6 U.S. PRIORITIES FOR MULTILATERAL PARTNERS

INTRODUCTION

This chapter focuses on five multilateral institutions of central importance to any discussion of U.S. policy approaches to global health: the World Health Organization (WHO); the Global Fund to Fight AIDS, Tuberculosis and Malaria; the GAVI Alliance; UNAIDS; and the World Bank Group. In each case, the authors define how the organization specifically aligns with key U.S. interests; summarize the major policy developments seen during the first Obama administration, followed by the outstanding challenges that remain today; and outline select policy priorities for the second Obama term and the incoming Congress.[1] Three propositions emerge across the five brief analyses.

First, despite weaknesses in their governance and performance, these institutions advance U.S. interests.

Across a widening agenda of health priorities, these institutions provide access, vital data, technical expertise, legitimacy, and perspective that cannot be attained simply through unilateral U.S. action. They have a proven record of generating consensus, legal frameworks, and timely guidance on present and emerging U.S. policy priorities. They are getting better at measuring and demonstrating their outcomes.

Moreover, in an era of scarce resources, these multilateral institutions have arguably become even more important to U.S. goals in global health. In part, that is because they can mobilize greater burden sharing by other donors; in addition, they can spur partner national governments to take better ownership of their health agenda and invest more political and financial capital in creating effective health services and fiscally sustainable health systems.

Second, for each of these organizations there are important ready opportunities for the United States to partner operationally in advancing key common policy priorities.

For example, the United States has moved the President's Emergency Plan for AIDS Relief (PEPFAR) closer to the Global Fund as an essential step in enlarging global access to antiretroviral treatment. It has done the same with WHO on building order, predictability, and health safety across the world. It relies deeply upon UNAIDS for reliable trend data on the global AIDS pandemic, strategic thinking on investments, and approaches to marginalized populations and regressive regimes. The U.S. linkage with the GAVI Alliance is fundamental to reducing preventable childhood deaths; and its partnership with the World Bank in developing countries helps promote effective self-financing of health.

1. The priority multilateral institutions could well include UNICEF, the UN Development Program, and others; however, space and time demand selectivity.

Indeed, the strategic synergy between the United States and its key multilateral partners—the deepening alignment of policies and programs—has become an ever-more-visible requisite to achieving U.S. policy goals.

Third, while each of these institutions has room to improve its management and operational performance, steady progress requires effective engagement by competent, working-level U.S. managers and diplomats, as well as sustained attention at high U.S. political and diplomatic levels.

To varying degrees, each of the multilaterals under consideration operates in a state of fluid stress. In the face of declining resources, they increasingly compete for funding, and are subject to heightened scrutiny, including demands to reaffirm their comparative value and provide concrete outcomes. To regenerate, reform, be fiscally sound, and perform effectively, each institution's leaders must ultimately be responsible for guaranteeing continued progress. Durable progress also requires that the United States have an ongoing dialogue with these multilateral leaders based on candor, good faith, and respect; and that the United States provide hands-on managerial and technical support, based on long-term shared goals. The newly formed Office of Global Health Diplomacy has the potential to strengthen the United States' relations across these institutions.

Multiyear replenishments and periodic internal reviews provide the focal moments for these dialogues; those tests will be in full motion in 2013 and 2014.

THE WORLD HEALTH ORGANIZATION (WHO)

By Nellie Bristol[2]

Key Assets that Align with U.S. Interests

The World Health Organization (WHO) is a critical health security partner for the United States. The principal global authority for setting norms and standards for public health in areas such as medical-product quality and disease control, WHO enables worldwide disease surveillance and response, facilitates international negotiations on sensitive health and related trade topics, and is a key U.S. partner in the global effort to eradicate polio.

In recent years, WHO has faced serious budgetary woes. Its director-general Margaret Chan, elected in 2012 with strong U.S. backing to a second five-year term, has at the same time sought to advance management reforms to address chronic problems. These problems include, most importantly, weak financial controls, accountability, and monitoring of service delivery, especially in highly autonomous regional offices; rigid UN personnel policies; limited authority and budgetary clout of the Geneva headquarters, including the office of the director-general; and difficulty in prioritizing goals and programs. Chan's reforms are unfolding in the midst of intensified competition on an increasingly crowded global health stage that now includes multiple large organizations such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and the GAVI Alliance.

Despite increased competition, fiscal constraints, and complex management and governance challenges, WHO possesses critical assets that make it essential to the advancement of public health globally—an important component of U.S. security. Based on its broad political legitimacy and reputation as a neutral, fair space for setting common norms, standards, and guidelines, WHO has a proven ability to convene expert technical and policy panels to address sensitive, complex issues of common interest. It is welcomed virtually everywhere in the world, allowing it to facilitate disease surveillance and response in places where groups with a specific national identity may be seen as suspect.

To maximize WHO's value as a global partner, the United States, in concert with like-minded governments and through close engagement with the director-general, should continue to advance internal reforms essential to making the organization stronger and more effective.

