Staff will be made available for interviews with the evaluator during the course of the evaluation.

IX. EXPECTATIONS OF THE EVALUATOR

The evaluator will provide his/her own computer equipment and work space. He/she will be responsible for any and all data collection, synthesis of information, additional research, drafting, writing, and editing of the final product. It is expected that the evaluator will present a timeline for the evaluation within the first day, outlining the necessary steps to complete the evaluation and the plan for doing so. The Council will receive a copy of this timeline. Additionally, the Council will receive a copy of the draft evaluation for review, correction of factual errors, and comment on conclusions prior to completion of the final product.

ANNEX I — BACKGROUND INFORMATION ON GLOBAL HEALTH COUNCIL

PROGRAM FOCUS AND ANTICIPATED OUTCOMES (2004)

Education and Outreach

- 8 Local-global health forums respond to local initiatives and increase participation of local organizations on global health issues;
- Electronic method of communication among forum participants;
- 20 Special events, especially important global health dates (World Population Day, AIDS Candlelight Memorial, World Health Day, etc), through partnerships with others
- 30 Congressional educational/technical briefings

Building Global Alliances — Expanding Networks

- GHC Database - 100 percent increase in non-US organizations joining the council and actively using Council services
- Directory of global health organizations worldwide published
- 14 Regional forums outside the US, to stimulate organizational and individual partnerships between US and overseas organizations on global health issues
- Small grant fund used to support 95 non-traditional USAID partners (conference attendance, other events)
- 1 Council affiliate established
- 10 international/regional specialty health networks identified and supported

Communicating Best Practices

- 6 Advisory Committees established
- 3 technical staff working with the Advisory Committees to synthesize current knowledge and best practices
- Publications: 29 Council technical synthesis papers
- Web portal: 100 percent expansion of HealthLink and AIDSLink readership; web switchboard established
- 44 technical workshops for global health experts
- Annual conference: 5 annual conferences, with increasingly greater support from non-USAID sources (\$50,000 less from USAID each year); conference participation up by 100 percent; developing country participation up by 200 percent

Program Management

- Council revitalization - smaller board, stronger financial base, quarterly meetings
- Relationship to USAID - monthly meetings with USAID CTO
- Evaluation - full review of activities annually, by the Council President; full evaluation of agreement after 24 - 30 months of operations, with independent consultant, members of the Board of Directors, members of the Global Health Council and G/PHN rep; final evaluation after 48 months of operation
- Key dates — are listed in agreement, but variances can be explained

APPENDIX B

GHC RESPONSES TO SPECIFIC SOW QUESTIONS

B. GHC RESPONSES TO SPECIFIC SOW QUESTIONS

Key Questions

The evaluator will assess the extent to which the Council has worked toward achieving program outcomes as stated in the cooperative agreement.

1. How has the Council evolved since the reorganization as outlined in the Koop report?

The Global Health Council has gone through a major reorganization since the release of the Koop report. One of the most important conclusions of that report was that the overall goals and purpose of NCIH were still valid. An organization that attracted and aggregated the talents of development and global health NGOs, and helped them to have a voice in the larger debates about the distribution of information and resources that impact global health was essential. The Koop report agreed that this organization should serve as both an information source as well as a convener to broker policy compromises when necessary. The report included three main recommendations that have been put in place since the reorganization of NCIH:

First, the report recommended that the organization develop a new governance structure. Specifically, the report recommended that the Board of the organization be disbanded and a smaller, new board with fewer parochial interests be established. This has been done; the Board currently includes 12 high-level global health experts who have been directing the activities of the Council.

The report recommended that the Board be less involved in the day-to-day activities of the Council and that it focus on the larger policy issues that affect the viability of the Council. The by-laws and meeting structure that have been put in place since the Council's reorganization have been designed to foster this. Currently, the Council is discussing ways to increase NGO representation on the Board of Directors. This was brought to our attention by our members and will be brought to the attention of the Board during their fall retreat.

Second, the report recommended that the Council develop a new mission statement. This was done in 1998-1999 in an open process that included staff, senior management and the Board of Directors. A new mission statement was put into place at the end of 1999 and this still remains our mission.

Third, the report called for a complete overhaul of the operations of the Council in order to improve the efficacy of the management structure. A new CEO was hired and, following that, a complete overhaul of the programs and activities of the Council took place. The goal of this reorganization was to ensure that we were continuing the activities that were critical to the overall mission of the Council and our primary stakeholders. The new leadership, in consultation with the board, made a strategic decision to focus on three key activities: the annual conference (Efforts were made to restore the meeting as the key place to convene global health experts and practitioners.); advocacy (A new Director of Public Policy was hired to strengthen our presence on Capitol Hill and to ensure that global health interests were represented there); and public

outreach (The Council made special efforts to increase general media attention to global health issues.).

2. *Is the Council fulfilling its current mission? If not, what additional activities could be undertaken?*

We have actively engaged in the portion of mission that discusses the need to significantly increase resources for global health. In 1999, the Council undertook a campaign to double US government spending on global health programs. This was achieved by 2002.

At this time, the Council is deepening our engagement with our mission by determining how to more effectively use global health spending through the dissemination of more global health information. Rather than replicating the efforts of our members by conducting original research on key global health initiatives, the Council is working to synthesize existing information regarding best practices, and then efficiently and effectively provide that synthesis to our membership and other global health practitioners. Our Research and Analysis department is both synthesizing research and working with our Publications and Communications staff to determine the best way to disseminate this best practices information.

3. *Does the current mission of the Council complement the mission of USAID?*

USAID's programs in global health are committed to preventing suffering, saving lives, and creating a brighter future for families in the developing world. The agency is working to protect human health through programs in maternal and child health, HIV/AIDS, family planning and reproductive health, infectious diseases, environmental health, and nutrition.

The Global Health Council's programs promote better health around the world by assisting all who work for improvement and equity in global health to secure the information and resources they need to work effectively. We bring together the global actors in health around seven key issues which have been identified as critical to improving health and promoting equity. These issues are:

- Child Health and Nutrition
- Reproductive Health
- Maternal Health
- HIV/AIDS
- Infectious Diseases
- Disaster and Refugee Health
- Health Systems

There is a strong synergy between the two organizations in terms of not only mission and issue-focus, as well as strategies for achieving our mutual goals.

ADVOCATING FOR GLOBAL HEALTH

1. *Have the local-global forums increased the engagement of the public and influential members of their communities in global health issues?*

Local Global Health Forums are regional multi-disciplinary educational seminars that focus on key global health issues and interventions at the local and international level. They are designed to increase public awareness of the interconnectedness of the local and the global, and are one part of our strategy for mobilizing broad-based support for decreasing disparities in global health.

During the first year of the grant we held our first four forums, in New York, Massachusetts, Washington, DC, and California. We then undertook a review process in order to pinpoint what worked and what could work better as we moved forward with more events.

Among the outcomes of this review was a tool for determining optimal venues for future sites. In order to assess the value of hosting a Forum in a particular locale, we map the site against *six criteria*:

1. Is there a public health problem local communities can relate to?
2. Would a presence in the area help to further the Council's education and outreach efforts among key policy makers?
3. Is there potential for gaining media attention/is the media market large enough to garner significant audience?
4. Does our database reveal a good proportion of prospective attendees and participants?
5. Do we have high-profile individual or organizational members with whom we can partner to organize an event of the highest quality and visibility?
6. Is there potential for building strong alliances based on the Council's current education and outreach agenda?

We used these criteria to guide the planning of our next three forums, which were held in Illinois, Arizona, and Florida. By continually assessing what works and what doesn't and by combining our special events efforts with our grassroots work and our media strategy, Local Global Health Forums have engaged and mobilized members of the public in the communities in which they have been held. At the same time, by hosting forums in key congressional districts, we have been able to engage a small but influential number of Members in the global health issues, which the forums were designed to address.

2. *Have electronic methods of communication been established to facilitate dialogue among forum participants?*

While the Council has moved forward with a number of methods for facilitating dialogue among forum participants, we have not focused specifically on developing electronic methods. As these forums were held around the country, it was found that health advocates in each city communicated in different ways. Therefore, we have worked to follow up with participants in other ways. For example, in March of 2000, the Council held a forum in San Diego to highlight

World Tuberculosis Day. As a result of our outreach efforts, the local media was very interested in the event and the general public as well as local politicians became involved in the issue. One year later, the Council returned to San Diego and sponsored a study tour of the tuberculosis clinics in San Diego and in Tijuana, Mexico. This event was attended by Rep. Susan Davis, D-CA as well as bipartisan members of the local government. Following this study tour, the local government significantly increased its resources for cross-border tuberculosis programs and local activism related to this issue has significantly increased. This is an example of how the Council was able to continue its relationship with advocates who attended our forums and encourage them to take local action on a key global health issue.

