



Global Health Initiative 2.0: Effective Priority-Setting in a Time of Austerity

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

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The past decade has seen tremendous growth in global health funding; total health aid went from \$11 billion in 2000 to \$27 billion in 2011,² with the emergence of new public-private partnerships (Global Fund, GAVI), private foundations (Bill and Melinda Gates Foundation), and steadily increasing bilateral contributions. The United States gradually increased its dominance in the field, with disbursements totaling 19 percent of all health aid in 2000 to 31 percent in 2008, largely due to increased funding to HIV/AIDS via PEPFAR.³

But the honeymoon is over: donor spending began to flat line in 2008 with the financial crisis. Even public-private partnerships are having trouble with financing: the Global Fund cancelled its Round 11 grants and is moving toward a leaner grant-giving structure. Austerity seems to be affecting every donor and is set to define budgets in 2012: the recently passed U.S. Foreign Operations budget hints at the future, as total global health appropriations for FY2012 are \$8.468 billion, or \$39 million less than 2011 appropriations. PEPFAR's budget is set to drop by 3.8 percent, from \$5.54 billion to \$5.33 billion, and contributions to the Global Fund remain the same.⁴

As funding for health stagnates, the inefficiencies of U.S. global health aid architecture become increasingly visible and will become even more so if funding decreases in the future. The specific

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² K. Leach-Kemon, D.P.Chou, M.T. Schneider et al. "The Global Financial Crisis Has Led to A Slowdown in Growth of Funding to Improve Health in Many Developing Countries," December 2011, Health Affairs <http://content.healthaffairs.org/content/early/2011/12/12/hlthaff.2011.1154.full>

³ IHME DAH Database (2011), <http://www.healthmetricsandevaluation.org/ghdx/record/development-assistance-health-database-1990-2009>.

⁴ Foreign Operations and Related Programs Appropriations Act, 2012. http://rules.house.gov/Media/file/PDF_112_1/HR2055CRbill/pcConferenceDivI-BilloCR.pdf; calculations by Connie Veillette. Figures from the 2012 conference report and 2011 enacted bill, including the funds appropriated to USAID and State Department for global health programs, as well as funds appropriated to HHS for the Global Fund.

responsibilities of each agency still lack definition and coherence, and there is much duplication, especially in service delivery. USAID, HHS and the State Department each have different strategies, with vague, difficult-to-measure targets and overlapping areas of work.

The Global Health Initiative was intended to address many of these challenges. However, the Initiative emerged without clear and aligned institutional and budgetary arrangements, weak accountability mechanisms, and little attention to value for money. The recently passed State Foreign Operations Bill envisions a path for the GHI's transition to USAID and reaffirms the need for the GHI, yet the details are still far from certain.

In this note, we summarize the rationale for continued U.S. investment in global health, look into the evolution of the GHI, and recommend a re-boot for the whole enterprise.

Rationale for investing in global health

It's the right thing to do: Cost-effective health interventions are the basis for development. Many Americans believe that aid for global health is the “right thing to do,” a moral imperative. While the majority of Americans believe that the United States spends too much on foreign aid (61 percent), most Americans think that it spends the right amount or too little on global health (72 percent).⁵ Responding to the preventable communicable diseases concentrated in LMIC seems to resonate with the American public.⁶ Further, global health has traditionally had bipartisan support.

Global health can be a global public good: Health aid that reduces suffering from noninfectious health conditions such as malnutrition, trauma, or mental illness contributes to global health and can be justified on altruistic grounds. But some components of health aid reduce suffering from infectious causes of poor health—diseases such as HIV, malaria, tuberculosis, measles, and influenza—and also, arguably, risky behaviors such as cigarette smoking, high-sugar diets, and risky sex. Health aid that reduces the spread of infectious health conditions also contributes to global health, but it is further justified to the extent that such aid produces or sustains a global public good.

Reducing the prevalence in a country's population of any infectious cause of ill health meets the two formal criteria for a global public good: *global non-rivalry* and *global non-excludability*. The reduced prevalence of an infectious condition in an individual country is *globally non-rivalrous*, that is, the magnitude of the beneficial spillover onto one neighboring country does not

⁵ Henry K. Kaiser Family Foundation, “2010 Survey of Americans on the U.S. Role in Global Health” (2010), <http://www.kff.org/kaiserpolls/upload/8101.pdf>.