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Policy Developments under the First Obama Administration

The United States' annual assessed contributions stayed steady at $109 million in 2010 and 2011,[3] a level equaling 22 percent of the organization's regular budget.[4] U.S.-assessed contributions to WHO totaled $107 million in fiscal year 2009 and $101 million in fiscal year 2008.[5] Additional voluntary funding from the United States totaled $424 million for the 2008–2009 period[6] and $438 million for 2010–2011.[7] U.S. voluntary contributions helped support WHO activities in areas such as tuberculosis control and pandemic influenza preparedness.[8]

WHO officials and other observers credit the Obama administration with significantly improved diplomatic interactions with WHO and other member states compared to the previous administration. The change helped encourage member states to support reforms and fostered important diplomatic gains especially with respect to sharing virus specimens and resolving related intellectual-property disputes. A framework arranging the sharing of pandemic flu virus samples needed for vaccine production serves as one example. In April 2011, the WHO Open-Ended Working Group of Member States on Pandemic Influenza Preparedness agreed on the document after five years of negotiation.[9] The framework responds to the concerns of the governments of Indonesia and of other developing countries that have been reluctant to share virus samples with WHO, since resulting vaccine manufacturing is carried out largely by developed countries and sold at prices unaffordable in the developing world. The framework outlines a Benefit Sharing System that will provide and build capacity for pandemic surveillance for all countries and provide more equitable access to antiviral medicines and vaccines against H5N1 and other potentially pandemic influenza viruses.

WHO-U.S. dialogues also have advanced on health security priorities. In September 2011, WHO and the U.S. Department of Health and Human Services signed a memorandum of understanding to increase cooperation on disaster and pandemic preparedness as well as disease surveillance, reporting, and response. The agreement encourages coordination between the United States and WHO in enhancing the existing global alert and response network; supporting the implementation of the International Health Regulations (for more detail, see the chapter on global health

3. World Health Organization, "Status of Collection of Assessed Contributions, Including Member States in Arrears in the Payment of Their Contributions to an Extent That Would Justify Invoking Article 7 of the Constitution," April 5, 2012, http://www.who.int/about/resources_planning/A65_30-en.pdf.

4. World Health Organization, "Scale of Assessments 2010–2011," February 16, 2010, http://www.who.int/about/resources_planning/scale_of_assessement_2010-2011_a63_31-en.pdf.

5. Marjorie Ann Browne, "United Nations System Funding: Congressional Issues," Congressional Research Service, January 14, 2011, http://www.fas.org/sgp/crs/row/RL33611.pdf.

6. World Health Organization, "Voluntary Contributions by Fund and by Donor for the Financial Period 2008–2009," April 29, 2010, http://apps.who.int/gb/ebwha/pdf_files/WHA63/A63_ID4-en.pdf.

7. World Health Organization, "Voluntary Contributions by Fund and by Donor for the Financial Period 2010–2011," April 5, 2012, http://apps.who.int/gb/ebwha/pdf_files/WHA65/A65_29Add1-en.pdf.

8. Office of Management and Budget, "Annual Report on United States Contributions to the United Nations," June 6, 2011, http://www.whitehouse.gov/sites/default/files/omb/assets/legislative_reports/us_contributions_to_the_un_06062011.pdf.

9. World Health Organization, "Pandemic Influenza Preparedness: Sharing of Influenza Viruses and Access to Vaccines and Other Benefits: Report by the Open-Ended Working Group of Member States on Pandemic Influenza Preparedness," May 5, 2011, http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_8-en.pdf.

security); strengthening global, regional, and national public health systems; and enhancing global health leadership and cooperation.[10]

WHO also is taking a role in addressing the critical problem of production and distribution of substandard and fraudulent medicines, an issue increasingly important to the United States as more products and ingredients originate overseas. In recent action, WHO cosponsored in November 2012 the first meeting of the Member State Mechanism on Substandard/Spurious/Falsely-Labelled/Falsified/Counterfeit Medical Products with the goal of developing strategies for promoting national regulatory capacity to ensure the quality of medical products.[11]

Improving research and development (R&D) that meets the specific health needs of developing countries is another WHO priority. At the May 2013 World Health Assembly, member states will consider adopting a resolution to establish a Global Health R&D Observatory housed at WHO, intended to monitor and analyze relevant information, identify gaps and opportunities, and define health R&D priorities in consultation with member states.

On broader issues, WHO is taking center stage in devising indicators for the control of noncommunicable diseases (NCDs), including cancer, cardiovascular disease, diabetes, and chronic respiratory disease. Currently, the organization is developing an updated action plan for a strategy for controlling and preventing NCDs that would cover 2013–2020, with a global goal of reducing premature mortality from NCDs by 25 percent by 2025.[12]

WHO also is leading discussions on universal health coverage, an overarching concept that would foster equitable access to health services while ensuring against catastrophic health-related financial losses. Universal health coverage is intended to serve as an umbrella approach that encompasses infectious diseases, maternal and child health, and NCDs. The goal is to facilitate self-reliant, sustainable, country-level mechanisms for health financing involving a mix of public and private resources.

Ongoing Challenges

Excessive financial earmarks. There is a serious imbalance between annual assessed contributions to WHO and those earmarked for specific projects. This stems to a significant degree from a lack of confidence in WHO's financial controls, accountability, and performance, especially in its regional offices. This budgetary imbalance, however, hinders the director-general's ability to fund administrative core costs in Geneva, preserve technical expertise, and use her budgetary sway both to encourage reforms and to pursue priority global health objectives.