3. *Has the Council partnered with others to support and publicize key events?*

The Council has consistently worked to develop partnerships with NGOs, professional organizations, government agencies, and multilateral organizations as it plans and executes its special events, both in Washington and throughout the country. We consider the establishment of working partnerships to be a key strategy in pursuit of our mission, and have developed and sustained partnerships with organizations at the local, national, and international levels. Every Congressional briefing we have hosted, for example, brings together voices from the field with representatives from either government agencies, multilateral organizations, or representatives from the private sector.

4. *Is the Council recognized by Congress as a source of non-partisan, unbiased and high quality information on global health issues?*

Through its sponsorship of Congressional briefings with strong competent speakers, by hosting issue-oriented, bi-partisan study tours, and by involving Members from all parties on our regional events, the Council has earned its reputation as a non-partisan resource for reliable and *accessible* information on global health issues. Our position has enabled us to not only reach across political divisions, but reach across divisive issues in pursuit of better health. We are able, for example, to show the fundamental linkage between children's health and the health of women, between family planning and child survival, between reproductive health and HIV/AIDS. By explicating these linkages, we often create converts to the cause of global health from sources that some would consider highly unlikely. Congressional staff look to the Council when seeking information about global health issues and how programs are or are not working in the field.

5. *Are the Congressional Educational Briefings well attended by congressional staff?*

The Council has generally been able attract a significant number of Congressional staff to our briefings. While some highly specialized events, such as our brown bag lunch on HIV/AIDS Prevention and Care, were attended by a relatively small number of staff members, other events such as HIV/AIDS in Latin America have been "standing room only" events.

Recently the Council has instituted a new format for its educational events on Capitol Hill: the brownbag lunch. These events are only for Congressional staff and have been quite well received, with between 12 and 15 staff members attending.

6. *Has the overall attention and knowledge of global health issues increased on Capitol Hill and among the general public?*

By augmenting our presence on Capitol Hill, and building our reputation as a factual and unbiased source of information related to global health, the Council has helped to keep global health on the political agenda during times of rapid change. Our efforts have helped to ensure that global health issues did not lose the battle of competing priorities within the national legislative agenda. Additional legislation has been introduced related to global health, including legislation to increase funding for global health overall, authorize HIV/AIDS programs and to expand support for infectious disease programs. Although the introduction of legislation indicates an increased interest in global health issues, it is difficult to measure an increase in knowledge in this area. It will be critical to determine a way to quantitatively measure knowledge in order to measure our success.

Our efforts beyond Washington have also had an impact. The news media are a critical conduit for providing information on global health issues to the public, and in the past few years there has been a shift in both the number of news outlets that are interested in covering global health stories and the manner in which they do so. Increasingly journalists are recognizing:

- The relationship between global health and issues of health and security in the U.S.
- The fact that events related to infectious disease, are not “one-time” stories, but rather represent ongoing issues that require continuous monitoring and attention.

The Council conducts ongoing assessments of public opinion and attitudes with the assistance of Lake, Snell and Perry, a public opinion polling firm. Through quantitative surveys and focus groups, we gauge opinion on our core issues. Our research demonstrates an increasing awareness or global health issues and receptivity to messages regarding maternal and child health, infectious disease and HIV/AIDS. The feedback we receive from focus groups and polling helps us shape messages used with a variety of audiences, including policy makers and the media.

BUILDING GLOBAL ALLIANCES

1. *What evidence is there that the Council’s activities and resources have enhanced networking among its members?*

The Council’s role as a networking entity has been increasing significantly each year as evidenced by the continuous growth of membership, conference attendance, and through the information collected through our web surveys (see attached). We have also begun developing connections through the Council’s Global Partnerships program and expect to link all interested members together on an ongoing basis to discuss or address issues of global significance regionally and internationally.

2. *Has the Council diversified its membership to include developing country members as well as a more diverse representation from the United States?*

Membership has grown from 399 individuals/organizations in October 1999 to a high of 1760 at the time of this writing. Over the same period, international membership has grown from 23 to 458 individuals/organizations. The Council now presently is in the early phases of a marketing effort to the lay-public in the US. We expect to reach 130, 000 individuals through this effort.

3. *Have the regional forums been effective in increasing consensus on global health issues outside the U.S.?*

Developing these key partnerships will allow the Council to establish a strong network worldwide. In the next two to three years, we see the partnership program aiming to reach the stated objective of implementing 10 forums. These forums will either be organized by the Council or co-hosted with our partners.

Results to Date: Partnerships that we have begun to develop address the different priorities of different partners. For example, the forum in India is an effort to organize individuals, NGOs, private organizations, academic institutions, and government entities around the right to comprehensive health care. ACOSHED in Nigeria hopes to replicate Council's structure and become a key NGO player in highlighting African health and development priorities at the global level. The five organizations in the NIS and CEE regions plan to develop a common agenda to advocate for better health in their own respective areas of focus (HIV/AIDS, palliative care, reproductive health, early childhood education). FESIRGUA is a network of organizations in Guatemala that expects to advocate on a local, regional as well as a global level for reproductive health issues. These different partnerships, which are focused on the priorities that exist in particular regions, set the stage for the Council to develop regional forums around specific health issues that also are part of both the Council's and USAID's key focus areas

Expectations thru 7/31/04: Implementation of such forums is one part of our effort to highlight regional health issues of concern and help our partner organizations to further consolidate program approaches and a global health agenda.

Problems and suggested problem resolution: Implementation of forums in the manner described will require allocation of funding for this purpose. This allocation will further assist the Council in leveraging additional funds for such forums. It will also create the capacity to be part of program development for the forums and help in increasing consensus on global health issues.

4. *Have specialty health networks been identified and supported?*

At this time, specialty health networks have not been established. Please see the explanation in the Annex section of this report.

5. *Are there plans to establish one model Council affiliate?*

The Council is in the process of examining the feasibility and appropriateness of establishing an affiliate.

Results to Date: See the discussion/explanation in the annex section.

Expectations thru 7/31/04: The Council will be able to determine feasibility and appropriateness of establishing an affiliate.

6. *Are non-US organizations actively using Council services?*

This year all partners working with the global partnerships department have been able to attend the Council's 29th Annual Conference. Partners and members are receiving Council publications and have access to our electronic resources and databases. We are also in the process of translating selected articles from *Health Link* and *AIDS link* into Russian for our members in the NIS/CEE regions. These will be made available to the members electronically and will also be posted on the Council's Web site.

At the 29th annual conference, the Council was pleased to facilitate an auxiliary event for the African Council for Sustainable Health Development (ACOSHED) in their first major public introduction of this pan-African non-state institution. The Council likewise hosted onsite events for delegations from India and Nigeria, and was instrumental in coordinating high-level meetings between the First Lady of Rwanda and potential funders during her attendance at the conference.

7. *Have the activities of the Council had an influence in expanding the network of organizations and individuals working on global health issues?*

All of our activities – from our sponsorship of the AIDS Candlelight Memorial to our educational programs on Capitol Hill to our Local Global Health Forums – are designed in part to expand the network of individuals and organizations that are working to address key global health issues. As mentioned, we view this networking as a critical strategy in pursuit of our mission. We believe that not only have we been influential, but have been instrumental in the expansion of this global network.

COMMUNICATING BEST PRACTICES

1. *Has the Council expanded its staff to include experts who are able to synthesize research findings for its members?*

At this time, the Research and Analysis Department consists of four staff members who are working with our director, Dr. Jimmy Volmink to synthesize global health research. In terms of full staffing for this department, we must recruit at least one additional staff with substantial experience in this area. It will continue to be a small department but we will be hiring additional staff that have strong global health and analytical skills.

2. *Are Technical Synthesis Papers adequately disseminated and used?*

The R&A department's goal is to disseminate rigorously assessed evidence on the effects of health care interventions to professionals in need of such information. The department has produced targeted information in a variety of formats, including journal articles, one-page summaries, book chapters and technical reports. Our *Evidence for Action* series (monthly summaries of systematic reviews) has been downloaded from the Council's Web site more than 1,000 times during the past 8 months. Full-length systematic reviews of interventions are being published electronically in the Cochrane Library – a widely used, international database of the best available evidence on health care.

3. *Have technical workshops brought together global health experts to encourage timely consensus on key issues?*

The R&A department has also conducted two GRIPP (Getting Research into Policy and Practice) workshops in Sharm El-Sheikh, Egypt and Washington, DC this year. The goal of these workshops is to promote better understanding between researchers, policy makers, and practitioners and encourage the use of research evidence in decisions about healthcare.