⁶ Amanda Glassman, Denizhan Duran, and Andy Sumner, “Global Health and the New Bottom Billion: What Do Shifts in Global Poverty and the Global Disease Burden Mean for GAVI and the Global Fund?” CGD Working Paper 270 (Washington: Center for Global Development, 2011).

compete with, or reduce in any way, the magnitude of the beneficial spillover on other neighboring countries. For example, preventing an outbreak of a new variety of influenza in Indonesia helps the United States regardless of the degree to which it also helps China, Peru, or Sri Lanka. The reduced prevalence of an infectious condition in an individual country is also *globally non-excludable*. Once the global beneficial spillover commences, there is no technically feasible way to prevent the benefits from going to all countries.

Other examples of health-related global public goods include minimizing drug resistance, conducting disease surveillance, research, and development on health-system inputs (such as pharmaceuticals or better diagnostic technologies), and generating standardized data.⁷

The United States itself benefits directly from the successful control of an infectious disease; in 2006, for example, it was estimated that the United States had saved more than \$180 billion as a result of its investment in polio vaccination in low- and middle-income countries.⁸ But the fact that American expenditure on controlling infectious causes of ill-health is likely to eventually benefit the health of Americans is only a small part of the reason that U.S. health assistance should prioritize spending on health-related global public goods.

Global, and American, well-being is particularly enhanced when donors jointly contribute to producing global public goods. While an individual country reaps most or all of the health benefits from its expenditures to combat noninfectious causes of ill health, it receives only a small portion of the worldwide benefits from its expenditures on controlling infectious causes within its borders. Individual countries, especially poor ones, would be irrational to unilaterally spend as much on global public goods as on goods that are internationally rivalrous or excludable, since so large a proportion of the benefits from global public goods go to others. Therefore, the only way for worldwide spending on health-related global public goods to reach the level that global citizens would jointly choose is for the countries of the world to coordinate in their production. In today's world such coordination works best when the United States takes the lead. To the extent that coordination enhances or sustains the production of health-related global public goods, coordination itself is a global public good; its benefits are non-rivalrous and non-excludable.

Global health aid can be a tool of soft power: Aid is increasingly gaining importance as a tool of soft power, particularly with the emergence of new donors in Africa. One of the biggest issues at the 4th High-Level Forum on Aid Effectiveness in Busan was the behavior of new donors such as Brazil and China, and their compliance with the “rules of the game.” As the United States strives to protect its global leadership, global health aid will remain an important tool. As HHS Secretary

⁷ Working Group 2 of the Commission on Macroeconomics and Health, Chaired by Richard Feachem and Jeffrey Sachs. August 2002. “Global Public Goods for Health” <http://whqlibdoc.who.int/publications/9241590106.pdf>

⁸ Dan Nixon, Rotary International, 29 November 2010. “Benefits of polio eradication up to US\$50 billion” http://www.rotary.org/en/MediaAndNews/News/Pages/101129_news_GPEI.aspx Accessed January 25, 2012

Kathleen Sebelius noted at an event at the Kaiser Foundation, global health aid “bolsters America’s stature in the world.”⁹

The United States has a comparative advantage in health aid: The United States has a clear comparative advantage in global health aid. PEPFAR, together with the Global Fund, is the largest provider of HIV/AIDS treatment in Africa, which brings tremendous economies of scale. The United States has consistently been the top public funder of research in HIV/AIDS and other neglected diseases, contributing \$1.39 billion, or 67 percent of total global public funding in 2010.¹⁰ It is easier to benefit from economies of scale in research and public-private partnerships for vaccine and drug creation, as well as disease elimination and eradication, as upfront costs in these areas are very high and need sustained investment. Health expenditure currently makes up over 17 percent of U.S. GDP and is projected to grow to 19 percent by 2019.¹¹ Investing in drugs, vaccines, and R&D benefits the U.S. economy as much as it benefits global health efforts. The United States already possesses such technology and has committed resources to both pharmaceutical development and other forms of research on neglected tropical disease; cutting back and reversing the course after this point would be neither efficient nor feasible.