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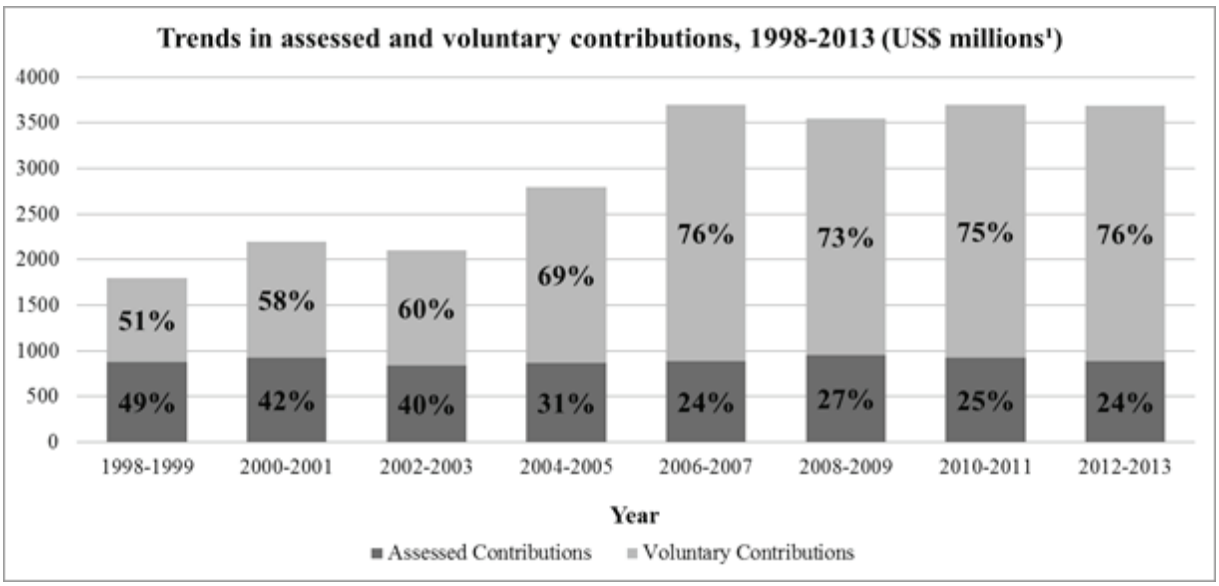
10. U.S. Department of Health and Human Services, "Memorandum of Understanding Between the Government of the United States of America and the World Health Organization Regarding Cooperation on Global Health Security Initiatives," September 19, 2011, http://www.globalhealth.gov/global-health-topics/health-diplomacy/agreements-and-regulations/20110922-mem.html.

11. World Health Organization, "New Global Mechanism to Combat Substandard/Spurious/Falsely-labelled/Falsified/Counterfeit Medical Products," November 21, 2012, http://www.who.int/medicines/news/TRA-SE_EMP.pdf.

12. World Health Organization, "Zero Draft: Global Action Plan for the Prevention and Control of Noncommunicable Diseases, 2013–2020," October 10, 2012, http://www.who.int/nmh/events/2012/ncd_zero_draft_action_plan_2013-2020.pdf.

Currently, about 75 percent of WHO's funding comes in the form of voluntary contributions while the remainder results from annual assessments (see Figure 1). Donors specify a large portion of voluntary funding for certain projects, diseases, or regions. The trend has turned WHO into a "donor-driven" organization with fragmented programs.[13] "Most voluntary funding is for short-term projects," explained WHO director-general Chan. "The management of a large amount of earmarked and specified voluntary income increases overhead costs…and reduces efficiency. Programmes and offices compete for funds and become territorial in protecting their interests, which works against policy coherence."[14]

Figure 1: Trends in Assessed and Voluntary Contributions, 1998–2013



[1] Data *exclude* in-kind contributions. Assessed contributions and voluntary contributions are projected for 2012–2013.

Source: World Health Organization, http://apps.who.int/gb/ebwha/pdf_files/EBSS/EBSS2_ID2-en.pdf.

Shrinking resources. Even as it confronts restrictions on how it can use its funds, WHO is downsizing its budget expectations. The organization had an approved budget for 2010–2011 of $4.54 billion, but because of the global economic downturn, was able to collect only $3.84 billion of the

13. Committee on the U.S. Commitment to Global Health, *The U.S. Commitment to Global Health: Recommendations for the Public and Private Sectors* (Washington, D.C.: National Academies Press, May 2009), http://www.iom.edu/Reports/2009/The-US-Commitment-to-Global-Health-Recommendations-for-the-Public-and-Private-Sectors.aspx.

14. World Health Organization, "Director-General Addresses Reforms in WHO Financing" (remarks by Dr. Margaret Chan, director-general of the World Health Organization, at the Programme, Budget and Administrative Committee of the Executive Board, Second Extraordinary Meeting, Geneva, Switzerland, December 6, 2012), http://www.who.int/dg/speeches/2012/reforms_20121206/en/index.html.

total.[15] WHO officials originally hoped for a budget of $4.8 billion for 2012–2013, but member states approved a budget of $3.96 billion.[16] The reductions have resulted in staff layoffs, focused primarily at the organization's Geneva headquarters and in the African region. Between the end of 2010 and August 2012, WHO reduced staff by 937 people with either long-term or temporary contracts. Nearly 500 staff members were eliminated at headquarters, while an additional 300 losses occurred in the Africa region.[17] The reductions and other management problems have raised questions about WHO's continued technical expertise.[18]

Cumbersome governance. WHO has a challenging management structure distributed across six geographic regions and subject to the direction of its 194 member states with divergent health needs, available resources, and political philosophies. WHO often is criticized for taking on too many activities to do them all effectively, but member states have had a difficult time agreeing on a select set of core priorities. In addition, accountability and transparency have been longstanding problems in the WHO regional offices. The ambitious and much-needed organizational reform initiated by Director-General Chan is at an early phase,[19] and the next few years will test what level of concrete progress is achievable. If even partially successful, the reform effort will help focus WHO's mission upon core priorities, better connect financing with that mission, enhance transparency and accountability, and create a far more effective secretariat.

A key goal of reform is narrowing WHO's mission to focus on its strengths. In 2012, the organization developed criteria to determine its priorities. They include current health problems, including burden of disease at the global, regional, or country levels; the needs of individual countries for WHO support; and WHO's comparative advantage, including capacity to gather and analyze data in response to current and emerging health issues. WHO also will focus on five technical categories: communicable diseases; noncommunicable diseases; promoting health through the life course, which considers the long-term health implications of biological and social experiences; strengthening health systems; and preparedness, surveillance, and response.[20]

Outmoded personnel rules. WHO is also hampered by outdated and cumbersome UN personnel rules that limit the secretariat's ability to employ the most-qualified people. Rules governing pensions, employment, and reemployment privileges need to be modernized to strengthen incentives for flexibility and nimbleness versus permanence and rigidity.