The enthusiastic participation of the workshop participants, as well as their high ratings of the workshop in the participant evaluations, reflects their appreciation of good quality research information in their work. The department has also received a number of requests for follow-up workshops. In the future, we are planning to contact participants to ask how the workshop may have helped them in their work in the global health field.

4. *Has readership of HealthLink and AIDSLink expanded?*

USAID supports the following areas of *HealthLink*: technical updates, best practices, global health news, Policy Makers, calendar, outbreaks, and On the Move.

The bi-monthly runs of both *Global AIDSLink* and *Global HealthLink* have increased substantially over the past few years. In 2000, an average of 2,500 copies of each issue of *AIDSLink* and each issue of *HealthLink* were distributed. At present we print an average of 4,000 copies. Both publications are sent to members of Congress and are sent to a select list of media outlets. By the end of 2002, *AIDSLink* and *HealthLink* will also be sent to a significantly expanded list of journalists. .

5. *Has the Web site been a successful vehicle for reporting findings and results of USAID-funded projects?*

By offering a link to the Web site of our members and partners through www.globalhealth.org, visitors to our Web site can connect directly to many organizations working in USAID-funded projects. Further, in the section entitled "Notes from the Field," Council members may directly share their experiences on front-line projects in developing countries. In addition, *Global AIDSLink* and *Global HealthLink*, which feature USAID funded programs, are also available to our members online. Finally, the Council emails members on a subscription list to inform them

of the latest additions to the web and in doing so highlights new information from or pertaining to USAID.

6. *Does the Annual Conference continue to serve as a leading mechanism for dissemination of information on global health issues?*

Not only does the conference continue to serve as a leading mechanism for dissemination of important global health information, it has significantly expanded its capacity to do so over the past several years. The International Exhibition portion of the conference has more than doubled during this period, creating a dynamic and highly valued venue for networking among participants, as well as a key event for exhibitors to engage participants and share information regarding new products, services, and projects. In addition, the Council has greatly expanded the capacity of the conference to accommodate auxiliary events, during which several organizations have staged launches for reports and initiatives. The core conference program also continues to grow in value as the implementation of a more intensive and rigorous abstract review process has resulted in a higher standard for the acceptance of panel, roundtable and poster abstract presentations.

7. *Have major sponsors begun to financially support the annual conference thereby reducing Council dependence on USAID support?*

In successive years beginning in 2000, the Council has removed over \$100,000 in USAID funding from its annual conference budgets. In addition, USAID's funding level as a percentage of total revenues for the conference has shrunk considerably. This is best demonstrated by the attached charts that show the percentage of funds used for conference over the past five years.

8. *Has conference participation increased? Has the quality of presentations improved at the annual conference?*

Conference attendance has increased by approximately 80 percent over the past four years, and we anticipate that by the end of the 2003 conference it will have increased by close to 100 percent. This is a remarkable rate of growth by any standard of measurement. In 2001-02, when many international conferences saw a decrease in their attendance, the Council experienced nearly a 10 percent increase. As mentioned previously, the quality of presentations has improved due to the implementation of a revamped abstract review process and by more intensive content research and outreach activities during the planning phase of the conference program.

STAFF AND FINANCIAL MANAGEMENT

1. *Is the staff adequately qualified, trained and supported to complete their scope of work?*

In February of 2001, the Global Health Council hired a Human Resources Director to put in place human resources systems and practices to enhance and support the growing number of staff at the Council. Formalized recruitment and hiring practices and the analysis of the wage and salary program as it relates to market have resulted in attracting a high caliber of committed, qualified and professional staff to the Council team.

A strong orientation and training program, most recently on the new Performance Evaluation and Planning tool, continues to strengthen the skills of our workforce. Staff have the necessary resources and support to perform the responsibilities of their positions.

2. *Does the executive director give proper support and guidance to the USAID program?*

The CEO, the COO and the Director of Government Relations meet on a regular basis to assure that progress is being made in achieving the goals set in the cooperative agreement. Since late 2000, the Council has been providing quarterly reports to USAID on a regular basis and reporting of our activities has become more consistent.

3. *What steps have been taken to improve the overall management of the program?*

The Council has undergone a period of planned growth and expansion over the past several years. The expansion is designed to ensure that we manage and execute our work with the utmost skill, professionalism, and – most importantly – impact. The changes we have made throughout the organization have had a significant impact on the work that we do in conjunction with USAID; we have improved our reporting processes, expanded our formal and informal interaction with the Agency, and put in place a system for reviewing our work internally to be sure that we are meeting or exceeding the expectations outlined in our original agreement. When we find areas where our output has differed significantly from our planned efforts – either exceeding our original expectations or experiencing a change in direction – we inform USAID of our findings and work together to appropriately address the situation. We have increased our interaction with USAID as they relate to our agreed upon activities by holding regular meetings with staff and by increasing the number of meetings being held with our CTO.

4. *What steps have been taken to improve the overall financial management of the program?*

The Council has made a number of improvements regarding the financial management of our overall program. Some of the key improvements include:

- Hiring of all new senior Directors & key staff under the cooperative agreement. This includes core staff such as the Finance Director and Senior Development Coordinator who oversees USAID reporting.
- Diversification of program support funds to include many private donors including a higher percentage of unrestricted membership fees and conference registration receipts being programmed.
- Investment in an industry-leading accounting software system (Blackbaud Accounting for Non-Profits) that has vastly improved the ability of the accounting department to provide program managers with detailed financial information for decision-making.

5. *Has the Council been able to diversify its funding base and what proportion of the budget is from private and public funds?*

As the attached Financial Report details, the Council has significantly diversified its funding base. In FY 2001 Private funding was 76.5 percent of our revenue base and public funds from the US government (USAID & CDC) made up 18.2 percent and Multilateral funding was 5.3 percent.

USAID MANAGEMENT ISSUES

1. *Has there been proper technical oversight on the part of USAID?*

Since the inception of the grant, there have been regular meetings between the key agency contact and our CTO. In addition, the key Council contact meets regularly with the five SO team leaders to ensure that the agreed upon activities are being carried out in a manner consistent with their desires. More regular meetings with the CTO and the key Council contact have been established in the past 6 months and it is expected that this will even further strengthen the relationship and the ability of the Council to carry out the activities as outlined in the cooperative agreement.

2. *Has USAID offered proper assistance in the development of their program?*

The Council currently works with all five SO team leaders to develop the annual work-plan. While critical to the establishment of our programs, this can also of course be a cumbersome process and often leads to some delay in activities due to work schedules. This year the development of the workplan will occur in August and the key Council contact will be working with our SO team leaders to more deeply to discuss the content of our events in order to avoid delays later in the year.

3. *Does USAID provide assistance in proper and timely fashion?*

The CTO has been very responsive to requests and questions. As mentioned above, it can at times be difficult to reach the SO team leaders based on busy work schedules, but our new work-plan development process should help to make the consultative process more efficient.

4. *Has USAID supported the Council in reaching their program outputs?*

Yes.

5. *How could USAID improve their management of the program?*

Further consolidation of the planning process in August will help to improve the management of the program from the perspectives of both the Council and USAID. (Please see previous paragraphs for explanation of this process.)

ANNEX I — BACKGROUND INFORMATION ON GLOBAL HEALTH COUNCIL

PROGRAM FOCUS AND ANTICIPATED OUTCOMES (2004)

Education and Outreach

Eight (8) Local-global health forums respond to local initiatives and increase participation of local organizations on global health issues

Progress to date: 4 forums have been sponsored by USAID.

Planned through 7/31/04: The Council reviews and plans its LGHFs on an annual basis.

Discussion/explanation: To date, forums have focused on two principal themes: infectious diseases and maternal and child health. In each community where we have conducted forums local public health leaders in these fields have participated as speakers or attendees. In addition, we have consulted with local experts in San Diego, Miami, Chicago and Tucson, for example, to seek their assistance in building agendas that focus on local topics that can be bridged to their global counterparts. In making the local-global connection, we have focused on the commonalities as well as the contrasts. In addition community leaders -- including member of Congress -- have been invited to participate as speakers. US Representatives from Illinois, Florida, California and New York have provided support to forums through their active participation.

Electronic method of communication among forum participants

At this time, this method of communication has not been established due to the diversity of communication methods among participants in our forums around the country. (Please see above for more information on this topic.)