Health aid is effective: Cutting across the board in any budget is not efficient, and aid budgets are no exception: it is important to capitalize on effective, proven interventions while cutting more fragmented or inefficient interventions, or those with unknown effectiveness. The United States has identified many cost-effective global health interventions, and the GHI is currently focusing on them. Early diagnosis for HIV, childhood immunization, oral rehydration therapy for diarrhea, and micronutrient supplementation are such examples.¹² The U.K. aid agency, DfID, conducted a multilateral aid review in March 2011, showing that immunization via the GAVI Alliance was a cost-effective intervention consistent with their strategic development goals; as a result, the United Kingdom scaled up its contributions to GAVI Alliance while cutting back from organizations such as UNESCO, HABITAT, FAO, and ISDR.¹³ Furthermore, the United States gives health aid more efficiently than it gives other aid; an upcoming CGD working paper finds that

⁹ “Secretary Sebelius discusses HHS’s role in global health and its new global health strategy” <http://globalhealth.kff.org/Policy-Tracker/Content/2012/January/05/Sebelius-HHS-Global-Health-Strategy.aspx> January 5, 2012.

¹⁰ Mary Moran, Javier Guzman et al. “Neglected Disease Research and Development: Is Innovation Under Threat?” December 2011, G-FINDER.

¹¹ “NHE Fact Sheet,” Centers for Medicare and Medicaid Services website, https://www.cms.gov/NationalHealthExpendData/25_NHE_Fact_sheet.asp.

¹² “GHI: Doing More of What Works” <http://www.ghi.gov/what/works/index.htm>; Accessed December 20, 2011.

¹³ DfID, *Multilateral Aid Review: Ensuring Maximum Value for Money for UK Aid through Multilateral Organizations* (2011), http://www.dfid.gov.uk/Documents/publications1/mar/multilateral_aid_review.pdf.

the United States gives aid more efficiently in the health sector on a multitude of different metrics compared to its overall aid.¹⁴

The GHI's evolution¹⁵

The GHI was announced in May 2009 by President Obama as a way of consolidating global health programs under a single banner and exploiting synergies between various agencies, building on the growth in health aid via PEPFAR. The GHI covers all U.S. agencies that focus on health, but the largest ones are USAID, the State Department's Office of the Global AIDS Coordinator (OGAC), and the Centers for Disease Control and Prevention (CDC). We identify four challenges:

First is the *misalignment in institutional arrangements and budget authorities*. The December 2010 Quadrennial Diplomacy and Development Review (QDDR) states that the GHI is to be transferred to USAID leadership by September 2012, conditional on the fulfillment of benchmarks including ensuring independent, evidence-based monitoring and evaluation, optimizing resource impact, demonstrating increased alignment between partner countries and the United States, increasing country ownership, and creating a clear, single entity for the GHI.¹⁶ The recently passed 2012 appropriations bill ratifies this planned course of action via a clause on the transition of GHI leadership and the State Department's Office of the U.S. Global AIDS Coordinator (OGAC) into USAID. While such a move could generate benefits including unified leadership, integration with reproductive health, and improved coordination, there are structural issues that remain unresolved, with implications for GHI efficiency. Even if moved to USAID, OGAC remains an independent structure that reports independently to Congress until 2013. On the other hand, although USAID formally controls only a minority share of GHI's budget (30%, according to the proposed 2012 appropriations and the enacted 2011 appropriations), the agency executed \$3.7 billion of the total PEPFAR budget of \$6.6 billion (56%) in FY2011; including the contributions to the Global Fund.

The second challenge facing U.S. global health aid is the *sustainability of its investments*. Given technological advances and the success of PEPFAR and the Global Fund, among others, HIV/AIDS is now a chronic disease, one that requires lifetime care and support. As a result, PEPFAR's emergency set-up, involving direct funding of health service provision mainly via non-

¹⁴ Nancy Birdsall, Homi Kharas, and Rita Perakis, *Quality of Official Development Assistance*, Second Edition (Washington: Center for Global Development, forthcoming); Denizhan Duran and Amanda Glassman, 2012. "An Index of the Quality of Official Development Assistance in Health" Center for Global Development, forthcoming working paper.

¹⁵ For more details, refer to Oomman and Silverman, "GHI Mid-Term Review and a Way Forward" (Center for Global Development, 2012).