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15. Author communication with Elilarasu Renganathan, director of planning, resource coordination, and performance monitoring, World Health Organization, January 3, 2013.

16. Stephanie Nebehay and Barbara Lewis, "WHO Slashes Budget, Jobs in New Era of Austerity," Reuters, May 19, 2011, http://www.reuters.com/article/2011/05/19/us-who-idUSTRE74I5I320110519; also, author communication with Elilarasu Renganathan, January 3, 2013.

17. World Health Organization, "Human Resources: Annual Report," November 30, 2012, http://apps.who.int/gb/ebwha/pdf_files/EB132/B132_38-en.pdf.

18. Oxfam International, "Long-Term Future of World Health Organization at Risk from Financial Crisis," press release, May 18, 2012, http://www.oxfam.org/en/pressroom/pressrelease/2012-05-18/long-term-future-world-health-organization-risk-financial-crisis; also, Jack C. Chow, "Is the WHO Becoming Irrelevant: Why the World's Premier Public Health Organization Must Change or Die," *Foreign Policy*, December 8, 2010.

19. World Health Organization, "Implementation of WHO Reform, 2012," January 8, 2012, http://www.who.int/about/who_reform/managerial/B132_5Add8-en.pdf.

20. World Health Organization, "WHO Reform: Report by the Director-General," March 22, 2012 http://apps.who.int/gb/ebwha/pdf_files/WHA65/A65_40-en.pdf.

Advocacy challenges. Other challenges faced by WHO fall in the category of advocacy. For example, while universal health coverage provides the opportunity to encourage self-financing of country health systems, it may prove a hard sell to American audiences that view it as a vehicle for greater government involvement in providing and funding health services. Some universal health-coverage proposals call for mandatory participation of individuals in arrangements to pool health financing, another requirement that has attracted opposition in the United States. In addition, a focus on NCDs has turned attention to salt, sugar, and fat levels in commercial foods. While the movement has prompted some companies to reduce the amounts of those substances in their products, global goals on NCDs could call for further concessions from multinational food and beverage corporations and their suppliers, some of which are headquartered in the United States.

Palestinians and the WHO. The Palestinians in recent years have renewed efforts to seek membership in WHO. Since U.S. law calls for a funding halt to any UN agency that allows membership by the Palestine Liberation Organization, admittance would trigger a major disruption to WHO funding and to the U.S. partnership with the organization. The situation requires careful monitoring to avoid threatening the U.S. relationship with WHO and compromising global health security.[21]

Post 2015-MDG process. The United Nations has begun a process to formulate the future of the Millennium Development Goals (MDGs) after the current 15 year phase concludes in 2015. While the current goals include several related specifically to health, including reducing child mortality, improving maternal health and combating AIDS, malaria and other diseases, the next round could involve more general, overarching themes. While the creation of broad objectives would expand health concerns covered by the MDGs to emerging issues like noncommunicable disease and financial risk protection, a lack of specific targets and measurements could weaken accountability for health outcomes.

WHO and the private sector. WHO struggles with how to engage with the private sector in a way that avoids potential conflicts of interest. WHO is developing guidelines to govern interactions with both NGOs and private commercial enterprises. The U.S. is encouraging adoption of policies that allow the organization to receive input with sufficient transparency to ward against undue influence on WHO policy. Clearer guidelines should allow WHO to be more inclusive and better leverage the private sector's unique assets.

Lastly, WHO may have a difficult time keeping attention on preparedness: attention to global pandemic preparation often wanes in the absence of major threats, even though preparedness is essential to mitigating the effects of worldwide disease outbreaks.

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21. For more information see J. Stephen Morrison and Haim Malka, *U.S. Global Health Policy in Palestinian Hands?* Center for Strategic and International Studies, March 2012, http://csis.org/files/publication/120307_Morrison_GlobalHealthPalestinian_Web.pdf.

Policy Recommendations

In response to these challenges, the administration and Congress should consider the following policy options:

1. Maintain U.S. focus on critical priorities.

The United States should maintain focus through WHO on critical global priorities, including health security (disease surveillance and response, bioterrorism containment, and pandemic preparedness); norms and standards; and successful conclusion of global polio eradication.

2. Support WHO reform by providing incrementally greater flexibility for core secretariat needs and disease categories.

While ensuring that specific U.S. priorities continue to receive targeted support through WHO, the United States should at the same time be more flexible in its funding, rely less on earmarking, and encourage other donors to respond similarly. To that end, the United States should provide the director-general with increased budgetary clout and discretionary power by providing more flexible voluntary funds, tied to concrete proof that reform efforts are strengthening accountability and performance. That step will more effectively encourage better WHO personnel practices, greater management and financing flexibility, and improved long-term planning. It will provide incentives for reform, support comprehensive approaches to health, and attract and hold top talent. Directing a larger proportion of U.S. voluntary funds to broad categories such as infectious diseases or NCDs as opposed to allotments to specific diseases would provide WHO more leeway to target funding to areas with the greatest needs.

3. Continue to provide ample U.S technical expertise to extend WHO's capacity.

Traditionally, the United States has provided skilled personnel in areas of disease detection and control, health sciences, and operational leadership. As globalization continues, additional expertise is needed in areas such as advancing international regulatory structures to assure the quality of imported health-related products.

4. Actively contribute to debates over universal health coverage, the prevention and control of noncommunicable diseases, and global health research and development.