Twenty (20) special events, especially important global health dates (World Population Day, AIDS Candlelight Memorial, World Health Day, etc), through partnerships with others

Progress to date: To date the Council has held six briefings to coincide with global health dates. Due to the Congressional cycle and the fact that it is not always possible to schedule activities on Capitol Hill around particular global health dates, it has not been possible to fulfill this objective with respect to every important global health date. In lieu of holding events on days, which would not have a high impact, we have been holding briefings at more convenient times. We have also have instituted a new information source for Congressional staff that is sent out on all global health days. These fact sheets highlight the particular issue of interest and have been very well received by staff. We will be augmenting this information service in the coming year.

Planned through 7/31/04: We will be working with our SO team leaders to identify important dates that they would like to highlight in the coming years.

Thirty (30) Congressional educational/technical briefings

Progress to date: We have held 40 educational briefings on Capitol Hill. In the 2002 work-plan, there are plans to hold 5 additional briefings.

Planned through 7/31/04: We are planning on holding an additional 48 events on Capitol Hill during the remainder of the cooperative agreement.

Discussion/explanation: The Council has chosen topics for these educational briefings in cooperation with the SO team leaders at USAID. Due to the overwhelming success of the briefings, we have been asked to hold more briefings per year than was initially anticipated. In addition, we have now put into place two formats for these briefings – a standard Congressional briefing as well as a Brown Bag series of events. The format is chosen on the basis of such criteria as topic, agenda, and date, and we will continue to host briefings in both formats in the coming years.

Building Global Alliances — Expanding Networks

GHC Database - 100 percent increase in non-US organizations joining the council and actively using Council services

Progress to Date: Achieved. When we began tracking this indicator in 1999 we had 23 non-U.S. member organizations. We now have 282 non-US member organizations with 25 others currently in process. This reflects a significant increase over proposed target.

Planned through 7/31/04: 100 percent increase in non-US organizations joining the Council and actively using Council services with baseline as 282 members in 2002.

Discussion/explanation: We have used various strategies to increase our international membership. They have included direct solicitations, word of mouth, working through international exhibitions and showcasing the Council's mission and activities, including membership as a benefit for attending the conference; and working with donors and current members to under-write members for non-us organizations.

Expectations through 7/31/04: We will work to identify and address key global health issues in the seven focus areas with all the networks we have developed or become a part of.

Problems and suggested problem resolution: The Council has experienced phased growth in the past three years, and each department has grown at different speeds in terms of program development and human resource capacity. We are now at the stage where we have developed systems for our existing activities and are currently developing a strategic plan, which will allow us to re-focus our energies on a common organizational goal and objectives. As we use strategies to increase international memberships, we will also have to strengthen the Council's capacity to provide products and services in multiple languages.

Directory of global health organizations worldwide published

Since 1999, the Global Health Council in alternating years has completed the compilation of either the *Global Health Directory* and the *Global AIDS Directory*. Thus far, the Council has published the following: *2000 Global AIDS Directory*, *2001 Global Health Directory*, *2002-2003 Global AIDS Directory*. The *2003-2004 Global Health Directory* is scheduled to be published in March 2003. Future plans for the Web site include online versions of each Directory, to be made available to our members.

Fourteen (14) regional forums outside the U.S., to stimulate organizational and individual partnerships between US and overseas organizations on global health issues

Progress to date: One meeting held in India to develop structure for partnerships on global health issues. The Council has organized specific sessions in two international HIV/AIDS conferences and exhibited at them to develop relations with overseas organizations.

Planned through 7/31/04: Implementation of 10 regional forums, either organized by the Council or co-hosted with other partners.

Discussion/explanation: The Council established the Global Partnerships department in September 2001. Since its inception relationships have been developed with several organizations, including:

- Center for Enquiry into Health and Allied Themes and the National Center for Advocacy Studies in India
- African Council on Sustainable Health and Development in Nigeria
- 5 organizations in NIS/CEE regions
- FESIRGUA in Guatemala

These organizations all either lead networks or have strong regional affiliations. The next part of the reporting period will be directed to connecting these and other organizations by means of regional forums, technical exchange visits, internship programs and publications.

Small grant fund used to support 95 non-traditional USAID partners (conference attendance, other events)

Prior to its suspension in December 2001, the Council had awarded 32 Small Grant Awards to non-traditional partners in the field. These grants were used to support conferences in the developing world, core funding for small organizations that were just being established as well as workshops on particular areas of interest. In addition, the Council awarded scholarships to individuals who participated in the US Conference on AIDS in order to increase cooperation between NGO representatives from the developing world and HIV/AIDS programs here in the United States.

Due to negotiations between the Council, key Members of Congress and USAID, this program has been suspended.

One (1) council affiliate established

Indicator: 1 Council Affiliate established.

Progress to date: 150 organizations interviewed and two short-listed as partners to explore to establishment of an affiliate.

Planned through 7/31/04: Feasibility of establishing an affiliate determined.

Discussion/explanation: Since the formation of the Global Partnerships Program, the Council has been investigating the feasibility of establishing an affiliate in India. The process so far has entailed interviewing organizations, and identifying two partners (Center for Enquiry into Health and Allied Themes and the National Center for Advocacy Studies) to work with the Council in exploring this concept. Initial work has led to the development of a concept paper, which calls for organizations to address the issue of right to comprehensive health care. Another paper outlining the process to develop the organizational structure to support the concept has also been produced. The next steps are to form an advisory group and examine whether or not an affiliate should be established.

Ten (10) international/regional specialty health networks identified and supported

Progress to date: 2 Supported. Establishment and development of 4 others is in progress.

Planned through 7/31/04: 10 International/ regional specialty health networks identified and supported.

Discussion/explanation: During this reporting period the Council has supported the development of a network of committed individuals who organize a major community event as part of the International Candlelight Memorial. The program has grown significantly since the Council began to manage and oversee it; currently over 1000 communities worldwide are registered coordinators for the Memorial.

The Council has also supported the development and growth of the White Ribbon Alliance for Safe Motherhood. The role of the Council has been to work within the Steering Committee to help maintain focus on increasing awareness in the United States about global maternal health. In addition, the Council has supported the Global White Ribbon Contest for the past three years. This contest rewards organizations that are promoting safe motherhood in their communities by bringing them to the annual conference of the Council and enabling them to participate in the myriad learning opportunities that the conference presents.

The Council established the Global Partnerships department in September 2001. Through the various partnerships developing in Asia, Africa, Latin America and NIS/CEE regions, the Council has begun the process of identifying specialty health networks. In the remaining grant period, we will seek to develop strong program links with these networks.

Communicating Best Practices

6 Advisory Committees established

Progress to date: Not achieved to date.

Planned through 7/31/04: To Be Determined

Discussion/explanation: This objective was initially explored 24 months ago, at which time there was a lack of member interest in the formation of these committees. We will be revisiting this concept in the coming year; the Council's newly established Research and Analysis department will be spearheading this effort in collaboration with the Membership department. Our goal is to ensure that members see the value of these committees and are committed to furthering their success.

Program outcomes: Committees, if seen to be valuable by members, will serve as advisors to the Council by identifying key issues not already addressed, refining the Council's education and outreach agenda, and advising on new methods of identifying and disseminating best practices.

Problems and suggested problem resolution: 24 months ago, there was a lack of member interest in forming these committees. This, however, was during the time when the Council was still consolidating its program and organizational structure. The Research and Analysis Department was established last year and the Council plans to present this option to members again.

Three (3) technical staff working with the Advisory Committees to synthesize current knowledge and best practices

The new Research and Analysis Department has hired four employees who are working to synthesize both scientific and policy information into a format that can be used by our members. We will be happy to provide their CVs to you at your request.

Publications: 29 Council technical synthesis papers

At this time, the Research and Analysis Department has produced five Evidence for Action reports that synthesize research findings on global health issues. In addition, the department has produced a technical report on maternal health, which was released at our 2002 annual conference.

During the remainder of the cooperative agreement term, the department intends to produce an additional 20 Evidence for Action reports, 5 Systematic Reviews, and 3 Technical reports.

Web portal: 100 percent expansion of HealthLink and AIDSLink readership

Please see response in relevant section above.