¹⁶ U.S. Department of State and USAID, *Leading Through Civilian Power: The First Quadrennial Diplomacy and Development Review* (2010) <http://www.state.gov/documents/organization/153108.pdf>

governmental agencies, needs to evolve to a different, more development-based approach that will ensure that health systems in recipient countries are capable of providing lifetime, comprehensive care for patients suffering from HIV/AIDS or other diseases.¹⁷ In recent years, PEPFAR has added to its purview cervical cancer prevention and treatment for HIV positives,¹⁸ and it is integrating with maternal health care among other areas. Yet if integration and a functioning, sustainable health system are the goals of U.S. support, as described in GHI documents, the fact remains that 73 percent of U.S. global health funding is spent on HIV/AIDS through PEPFAR. This congressionally mandated earmark makes difficult any genuine effort to deal with the financing, payment, and coverage challenges in health systems sustainable or integrally.

Third, *progress toward the GHI's expected results remains unclear*. Building on PEPFAR, the GHI defines broad metrics of number of treatments provided or vaccines administered, outputs that may or may not be attributable to USG funding in any given country. Data to track outputs is not regularly or independently collected, nor are reports from secondary sources published regularly on the web.

The final challenge relates to the *selection of GHI focus countries*. In 2010, 8 countries (Bangladesh, Ethiopia, Guatemala, Kenya, Malawi, Mali, Nepal, and Rwanda) were selected as GHI Plus countries, which would receive additional technical resources to “quickly implement GHI’s approach,” focusing on maternal and child health, health systems and family planning.¹⁹ In November 2011, GHI Plus announced plans to expand to 21 more countries by helping partners create GHI plans²⁰, yet the rationale and the criteria for the selection of these countries remain unclear. There is, however, some progress on the front of prioritizing investments: in maternal and child health, the GHI is focusing on 24 priority countries which have 75 percent of the maternal and child health mortality burden. Such practices should be applied to other fields, and it remains important to see if the GHI can streamline processes and reporting to encourage easier collaboration in the field.

What is to be done? Rebooting GHI 2.0

The overall goal of the GHI remains relevant. In this section, through eight recommendations, we suggest a streamlined organizational and budgetary structure, a new strategic emphasis, a

¹⁷ PEPFAR Home Page, <http://www.pepfar.gov/about/index.htm> Accessed January 20, 2012

¹⁸ Alyson Clark (AIDSTAR-Two), “PEPFAR Cervical Cancer Prevention and Screening Regional Workshop Report,” submitted to USAID, http://pdf.usaid.gov/pdf_docs/PNADW680.pdf.

¹⁹ USAID, “U.S. Government Support for Global Health Efforts,” Accessed January 20, 2012, <http://www.usaid.gov/press/releases/2010/pr100618.html>; Henry J. Kaiser Family Foundation, “The U.S. Global Health Initiative (GHI): GHI Plus Country Funding by Sector,” <http://www.kff.org/globalhealth/upload/8140-C.pdf>.

²⁰ John Donnelly, “GHI Expands Focus Countries to 29,” *Global Pulse* November 5, 2011, Accessed December 20, 2011, <http://www.globalpost.com/dispatches/globalpost-blogs/global-pulse/ghi-expands-focus-countries-29>.

clear set of responsibilities and tasks for major U.S. global health agencies, and a narrowed focus for the GHI.

- 1. Streamline the GHI's institutional and budgetary arrangements:** We believe that consistent with current legislation, OGAC should remain intact but placed under USAID, since, as we indicated, USAID is already implementing the majority of OGAC's spending. This would protect OGAC's expertise, as well as reduce administrative redundancies. In a time of budget austerity, it is worth considering whether these multiple administrative and coordination instances continue to be required and whether they are facilitating greater impact and coordination or not. Proposals should be developed and consulted with Congress and civil society on budgetary arrangements for PEPFAR post-2013.
- 2. Leverage, not provide, to assure the sustainability of impact:** In all but the poorest, most fragile countries, PEPFAR should progressively phase out direct financing of the provision of HIV/AIDS services and instead use funding to leverage greater recipient government and local partner funding for prevention and treatment in the context of a functioning, sustainable health system. Shifting to a leveraging role implies that interventions that are financed are affordable and efficient with respect to alternative uses of public funding and that government has or develops capacity to either provide directly or contract competitively with the nongovernmental providers that have thus far been directly contracted under PEPFAR. A first step should be to set the course and build the analytical work that will allow for a responsible transition: PEPFAR is already on the right track through partnership frameworks, and will need to sustain this to ensure the sustainability of impact.²¹ Ensuring sustainability and reducing dependency go hand in hand: health aid, especially antiretroviral treatment provision, engenders a deep and corrosive form of dependency. Diplomatic benefits that are reaped from health aid would evaporate as ruptures in supply chains kill AIDS patients. Given this, the transition from direct treatment to sustainability proves to be essential, and it can be done through both channeling aid through the Global Fund and leveraging support through government health ministries.