The United States can offer significant expertise in a variety of arrangements to pool health-services financing, in both the public and private sector. In addition, the United States has struggled with the treatment and control of chronic diseases for several decades and can provide important guidance as well as learn new approaches from other countries. Finally, as a major funder in R&D that benefits the developing world, the U.S. can lead in the establishment of health R&D norms and priorities and encourage member states to increase R&D commitments.

THE GLOBAL FUND

By Todd Summers[22]

Key Assets that Align with U.S. Interests

The Global Fund to Fight AIDS, Tuberculosis and Malaria was established in 2002 to raise and disburse funds needed to address three of the world's deadliest epidemic diseases. Over the past twelve years, it has helped finance over 150 developing countries to mount prevention and treatment programs, contributing to millions of lives saved. By the end of 2012, the Global Fund had supported 4.2 million people on antiretroviral (ARV) drugs, treated 9.7 million cases of TB, and distributed 310 million insecticide-treated bed nets to protect against malaria.[23] It has recently adopted an ambitious five-year strategy and started its implementation by revamping its funding mechanism.

The U.S. government, under President George W. Bush, provided strong support; administration officials helped design and stand up the new entity, and the United States was one of its first major donors. Today, the United States remains the Global Fund's single largest donor, providing over $7.2 billion of the Fund's total contributions of $24.4 billion. Because U.S. law limits its contribution to no more than one-third of the total, it has also helped drive up funding from other donors. The U.S. government is also actively engaged in the Global Fund's governance, currently represented on its board by Ambassador Eric Goosby and his alternate Assistant Secretary of Health Nils Daulaire. It has led recent efforts to improve Global Fund operations and management, with the State Department's John Monahan serving as vice chair of the board's Finance and Operational Performance Committee, and Julia Martin serving on the board's Strategy, Investment and Impact Committee..

Together with U.S. bilateral programs, Global Fund disbursements account for a significant majority of donor assistance on all three diseases. For malaria, Global Fund support accounts for about half of all donor financing; for tuberculosis, about 80 percent of donor support flows through the Global Fund; and for HIV, it represents about one-quarter of donor funding. In sum, the Global Fund is a critical partner in all three diseases, as well as broader efforts to strengthen underlying health systems in developing countries and to address other urgent needs such as maternal and child health.

Going into 2013, the Global Fund faces an uncertain future: a new three-year replenishment cycle has begun, where donors will be asked to pledge support from 2014–2016; Dr. Mark Dybul, an American physician and former head of the President's Emergency Plan for AIDS Relief (PEPFAR) program under President George W. Bush, will start as the new executive director in January 2013; and an ambitious new funding model will be piloted, demanding greatly expanded technical and political engagement with recipient countries.

22. Todd Summers is a senior adviser with the CSIS Global Health Policy Center.

23. Global Fund, "The Global Fund's 2012 End-Year Results at a Glance," http://www.theglobalfund.org/en/mediacenter/videos/Video_The_Global_Fund_2012_End-Year_Results_at_a_Glance/.

Policy Developments under the First Obama Administration

The Obama administration, led by the Office of the Global AIDS Coordinator at the State Department, has made a concerted effort to strengthen programmatic ties with the Global Fund as well as to push for essential reforms in its management, governance, and overall approach to financing country-led programs on the three diseases. Critical ties have been established with high-need countries, especially those in sub-Saharan Africa that carry the greatest shares of disease burden. Guidance for applications to PEPFAR now requires coordination with Global Fund-supported programs, making clear that their success is part of the PEPFAR mandate. Senior U.S. representation in Geneva has also helped, bringing day-to-day engagement between the United States and the Global Fund's secretariat.

Funding levels have also increased, with the United States making its first three-year pledge of $4 billion during the last replenishment cycle (2012–2014), although a tightened fiscal environment has made fulfillment of that pledge more challenging. However, the Global Fund has garnered important congressional support and has narrowly escaped the major reductions experienced by other foreign aid programs.

Ongoing Challenges

A major challenge in 2013 and beyond is turning reform commitments into action: getting the new leadership team in place, and implementing the Global Fund's reform overhaul in a timely, effective, and sustained fashion. Major governance and leadership reforms have been initiated, with a new executive director taking the reins and the search for a new inspector general under way. An ambitious new strategy and funding mechanism approved by the board now await concrete next steps in bringing them into force. These changes address some of the most pressing concerns raised by the United States and other donors, which had become increasingly unhappy with how the secretariat was being managed and how grant funds were being utilized. Moreover, the funding environment is forbidding. U.S. support remains strong, but mustering the political energy to increase funding as the Global Fund initiates its next three-year funding drive will be tremendously challenging. Other major donors, including France, Japan, and the European Commission, also face dwindling budgets, although advocates are working hard to maintain or increase their support as well as explore innovative financing mechanisms that could attract new sources of revenue.

One way to stretch funding is to get better value for money from grants, especially in the costs of goods and services purchased with Global Fund support. The board has already approved a focused "market-shaping strategy," charting a path to harness the Global Fund's immense purchasing power to drive down prices, improve quality, and ensure adequate supplies. For insecticide-treated bed nets used to protect against the mosquitoes that bring malaria, for example, one recent analysis estimated a potential savings of over $600 million dollars through an improved purchasing approach.[24] Most of this benefit would come to the Global Fund since it dominates the bed net market. Unfortunately, work to implement the market-shaping strategy has been slow.

24. Kanika Bahl and Pooja Shaw, *Expanding Access to LLINs: A Global Market Dynamics Approach* (Washington, D.C.: Results for Development Institute, 2012), http://www.resultsfordevelopment.org/sites/resultsfordevelopment.org/files/resources/R4D_LLIN%20report_24Apr_Final.pdf.