Web switchboard established

- The Publications and Web departments have forged links with our member organizations, including USAID, that provide information related to global health. We have linked to sources of information being created at the local, regional, national and international levels, gleaned material and information from public entities, private corporations, academic institutions, and advocacy organizations. The best source of information on this area can be found by accessing the site itself at www.globalhealth.org.
- Weekly global health electronic emails. These emails list all global health news, information sources, upcoming events, publications, and jobs that have been added to our Web site in the past seven days. We also use this newsletter to draw attention to special news and events that will take place in the coming week. As of July 15th, there are approximately 500 subscribers to this service; we hope to have more than 1,000 subscribers by the end of 2002 and more than 2,000 by then end of 2003.
- The home page of the Council's Web site is continually updated to provide up-to-the-minute information about breaking news related to global health, with links to related stories in other news outlets. The majority of these stories concern issues related to global infectious diseases.
- The Council web staff monitors Newsgroups and List serves on a daily basis, in order to tap into current discussions related to infectious disease. In the future, we plan to expand this from a monitoring to a generative function. As part of our newly-established Research and Analysis Department, in the coming year we will be developing the capacity to initiate and moderate debates on current health topics of relevance to the American public. Rather than reporting on ongoing discussions, in the future the Council Web site will itself be a forum for real-time debate and analysis.
- Redesign of the Candlelight Memorial Web site (<http://www.candlelightmemorial.org>) and introduction of interactive community online forum/discussion board in August 2002.
- All of our bi-monthly publications (HealthLink and AIDSLink) are available online in both HTML and downloadable PDF Format.
- The Council disseminates key findings from these systematic reviews in a monthly series entitled *Evidence for Action*. The series is posted on the Council's Web site and is published in both *Global HealthLink* and *Global AIDSLink*. To date, the Evidence for Action series includes the following pieces:
 - Fewer Antenatal Visits as Effective as Standard Antenatal-Visits Model
 - Melatonin effective for preventing or reducing jet lag from air travel
 - Condoms reduce, but do not eliminate, risk of heterosexual HIV transmission
 - Lack of evidence that directly observed therapy (DOT) improves cure or treatment completion rates in patients with tuberculosis

- Reduced osmolarity oral rehydration solution (ORS) more effective than standard WHO solution for treating acute diarrhea in children.
- Online up-to-date global health directory to be completed by December 2002. This directory will be online, searchable database containing information for organizations all over the world that are involved in global health issues. The base database will begin with all of the organizations currently listed in our paper publications of the AIDS Directory and the Global Health Directory. Visitors will have the opportunity to update existing records and add new organizations.

The site, www.globalhealth.org, features the current and archived issues of *Global HealthLink* and *Global AIDSLink*. This has increased our capacity to disseminate information to our members domestically and abroad. Readers can share individual articles with member colleagues around the globe merely by sending a hyperlink. Because archived issues of both publications are available online, members can access information from current and past issues anywhere they can access the Internet. Future plans for the Web site include online versions of the Global Health Directory and Global AIDS Directory, and establishing bulletin boards and technical chats on the web to make the Web site dynamic and interactive.

Aside from current global health news, the Web site offers links to our members, their programs, their publications, their resources, their jobs openings, and their educational opportunities. With a click of a button, visitors to our Web site are linked to a wealth of information, on www.globalhealth.org and beyond.

Forty-four (44) technical workshops for global health experts

Since the inception of the cooperative agreement, the Council has partnered with Management Sciences for Health and the Pan American Health Organization to support a technical workshop series at the National Press Club; at least 24 of these workshops have occurred.

In addition, the Research and Analysis Department will be holding GRIPP workshops around the world (please see explanation of GRIPP workshops in earlier question). At this time, we have held 2 of these workshops and it is expected that we will be holding six more in the next two years.

Annual conference: 5 annual conferences, with increasingly greater support from non-USAID sources (\$50,000 less from USAID each year)

Please see response in relevant section above. Further detail is also provided in the attached Excel file.

Conference participation up by 100 percent

Please see response in relevant section above.

Developing country participation up by 200 percent

We have increased international participation by 300 percent.

- 1998 Developing Nation Attendance = 78 / Countries Represented = 32
- 1999 Developing Nation Attendance = 86 / Countries Represented = 35
- 2000 Developing Nation Attendance = 131 / Countries Represented = 32
- 2001 Developing Nation Attendance = 237 / Countries Represented = 46
- 2002 Developing Nation Attendance = 231 / Countries Represented = 69

Program Management

Council revitalization - smaller board

The Council currently has a Board of 12 individuals, which is significantly reduced from the former size of the Council's Board previously. This change was strongly recommended by the Koop report. A list of our current board members is attached.

Stronger financial base

As the attached annual reports of the Global Health Council demonstrate, the Council has been able to both greatly expand its funding base as well as significantly increase our overall budget over the last few years. We plan to continue this trajectory, with increased diversity among our funders, in the coming years.

Relationship to USAID

Monthly meetings with USAID CTO

We have been holding meetings with our CTO on an as needed basis. Recently, we have instituted a more regular schedule.

APPENDIX C

USAID FUNDING TABLES

- C-1. Budget Summary: USAID-GHC Cooperative Agreement (Original Agreement)**
- C-2. USAID Funding Provided to Date by Strategic Objective: FY99/00-03/04**
- C-3. GHC Budget and Expenditures by Line Item**
- C-4. USAID Expenditures as a Percentage of all GHC Expenditures by Budget Category, FY02**
- C-5. USAID Program Expenditures as Percentage of all GHC Program Expenditures, FY02**

C-1. USAID BUDGET SUMMARY — ORIGINAL AGREEMENT

Program Function of Activity

- Advocacy: \$907,133
- Building Global Alliances: \$1,810,011
- Communicating Best Practices: \$3482,856

Object Class Category

- Personnel: \$2,297,015
- Fringe Benefits: \$574,256
- Travel: \$292,389
- Equipment: \$0
- Supplies: \$475,591
- Contractual: \$735,818.

Anticipated Annual Obligations

- Year 1: \$1,050,000
- Year 2: \$1,287,500
- Year 3: \$1,287,500
- Year 4: \$1,287,500
- Year 5: \$1,287,500

C-2. USAID FUNDING BY STRATEGIC OBJECTIVE

<i>GHC — USAID AGREEMENT #HRN-A-00-99-00018-00</i>								USAID Funding Allocation by Agreement Year					
Mod	Mod	USAID Funding by Strategic Objective						Total	08/99 to 07/00	08/00 to 07/01	08/01 to 07/02	08/02 to 07/03	08/03 to 07/04
#	Date	SO1	SO2	SO3	SO4	SO5	FS	to Date	FY 99/00	FY 00/01	FY 01/02	FY 02/03	FY 03/04
Orig.	####		\$100,000	\$300,000	\$450,000	\$100,000		\$ 950,000					
1	####	\$150,000						\$ 150,000	\$1,100,000				
2	####		\$280,000	\$400,000	\$400,000	\$150,000		\$1,230,000					
3	####	\$150,000					\$50,000	\$ 200,000		\$1,430,000			
4	####			\$375,000	\$500,000	\$175,000		\$1,050,000					
5	####						\$40,000	\$ 40,000			\$1,240,000		
6	####	\$300,000	\$138,000	-				\$ 438,000					
7	####		\$ 91,000	\$375,000	-	\$175,000		\$ 641,000				\$929,000	
8								-					
9								-					
10								-					
11								-					
12								-					
	Totals	600,000	\$609,000	\$1,450,000	\$1,350,000	\$600,000	\$90,000	\$4,699,000					
					Total Agreement:			\$6,200,000					
					Balance to Allocate:			\$1,501,000					
				Anticip't'd	SO 4 allocation for FY 2003 (less)			\$649,000					
					Balance of funds for FY2004			\$852,000					
					Less Average Burn Rate			\$1,337,000					
					Amount needed to raise ceiling:			\$485,000					

C-3. GHC BUDGET AND EXPENDITURES BY LINE ITEM FOR USAID AGREEMENT

GLOBAL HEALTH COUNCIL

Cooperative Agreement Analysis Report

Name: USAID # HRN-A-00-99-00018-00

Period: August 3, 1999 to July 31, 2004

CONSOLIDATED REPORT				
		TOTAL	Total	
USAID		Proposal	Cumulative	Budget
<i>Lines:</i>	<i>GHC Line Item Expenses:</i>	<i>Budget</i>	<i>Expenditures</i>	<i>Balance</i>
Salaries	Salaries	2,297,025	1,125,956.44	1,171,068.57
Benefits	Benefits	574,256	255,353.59	318,902.41
Supplies:	Office Consumables	115,000	39,723.56	75,276.44
	Copier & Reproduction	49,000	16,326.30	32,673.70
	Communications	97,500	39,474.78	58,025.22
Contractual:	Meeting & Conference Exp	210,800	549,545.65	(338,745.65)
Travel:	Travel / Hotel & Per Diem Exp	292,389	213,375.61	79,013.39
Supplies:	Web/Internet & Network	59,000	37,897.20	21,102.80
Other:	Staff Training Expense	27,250	6,001.41	21,248.59
Supplies:	Membership & Subscription	34,200	7,652.05	26,547.95
Contractual:	Professional Fees & Services	112,000	154,228.68	(42,228.68)
	Printing & Publications Exp	189,825	163,263.65	26,561.35
Supplies:	Advertising & Marketing	13,000	13,063.10	(63.10)
	Distribution & Shipping	82,500	89,544.46	(7,044.46)
	Equipment under \$5,000	25,391	25,150.67	240.33
Construction:	None	-	-	-
Contractual:	Sub Grant & Sub Contract	223,193	156,072.00	67,121.00
Other:	Insurance Expense	2,500	-	2,500.00
	Occupancy	325,500	50,062.15	275,437.85
Equipment:	Equipment Over \$5000.00	-	-	-
Other:	Depreciation	-	-	-
	Bank Charges	1,500	100.00	1,400.00
	Interest Expenses	-	-	-
	Board of Directors	1,145	-	1,145.00
	Total Direct Expenses	4,732,974	2,942,791.29	1,790,182.71
ICR	Indirect Cost	1,467,026	1,102,208.70	364,817.30
	TOTAL EXPENSES	6,200,000	4,045,000.00	2,155,000.00