Another issue that goes hand in hand with sustainability is volatility: given the need to finance recurring costs, health aid is tremendously affected by volatility. Antiretroviral treatment, for example, is an international entitlement program that expands as funding expands, but it is sticky downward: as health aid fluctuates, ART still grows as a proportion of health aid.²² A way to overcome this would be to give the GHI, and only

²¹ "PEPFAR Partnership Frameworks," Accessed January 28, 2012, <http://www.pepfar.gov/frameworks/index.htm>.

²² Mead Over, "Opportunities for Presidential Leadership on AIDS: From an "Emergency Plan" to a Sustainable Policy," in Nancy Birdsall, ed., *The White House and the World: A Global Development Agenda for the Next U.S. President* (Washington: Center for Global Development, 2008)

the GHI, the authority to make multiyear commitments, thus decreasing volatility and transitioning into sustainability.

- 3. Increase on-budget funding using results-based financing (Cash-On-Delivery Aid):** The United States should seek to avoid redundancies and fragmentation in partner countries, while creating incentives for greater recipient country funding of health priorities. Fragmented aid decreases the effectiveness of aid, as countries cope with the administrative burden introduced by each individual project.²³ Providing funding directly to governments, participating in pooled funding or co-financing development bank operations is feasible for USAID; modest efforts in Liberia and Nepal illustrate that, with proper fiduciary risk assessment and support, U.S. funds can be responsibly channeled through national systems.²⁴ Using cash-on-delivery methods that condition aid on performance is also possible given that many GHI outputs could be easily and independently tracked.²⁵ Such an approach would also contribute to the leveraging effort.

- 4. Consolidate PEPFAR service delivery purchasing via the least expensive, most effective U.S. government agency:** In fragile states and during the transition toward leveraging funds, PEPFAR will still be charged with directly funding and supervising the provision of HIV/AIDS prevention and care. At the moment, both USAID and HHS/CDC hold provider contracts. Each agency has a different model of contracting and technical assistance, the contracting process is fragmented and nontransparent, and the costs per case treated or averted are not well known in the public domain. From PEPFAR's website—where the most recent data is from 2008—it is possible to conclude that PEPFAR contracts a different contractor for each recipient country, although the scale and scope of projects are similar across the board.²⁶ PEPFAR's last cost estimates of treatment are from July 2010,²⁷ but it is unclear how they relate to PEPFAR's purchasing or contracting norms. More study is required to make sound recommendations, but the status quo raises a number of questions: Does it make sense to have both CDC and USAID split the purchasing function under PEPFAR? Which agency is lowest-cost, highest-effectiveness? Can efficiencies be generated by consolidating purchasing of service delivery in a single

²³ E. Frot and J. Santiso, "Crushed Aid: Fragmentation in Sectoral Aid," OECD Working Paper 284, <http://www.oecd.org/dataoecd/0/37/44341102.pdf>

²⁴ Jacob Hughes and Amanda Glassman. "Innovative Financing in Early Recovery: The Liberia Health Sector Pool Fund" CGD Working Paper, Forthcoming.

²⁵ William D. Savedoff and Katherine Douglas Martel, "Cash On Delivery Aid for Health: What Indicators Would Work Best?" CGD Working Paper 275 (Washington: Center for Global Development, 2011); Mead Over, *Achieving an AIDS Transition: Preventing Infections to Sustain Treatment* (Washington: Center for Global Development, 2011).

²⁶ PEPFAR, "Partners," accessed January 30, 2012, <http://www.pepfar.gov/budget/partners/index.htm>.

²⁷ PEPFAR, "Report to Congress on Costs of Treatment in the President's Emergency Plan for AIDS Relief (PEPFAR)," accessed January 30, 2012, <http://www.pepfar.gov/documents/organization/144993.pdf>.

contracting agency? Can further economies of scale be achieved by employing alternative purchasing strategies? Overhead costs by each agency are not transparent, which prohibits efficient decision-making: CDC, for example, might have lower costs and have greater effectiveness.