Beyond funding levels, major challenges continue to threaten to reduce the impact of Global Fund grants. Many countries hit hardest by the three diseases also face considerable problems designing and implementing grant-supported programs because of limitations in health infrastructure and human resources, as well as limited political support for tackling stigmatized diseases and investing domestic resources into health. This makes long-term sustainability of these programs an urgent challenge to the Fund and its supporters. Countries that can do more to finance their own response often don't, letting the Global Fund and other outside donors carry the load. Even for countries that will continue to require substantial external funding, real political leadership is often lacking.

This makes it particularly difficult to overcome the broader social and political challenges that limit access to prevention and treatment services for a variety of marginalized groups that are disproportionately at risk. The Global Fund operates in environments where human rights violations, discrimination, and gender inequity are real threats to the very people it's trying to help. While the Global Fund's 2012–2016 strategy identifies promoting and protecting human rights as one of its five core objectives, engaging successfully on what are often highly political issues is going to be difficult and will require the Global Fund to develop its own capacity for political engagement as well as to utilize better the influence of its donors and partners.

Policy Recommendations

To address these challenges the administration and Congress should consider the following policy options:

1. Maintain strong U.S. leadership and support.

The Global Fund needs continued high-level support from the administration, both at the Geneva level to help incoming Executive Director Mark Dybul succeed, and at the country level, where Global Fund-supported and U.S. bilateral programs must work synergistically to achieve maximum public health impact. The Global Fund's recently approved new funding model offers tremendous opportunity to refocus Global Fund grants to harmonize better with U.S. bilateral funding, but a major culture change is also required to seize this opportunity and overcome years of risk aversion, inflexibility, and insularity. It will also require work by PEPFAR, UNAIDS, the World Health Organization, and others like the Roll Back Malaria and Stop TB Partnerships to help countries develop better national disease strategies around which funders can organize.

2. Promote a whole-of-government approach.

Despite the apparent demise of the U.S. Global Health Initiative, its call for cross-agency coordination and coherence should remain an important goal of the U.S. approach to health, including the United States' relationship with the Global Fund. For grants to succeed, help is needed not only from the United States but also from an array of multilateral and technical partners—including the U.N. Joint Program on AIDS (UNAIDS), the World Health Organization, and the World Bank—all of whom are supported and influenced by the United States. In addition, important bilateral trade and military relationships can help—or hinder—success in Global Fund and bilateral health programs and so require a "whole-of-government" approach.

3. Focus on the most urgent cases.

While the Global Fund has committed to remaining a global institution, working in over 130 developing countries, most of the burden of AIDS, TB, and malaria rests in about 20 countries. The United States needs to work assiduously with the Global Fund and other partners to get those countries' efforts in high gear, which includes: developing optimized national plans that identify the core prevention and treatment interventions needed to achieve maximum health impact; harnessing the domestic political, financial, and policy supports needed to implement those strategies; complementing those resources, as needed, with external support from the Global Fund and others; and ensuring real-time monitoring to course correct as needed to keep up with these three dynamic epidemics.

4. Implement the market shaping strategy.

The United States should push and support the Global Fund to extract maximum value for money for its grants by implementing rapidly the board-approved market dynamics strategy. It should also work to better leverage the capacity of UNITAID, another multilateral organization established by France and others to help address market failures in HIV, TB, and malaria that lead to higher prices or reduced availability of key medicines, diagnostics, and other health commodities. Up until now, UNITAID has provided a lot of funding directly to the Global Fund, and helped with the supply and price of a number of key commodities like pediatric antiretroviral treatments for AIDS, but there's been inadequate attention from the Global Fund to maintain and optimize what should be a symbiotic relationship.

5. Keep Global Fund contributions at or above current levels.

The Global Fund is a smart investment, leveraging U.S. donations by 2:1. It also offers a significant opportunity to transition some countries from heavy reliance on bilateral support to a higher percentage of Global Fund financing (coupled with increased domestic contributions). The United States should work hard to expand its funding to the Global Fund, and push other donor countries to also do better.

THE GAVI ALLIANCE

By Amanda Glassman[25]

Key Assets that Align with U.S. Interests

Though vaccines are among the most cost-effective interventions to improve health, low-income countries have historically benefited the least.[26] To remedy this situation, the public-private GAVI Alliance was created in 2000 with active support from the governments of Norway and the United States, the Bill & Melinda Gates Foundation, and other organizations, with a mission to "save children's lives and protect people's health by increasing access to immunization in the world's poorest countries."[27] GAVI defines "poorest countries" as countries with an average income of less than US$1,500 per capita. In these countries, GAVI provides financial support for new and underused vaccines, immunization services, vaccine introduction, civil society organizations, and activities to strengthen related health systems. Its mission and track record of effective spending align closely with the growing U.S. interest in enhancing child survival.[28]

The total resources available to GAVI from 2011–2015 are $7.6 billion,[29] and annual spending has risen from $350 million in 2008 to $1.1 billion in 2012. U.S. contributions and pledges to GAVI between 2000 and 2014 total almost $1.1 billion (see Figure 1). The United States currently funds 11.2 percent of GAVI's annual budget.[30]

25. Amanda Glassman is the director of global health policy and a senior fellow at the Center for Global Development.

26. GAVI Alliance, "Cost-effective," http://www.gavialliance.org/about/value/cost-effective/; and Centers for Disease Control and Prevention, "CDC Global Vaccines and Immunization," http://www.cdc.gov/globalhealth/immunization/.