**C-4. ESTIMATED USAID EXPENDITURES AS A PERCENTAGE OF FY02 OVERALL
GHC EXPENDITURES — BY AGREEMENT CATEGORY**

Global Health Council, Inc. FY 2002 Agency-Wide Board-Approved Planning Budget			
		06/30/2002	
REVENUES	Board-Approved FY 2002 Budget	YTD Revenues & Expenditures	Percentage of Rev/Exps. USAID
Restricted Grants & Contracts	5,523,200	4,773,656	20.9%
General Unrestricted & Sponsorships	1,476,800	1,115,406	0.0%
Total Revenue	7,000,000	5,889,062	16.9%
EXPENDITURES			
Employee Wages & Benefits	3,412,487	2,215,606	22.6%
Office Consumables & Equipment	260,785	102,750	17.4%
Communications	202,198	108,785	9.0%
Meeting & Conference	539,737	521,000	50.5%
Travel/Lodging/Per Diem	689,960	355,066	16.1%
Web, Internet & Network	263,000	96,108	0.0%
Staff Training Expense	95,500	48,631	4.1%
Professional Fees & Services	782,333	533,679	4.1%
Printing, Copying & Publication	380,364	189,021	15.7%
Recruitment & Advertising	135,227	50,400	1.7%
Distribution /Shipping	213,909	126,247	31.8%
Small Grant & Sub-Contract Exps	1,125,000	1,038,500	5.2%
Insurance Expense	27,000	14,121	0.0%
Occupancy Expense	282,500	256,746	0.0%
Capital Equip. & Depreciation. Expense	90,000	68,261	0.0%
Total Expenses	8,500,000	5,724,922	17.4%
Net Income (Loss)	(1,500,000)	164,140	

C-5. USAID PROGRAM EXPENDITURES AS A PERCENTAGE OF ALL GHC PROGRAM EXPENDITURES

Actual USAID expenditures for 2002 as a percentage of overall GHC spending on these activities:

- Congressional Briefings: 34.70%
- Local-Global Forums: 0.11%
- Special Events: 70.75%
- Evidence for Action reports: 0.79%
- HealthLink: 42.61%
- AIDSLink: 98.70%
- Small Grant Fund: 100% of funds provided to grantees
- Regional Forums: 39.22%
- White Ribbon Alliance activities: 0.14%
- US Coalition for Child Survival activities: 0.0%
- Annual Conference: 40.30%
- Web site: 0.0%
- Database: 39.59%
- Directories: 38.36%

Note: GHC does not utilize USAID funds for any international travel by GHC staff.

APPENDIX D

GHC FINANCIAL TABLES AND CHARTS

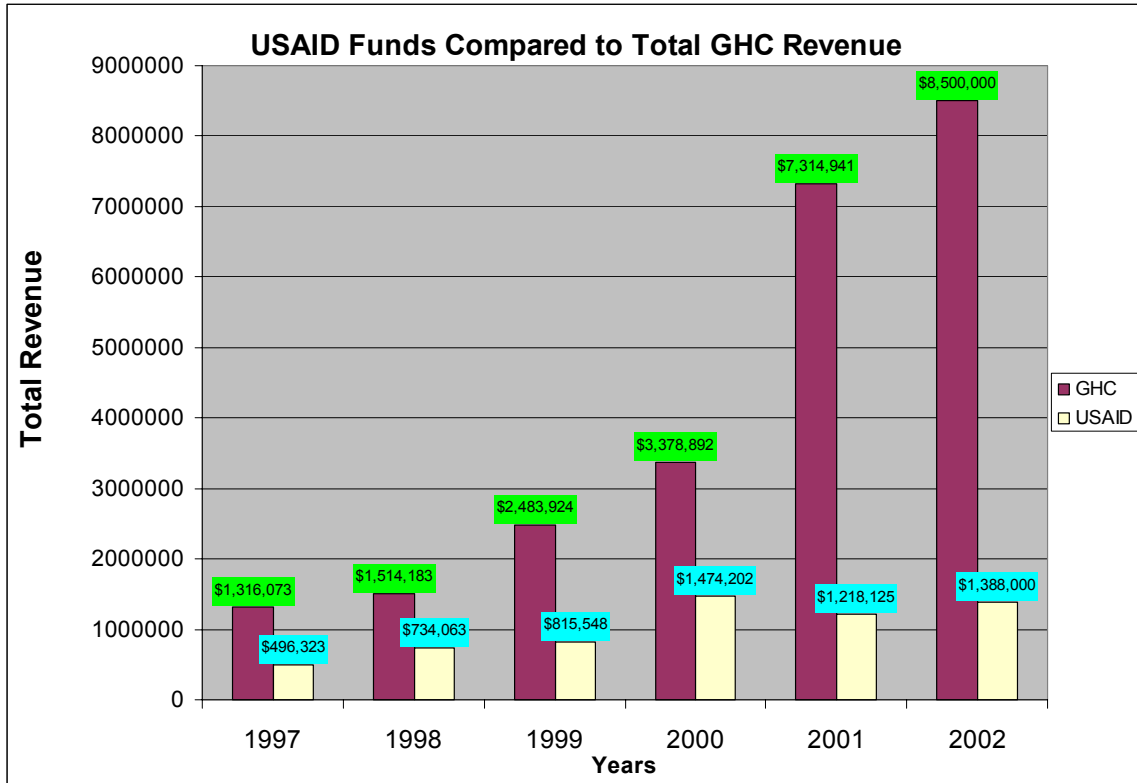
D-1. USAID Funds Compared to Total GHC Revenue: 1997-2002

D-2. GHC Annual Comparative Income Statement and Financial Information FY97-01

D-3 (a & b). GHC Annual Report — 2001 Revenues and Expenditures (Table and Graphic)