- 5. Assure adequate coverage of global public goods:** HHS/CDC has a vital global role in disease surveillance, laboratory support, and outbreak investigation and response; however, these functions are not highlighted in GHI documents. Recent reports also suggest that these GPG functions are under-financed relative to need²⁸. HHS' recently issued global health strategy states that it will “contribute to the achievement of (every GHI goal), as well as supporting the integration of public health services for key diseases such as HIV/AIDS and vaccine-preventable diseases.”²⁹ In lieu of this broad scope, we recommend that HHS/CDC further consolidate and focus on assuring the adequate funding and provision of global public goods with large positive externalities for the United States, with due attention to U.S. influence on WHO reforms. CDC is an intellectual leader in the health sector, and their core business and competencies should be highlighted, protected and nurtured by whoever heads GHI and PEPFAR.
- 6. Track progress through rigorous evaluation:** One of the principal issues in health aid is to connect inputs to results. In addition to determining cost-effective interventions ex ante, the GHI should help countries establish independent, rigorous monitoring and evaluation mechanisms to track progress toward their objectives. This would further feed into ensuring value for money, and is consistent with USAID's new evaluation policy: USAID's expertise on population-based surveys gives it a comparative advantage on expanding monitoring and evaluation. Implementing this new evaluation policy across all U.S. global health agencies and their investments would create an incentive for improved efficiency.
- 7. Shift towards multilateral aid:** Multilateral aid has lower administrative costs and greatly reduces burden on recipients. As the United States consolidates its global health portfolio, it could benefit from channeling more of its limited funds to multilateral organizations that leverage U.S. funding and impact. The United States provides only 7 percent of its health aid via contributions to organizations such as the Global Fund, GAVI, PAHO, WHO, and UNICEF.³⁰ Yet in a context where the GHI would prefer to

²⁸ Amanda Glassman, “Contagion: Help Congress Protect the CDC’s Outbreak Investigation Budget,” Global Health Policy Blog (Center for Global Development), accessed January 25, 2012, <http://blogs.cgdev.org/globalhealth/2011/09/contagion-help-congress-protect-the-cdc%E2%80%99s-outbreak-investigation-budget.php>

²⁹ U.S. Department of Health and Human Services, *The Global Health Strategy of the U.S. Department of Health and Human Services*, (Washington: DHHS), <http://globalhealth.gov/pdfs/GlobalHealthSecretary.pdf>.

³⁰ Denizhan Duran and Amanda Glassman, 2012. “An Index of the Quality of Official Development Assistance in Health” Center for Global Development, forthcoming working paper.

leverage on-budget, sustainable health-system responses to HIV/AIDS in recipient countries, increasing investment in effective multilateral organizations becomes increasingly relevant. The United States has never directly addressed the parallel administrative structures and missions of PEPFAR and the Global Fund, and it is not clear why U.S. effort and monies would not be better spent improving the effectiveness and scope of the Global Fund in lieu of continuing its own large-scale independent bilateral program on HIV/AIDS. There is much discussion of the relative efficiency and quality of Global Fund versus PEPFAR, but the case for multilateralism has not been rigorously analyzed using empirical evidence.

- 8. Consolidate GHI's scope:** The scope of GHI is large: the United States gave health aid to over 80 countries in 2011, and identified eight of these countries as GHI Plus countries. The United States could increase its bang for the buck by focusing health aid on a smaller number of countries and clarifying the GHI Plus selection process: in 2009, there were 26 countries receiving less than \$500,000 in health aid.³¹ Health aid disbursements could follow an MCC model, awarding GHI Plus status, enhanced funding and technical assistance based on a set of threshold criteria that would reward greater country effort in public spending, coverage of key interventions and health outcomes.

It is possible to reshape the GHI as a model for effective global health aid in a period of austerity, and as a model for other aid sectors. By improving service delivery through consolidating administrative structures and eliminating redundancies, ensuring better monitoring and evaluation practices to increase value-for-money, increasing contributions to multilaterals and collaboration through pooled funds, and consolidating its partnerships, the GHI can weather the budget cuts and improve health outcomes for the poorest, while securing U.S. national interests.

³¹ OECD Creditor Reporting System Database, 2009