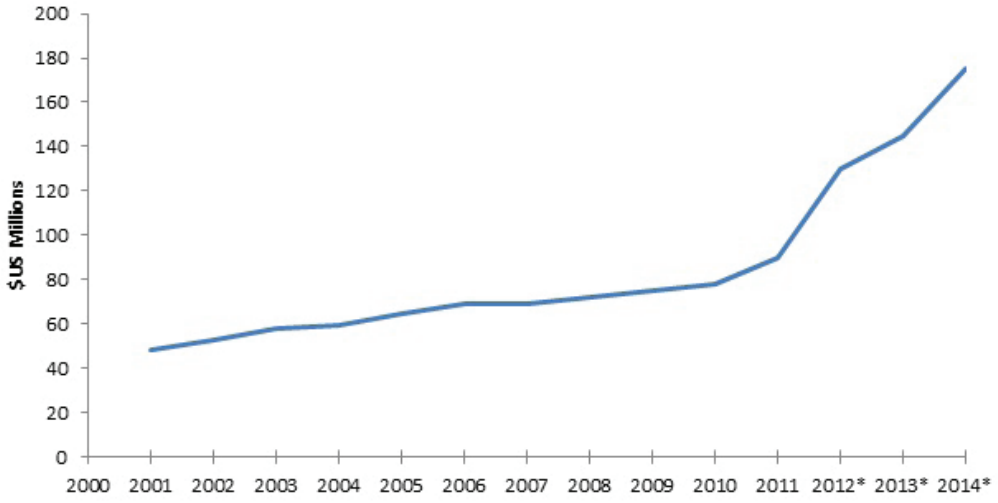
27. GAVI Alliance, "Cost-effective."

28. USAID, "Every Child Deserves a 5th Birthday: Vision," http://5thbday.usaid.gov/pages/Vision.aspx.

29. Ann Danaiya Usher, "GAVI funding meeting exceeds expectations," *Lancet* 337, issue 9784 (June 25, 2011): 2165–66.

30. GAVI Alliance, "United States of America: Proceeds to GAVI from donor contributions & pledges (2011–2015) as of 5 September 2012," http://www.gavialliance.org/funding/donor-profiles/united-states/; and GAVI Alliance, "Annual donor contributions to GAVI 2000–2031 as of 5 September 2012," http://www.gavialliance.org/library/gavi-documents/funding/annual-donor-contributions-to-gavi-2000-31-as-of-5-september-2012/.

Figure 1. Actual and Pledged U.S. Contributions 2000–2014, as of September 2012[31]



*Pledges

The United States represents Canada, Australia, Japan, and Korea on the GAVI Alliance board. The board is responsible for strategic direction and policymaking, oversees the operation of the Alliance, and monitors program implementation. During the second Obama administration, the board will oversee an important external evaluation of the Alliance's activities. It will also weigh measures to improve the quality of data, strengthen the incentives of partner governments to use vaccines more effectively, and better assess whether to adopt new cost-effective vaccines.

Policy Developments under the First Obama Administration

In recent years, following a difficult period of leadership change and funding uncertainty, GAVI has undergone a promising renewal.[32] During the GAVI Alliance's first pledging conference in June 2011, the United States pledged $450 million over three years (fiscal years 2012–2014) subject to congressional approval.[33] This represented a substantial increase over the previous year U.S. $90 million annual contribution. Overall, the replenishment was quite successful, with $4.3 billion pledged over five years. Meanwhile, a strong new chief executive officer, U.S. citizen Seth Berkley, and a new board chair, Norway's Dagfinn Høybråten, have generated a renewed sense of purpose and commitment among Alliance members.

31. GAVI Alliance, "Annual donor contributions to GAVI 2000–2031 as of 5 September 2012."

32. Lisa Carty, Amanda Glassman, Stephen Morrison, and Margaret Reeves, "GAVI'S Future: Steps to Build Strategic Leadership, Financial Sustainability, and Better Partnerships" (Washington, D.C.: CSIS, June 2011), http://csis.org/files/publication/110609_Carty_GAVI_0.pdf.

33. GAVI Alliance, "Donors commit vaccine funding to achieve historic milestone," June 13, 2011, http://www.gavialliance.org/library/news/press-releases/2011/donors-commit-vaccine-funding-to-achieve-historic-milestone-in-global-health/.

Due to U.S. Department of the Treasury and congressional objections,[34] the United States has not provided funding support to the GAVI Alliance's longer-term funding sources, the International Finance Facility for Immunization (IFFIm) and the Pneumococcal Vaccine Advanced Market Commitment (AMC).[35] These multiyear funding sources enable the Alliance to make longer-term commitments to countries and to vaccine manufacturers that can lead to reduced vaccine prices and quicker scale-up in country.

On the programmatic side, pneumococcal and rotavirus vaccines have been introduced in many GAVI-eligible countries, and although progress to date is slower than expected,[36] the pace is expected to increase and GAVI estimates that the introduction of the vaccine against pneumococcal disease in eligible countries could prevent approximately 500,000 premature deaths by 2015 and up to 1.5 million premature deaths by 2020, while the vaccine against rotavirus would prevent 2.4 million child deaths by 2030.[37]

The vaccine portfolio has recently been expanded to include vaccines against the human papilloma virus (HPV) and measles/rubella. The board has also agreed to future investments in vaccines against Japanese encephalitis and typhoid, when appropriate vaccines become available and have been reviewed by the World Health Organization (WHO). GAVI is also considering investments in additional vaccines, including inactivated poliovirus vaccine. An expert group supported by the GAVI secretariat—tasked with developing the next vaccine investment strategy[38]—will consider these proposed investments.