D-4. GHC Active Grants and Cooperative Agreements

**D-1. USAID FUNDS COMPARED TO TOTAL GHC REVENUE:
1997-2002**



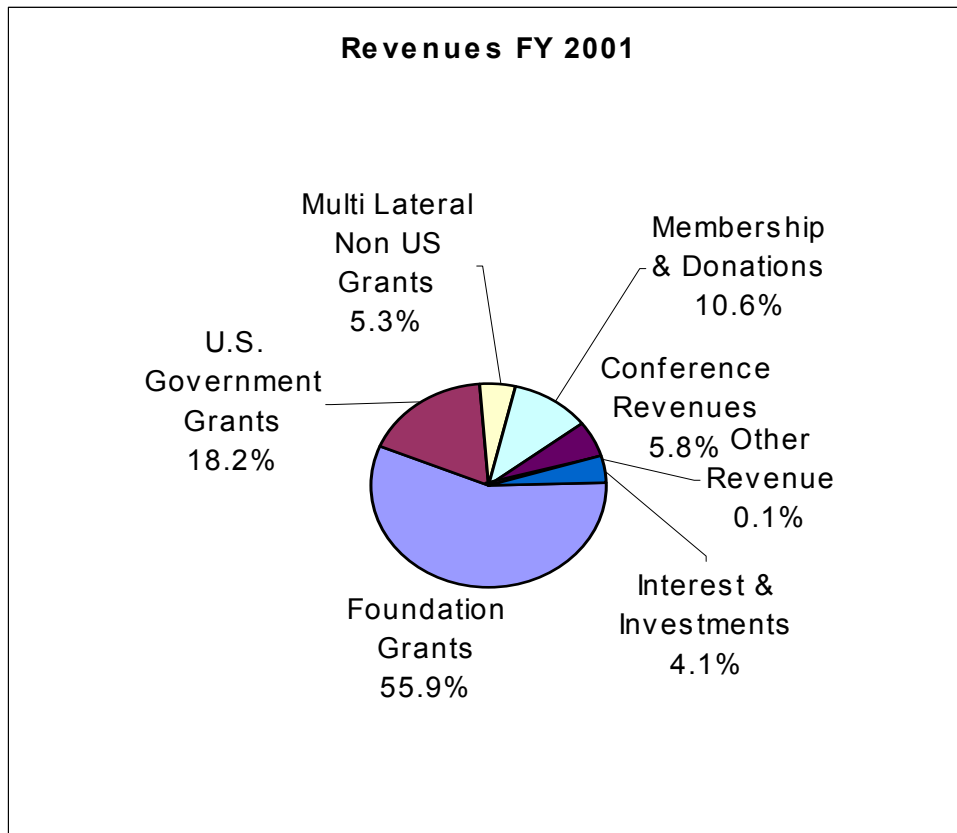
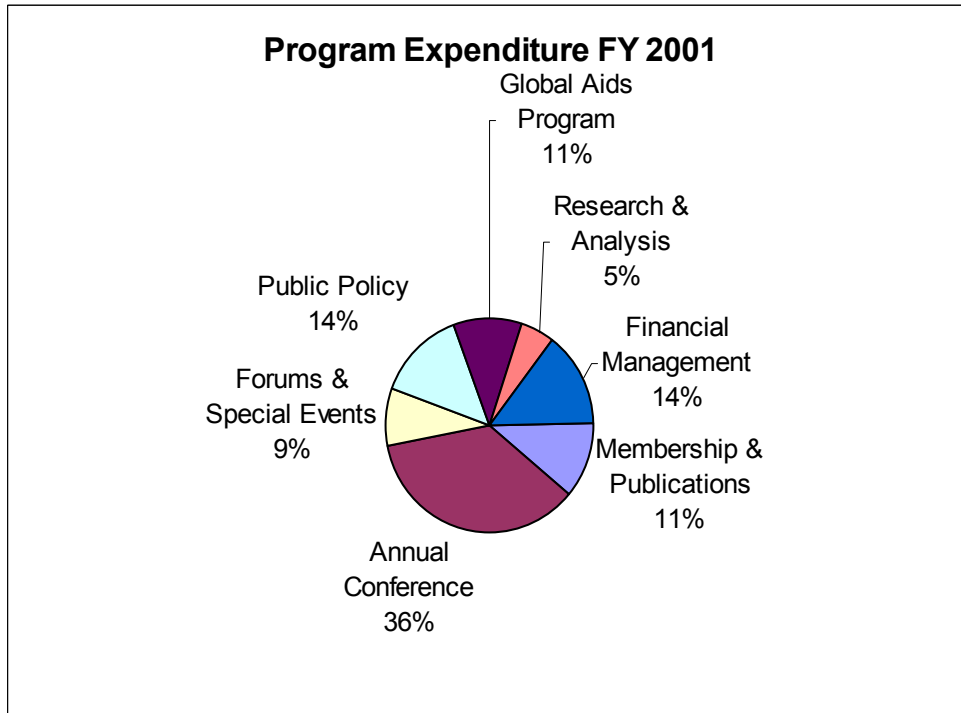
D-2. GHC ANNUAL COMPARATIVE INCOME STATEMENT AND FINANCIAL INFORMATION

Global Health Council					
	Annual Comparative Income Statement & Financial Information				
Support & Revenue	FY 2001 Year End 9/30/01	FY 2000 Year End 9/30/00	FY 1999 Year End 9/30/99	FY 1998 Year End 9/30/98	FY 1997 Year End 9/30/97
Foundation Grants	\$3,949,567	\$600,995	\$650,533	\$386,374	\$407,193
US Government Grants	1,468,988	1,634,202	925,548	734,063	496,323
Multi Lateral Non US Grants	390,000	220,000	243,500	35,000	36,000
Membership & Donations	697,118	549,711	344,770	124,719	159,148
Conference Revenues	526,235	290,797	292,342	200,007	180,454
Other Revenue	9,583	15,412	15,461	29,396	28,813
Interest & Investments	273,449	67,775	11,770	4,624	8,142
Total Support & Revenue	\$7,314,940	\$3,378,892	\$2,483,924	\$1,514,183	\$1,316,073
Operating Expenses & Changes in Net Assets					
Membership & Publications	\$675,332	\$286,621	\$231,300	\$147,350	\$168,004
Annual Conference	2,162,312	922,536	728,625	328,279	431,220
Forums & Special Events	521,074	206,716	138,960	15,097	34,330
Public Policy	875,138	452,881	413,231	267,479	229,471
Global Aids Program	663,966	564,263	490,138	356,010	245,095
Research & Analysis	307,301	64,600	50,072	-	-
General Management	867,752	210,917	165,350	319,820	248,282
Total Operating Expenses	\$6,072,875	\$2,708,534	\$2,217,676	\$1,434,035	\$1,356,402
Revenue over Expenses - Increase (Decrease) in Unrestricted Net Assets	\$1,242,065	\$670,358	\$266,248	\$80,148	\$ (40,329)
Non-Operating activity Increase (Decrease) in Temporarily Restricted Net Assets	(1,113,714)	4,710,428	339,957	(327,432)	142,594
Increase (Decrease) In Net Assets	\$128,351	\$5,380,786	\$606,205	\$ (247,284)	\$102,265
Net Assets at Beginning of Year	6,155,211	774,425	168,220	415,504	313,239
Net Assets at End of the Year	\$6,283,562	\$6,155,211	\$774,425	\$168,220	\$415,504

D-3(a). GHC ANNUAL REPORT 2001 REVENUES AND EXPENDITURES (Table)

	FY2001	
Support & Revenues:		YR end 9/30/01
Foundation Grants		4,090,430.33
U.S. Government Grants		1,328,124.58
Multi Lateral Non US Grants		390,000.00
Membership & Donations		771,957.84
Conference Revenues		426,235.11
Other Revenue		9,583.36
Interest & Investments		298,609.50
Total:		7,314,940.72
Operating Expenses & Changes in Net Assets:		
Membership & Publications		675,331.53
Annual Conference		2,162,311.97
Forums & Special Events		521,074.38
Public Policy		875,137.90
Global Aids Program		663,965.91
Research & Analysis		307,300.60
Financial Management		867,752.08
		6,072,874.38
Revenue minus Exps		1,242,066.34
Non Operating Activity		(1,113,714.00)
Increase In net assets		128,352.34
Net Assets begin. of Year		6,155,211.00
Assets End of Year		6,283,563.34

D-3(b). GHC ANNUAL REPORT 2001 REVENUES AND EXPENDITURES (Graphic)



D-4. GHC ACTIVE GRANTS AND COOPERATIVE AGREEMENTS

Board Report		Grant Dates	Contract Amount	Funds Remaining to End of Grant	Remaining Funds Available FY 200	Funds Available FY 2003	Funds Available FY 2004	Funds Available FY 2005
Active Private Funding Sources	Dept #							
MacArthur - Nat'l Advocacy Plan	09	07/01/99 06/30/02	320,000	-	-	0.00	0.00	0.00
RWJ Public Education	18	08/01/00 07/31/03	714,135	287,678	58,126	229,552	0.00	0.00
Gates Foundation	24	08/01/00 08/01/03	4,800,000	2,109,033	540,370	1,568,663	0.00	0.00
Rockefeller - Education Outreach	26	08/01/00 07/31/03	248,950	53,056	(16,237)	36,819	0.00	0.00
Ford Foundation 2000-2001	28	01/01/01 12/31/02	150,000	55,157	12,733	42,424	0.00	0.00
Gates Global Health Award	33	11/16/00 11/16/03	2,966,012	62,402	62,402	0.00	0.00	0.00
Hewlett Foundation	34	10/01/00 9/30/03	750,000	557,664	245,977	311,687	0.00	0.00
Dreyfus Health Foundation	002	02/01/02 01/31/03	40,000	46,102	27,661	18,441		
Foundation Open Society Institute	003	02/01/02 01/31/03	80,000	79,542	47,725	31,817		
Packard - Learning Organization	004	01/01/02 12/31/02	76,000	76,000	50,160	25,840		
David & Lucile Packard Foundation		01/1/2002 12/31/04	975,000	955,367	238,842	318,456	318,456	79,614
PAHO 2002-2003		03/01/02 02/28/03	85,000	-	-	0		
TOTAL Active Private Funding Sources			12,404,097	3,103,188	1,267,760	2,583,699	318,456	79,614
U.S. Government Agreements								
USAID Cooperative Agreement	50	08/01/99 07/31/04	6,200,000	2,155,000	124,940	1,350,000	680,060	0.00
CDC Conference 2002		01/01/02 12/31/02	150,000	70,534	70,534	-	-	
TOTAL Government Agreements			6,350,000	2,155,000	195,474	1,350,000	680,060	0.00
AGENCY TOTALS:			18,754,097	5,258,188	1,463,234	3,933,699	998,516	79,614
Grants Pending OR in Development Process for FY 2002 & 2003								
Gates & Rockefeller		04/01/02 03/30/05	990,000		165,000	330,000	330,000	165,000
UNAIDS		01/01/02 12/31/02	100,000		53,000	47,000	0.00	0.00
Ford Foundation 2003 – 2004	28	01/01/03 12/31/04	150,000			75,000	75,000	0.00

CDC Conference 2003	01/01/03 12/31/03	150,000	-	-	150,000	-	
Gates Award - Event Money Only	10/01/02 09/30/05	1,500,000		0.00	300,000	310,000	325,000
Gates Award - Endowment	2003-2034	32,000,000			1,000,000	1,000,000	1,000,000
TOTAL GRANTS IN DEVELOPMENT		34,890,000		218,000	1,902,000	1,715,000	1,490,000
Grant Money & Anticipated Money for Budgeting					5,835,699	2,713,516	1,569,614

APPENDIX E

LIST OF PERSONS INTERVIEWED

E. LIST OF PERSONS INTERVIEWED

Global Health Council

Board of Directors

William Foege, Chair
Carol Emerling, former chair
Helene Gayle
James Strickler
Helen Gayle
Barbara Pillsbury, Secretary

Staff

Nils Daulaire, President and CEO
Jonathan Barth, Asst. Director of Membership
Ann Bauer, Chief Operating Officer
Ted Bolognani, Business Manager and Controller
Annmarie Christensen, Director of Publications
Leslie Gianelli, Director of Public Outreach
Kathryn Guare, Deputy Director of Conference
Sadhana Warty Hall, Director of Global Partnerships Dept.
Michele Sumilas, Director of Government Relations
Jimmy Volmink, Director of Research and Analysis Department
Jim Wiggins, Manager of Forums and Special Events

USAID

Celeste Carr, Cognizant Technical Officer
Duff Gillespie, Deputy Assistant Administrator, Global Health Bureau
Bob Emrey, Director, Policy Division, Office of Health
Betsy Brown, Director, Office of Health
Margaret Neuse, Director, Office of Population
Paul Ehmer, Deputy Director, Office of Health
Mary Ellen Stanton, SO team leader
Al Bartlett, SO team leader
Mike Zeilinger, SO team leader
Gabrielle Bushman, SO team leader
Barbara Bennett, Office of Legislative Affairs
Ron McInnis, HIV/AIDS specialist

Others

Jim Sherry, UNAIDS

David Hayman, World Health Organization

Joy Riggs-Perla, former USAID Director, Office of Health

Tom Merrick, World Bank

Elaine Murphy, PATH

Carol Miller, SAVE

Tim Rieser, Operations Sub-Committee, Senate Appropriations Committee

APPENDIX F

LIST OF DOCUMENTS REVIEWED

F. LIST OF DOCUMENTS REVIEWED

USAID-GHC Cooperative Agreement HRN-A-00-99-00018-00, August 1999.

Midterm Evaluation of the National Council for International Health Cooperative Agreement, Barry Sidman and Clarence Pearson, July 1997.

Response to the Draft Midterm Evaluation, NCIH, June 1997.

Response to Midterm Evaluation Summary of Conclusions and Recommendations, NCIH, July 1988.

Final Evaluation, National Council for International health AIDS Initiative, John Pielemeier, February, 1997.

Executive Summary, Senior Consultative Group (the "Koop" committee), November 1997.

All GHC Quarterly Technical and Financial Reports to USAID.

Letter, Senator Jesse Helms to Secretary of State Colin Powell, March 9, 2001.

Letter, Senators Patrick Leahy and James Jeffords to Secretary of State Colin Powell, March 23, 2001.

Letter, Robert Lester, Acting Deputy Assistant Administrator, Bureau for Legislative and Public Affairs, USAID to Garrett Grigsby, Deputy Staff Director, Committee on Foreign Relations, United States Senate, July 25, 2001.

Audit of Global Health Council financial statements for year ending Sept. 30, 2001, Goodman and Company, December, 2001 (and previous audits).

Global Health Council Annual Reports 1999, 2000 and 2001. GHC.

Global Health Council Work Plan, Oct 2001-Sept 2002, revised May 2002.

Memo to GHC: Results from 5/29/01 Member Focus groups, Lake, Snell and Perry; June 2001.

GHC Member Survey, Powerpoint slides; GHC Research and Analysis Department, May 2002.

Annual GHC Conference Final Program, 2000: A Century of Health for the Children of 2000.

Annual GHC Conference Final Program, 2001: Health Women, Healthy World: Challenges for the Future.

Annual GHC Conference Final Program, 2002: Global Health in Times of Crisis.

“Global Health Link,” issues 101-114 (2000-2002).

“AIDSLink,” issues 60-74 (2000-2002).

Global AIDS Directory 2002-2003, GHC, April 2002.

Making Childbirth Safer Through Promoting Evidence-Based Care, GHC Technical Report, May 2002.

“Male Circumcision for prevention of heterosexual transmission of HIV in men” (Protocol for a Cochrane Library Review); various authors, July 2001.

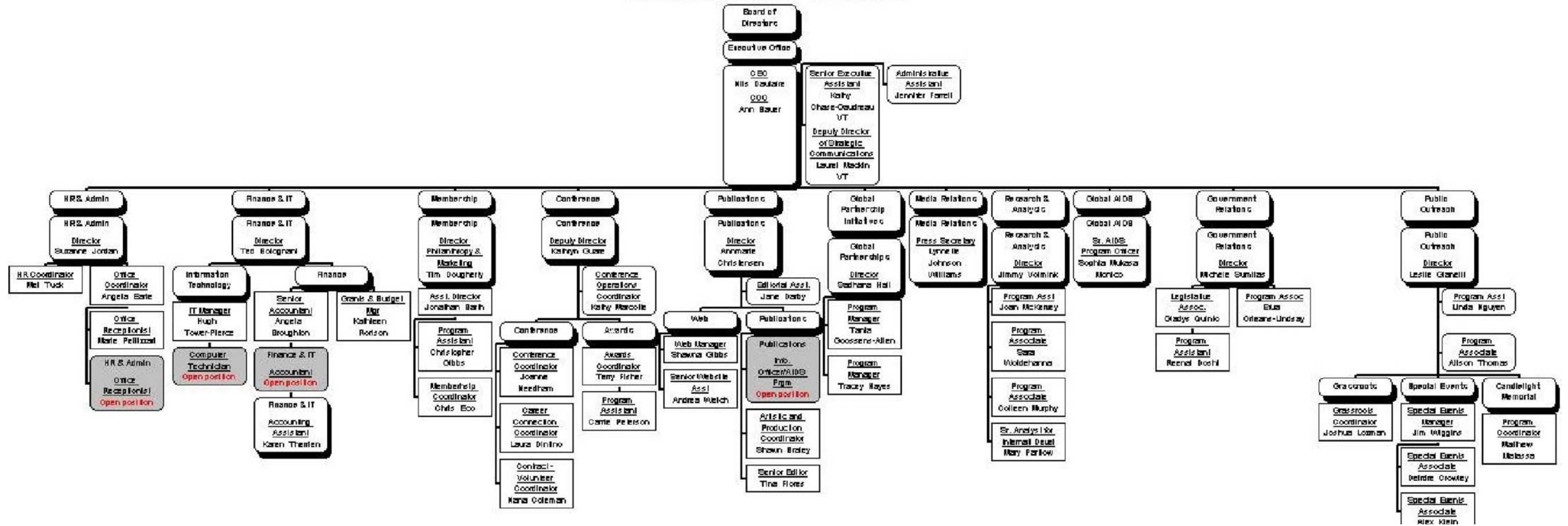
“Antiretrovirals for reducing the risk of mother-to-child transmission of HIV infection,” P Brocklehurst and J. Volmink, Cochrane Library Review, 2002.

APPENDIX G

GHC ORGANIZATION CHART

G. GHC ORGANIZATION CHART

Global Health Council



APPENDIX H

LIST OF GHC BOARD MEMBERS AND THEIR TERMS OF OFFICE

H. LIST OF GHC BOARD MEMBERS AND THEIR TERMS OF OFFICE

Foege, William, M.D., M.P.H., Chair (term expires May 2005)

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President, World Education

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f. (206) 709 3170

Meleis, Afaf, PhD, DrPS (hon), FAAN (term expires May 2005)

Professor and Margaret Bond Simon Dean of Nursing, Univ. of Pennsylvania School of Nursing
President, International Council on Women's Health Issues

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Updated: July 2002