The 2002–2010 GAVI-initiated partnership with China to combat vaccine-preventable hepatitis B[39] was a notable achievement, increasing HepB3 coverage to more than 85 percent and timely birth dose vaccination coverage to more than 75 percent. In recent years, GAVI has expanded its efforts in Afghanistan, the Democratic Republic of Congo, and Somalia. The Democratic People's Republic of Korea has just launched the introduction of the five-antigens-in-one pentavalent vaccine, as has Myanmar. The pentavalent vaccine is a single vaccine that protects against diphtheria, pertussis, tetanus, hepatitis B, and Haemophilus influenzae type B, the bacterial microorganism that causes several serious childhood illnesses like meningitis and pneumonia.

GAVI has commissioned external evaluations to be conducted in five countries over 2013–2016, with the aim of generating real-time quantitative analysis of the relevance, effectiveness, impact, efficiency, and sustainability of GAVI support.

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34. Benjamin Leo, *Can Donors Be Flexible within Restrictive Budget Systems? Options for Innovative-Financing Mechanisms*, Working Paper 226 (Washington, D.C.: Center for Global Development, October 2010), http://www.cgdev.org/files/1424497_file_Leo_Budget_Systems_Paper_FINAL.pdf.

35. IFFIm, *The International Finance Facility for Immunisation: Annual Report of the Trustees; Annual Financial Statements: Year Ended 31 December 2010*, http://www.iffim.org/finance/trustees-reports-and-financial-statements/; and GAVI Alliance, *Progress Report 2011* (Geneva: GAVI Alliance, 2011), http://www.gavialliance.org/results/gavi-progress-reports/.

36. Rotavirus vaccines have been rolled out in 9 countries since 2011, and to date, 18 countries have begun the introduction of pneumococcal vaccines. GAVI Alliance, "Vaccine goal indicators," http://www.gavialliance.org/results/goal-level-indicators/vaccine-goal-indicators/.

37. GAVI Alliance, "Factsheet: Advance Market Commitment," 2012; GAVI Alliance, "Factsheet: Rotavirus disease," 2012.

38. The board will consider this strategy at the end of 2013.

39. GAVI Alliance, "China's dramatic fall in hepatitis B infections," December 1, 2010, http://www.gavialliance.org/library/news/roi/2010/china-s-dramatic-fall-in-hepatitis-b-infections/.

Ongoing Challenges

Poor-quality data: GAVI and its partners face chronic data problems that significantly impede GAVI's ability to track coverage, progress, and health impacts. Currently, GAVI relies on country data and WHO-UNICEF estimates of vaccination coverage, which are mainly derived from routine administrative data, and are frequently uneven, inconsistent, and of poor quality.[40]

Poor-quality data means that neither recipient countries nor the Alliance have a reliable understanding of the effects of their programs or the degree to which children are truly protected from vaccine-preventable diseases. Although GAVI is actively working with partners to improve data, much more needs to be particularly if cash-based support is conditioned on improvements in coverage. GAVI is considering mandating that partner countries fund household surveys of vaccination coverage and timeliness, where needed.

Limited incentives for effective coverage: GAVI has provided limited incentives to partner countries to improve effective and equitable coverage of basic vaccines. GAVI offers support for new vaccine introduction conditional on a threshold level of DTP-3 coverage as reported to WHO/UNICEF; its discontinued Immunization Support Strengthening (ISS) program previously awarded cash for each additional child vaccinated beyond the baseline. However, GAVI funding was not directly tied to independently measured improvements in the coverage or equity of the vaccines actually financed by the Alliance. The GAVI board recently approved the consolidation of its cash-based support into one window that would have a performance-based element, tying funding directly to improvements in the coverage of DTP-3 and measles. However, the new system continues to rely on highly problematic data, and lacks an equity focus.

Few sources of long-term funding: Long-term, predictable funding will help GAVI scale up its programs, improve its demand forecasts, and increase UNICEF's leverage with producers to reduce prices. However, only a small share of the Alliance's funding is long-term; the rest is available on only the recently instituted three-year replenishment cycle.

Limited economic analyses for vaccine selection: GAVI needs a more rigorous, consistent, and country-specific approach to selecting vaccines that will take systematic account of the large pipeline of new vaccines, the higher relative prices of new vaccines compared to existing alternatives, the limited budgetary capacity of GAVI-eligible countries, and GAVI's country co-financing requirements. As GAVI begins its next vaccine investment strategy to guide future investment decisions, GAVI needs to accelerate this effort, make it a strategic priority, and put in place economic evaluation processes that reliably demonstrate the cost-effectiveness, affordability, and feasibility of new vaccines proposed for specific countries.

Dilemmas associated with graduation: There is a risk that countries that graduate from GAVI support will face challenges sustaining higher-cost, recently introduced vaccines. At present there

40. As the World Health Organization acknowledged in 2009, "In no instance do we have complete, consistent, multiple measures for an entire country/vaccine time series. In some instances, we have complete administrative data validated by periodic or occasional consistent survey findings. In others, data are available from a single source—usually administrative data—and appear internally consistent over time and across vaccines. In several countries, administrative data and survey results are inconsistent; in others, the administrative time series is incomplete, internally inconsistent or both." See Anthony Burton et al., "WHO and UNICEF estimates of national infant immunization coverage: methods and processes," *Bulletin of the World Health Organization* 87 (June 2009): 535–41.

is no explicit strategy to address this risk, although the GAVI secretariat is developing options for consideration by the GAVI board. GAVI's board has set a country-eligibility threshold that progressively graduates countries that obtain an average gross domestic product of more than $1,500 per capita. In 2000, 72 countries were eligible for GAVI assistance; currently 57 are eligible. By 2020, under GAVI's current policy and considering International Monetary Fund (IMF) growth projections, only 42 countries, representing half of the currently eligible population of children under 5 years old, will qualify for new GAVI support.[41]

Policy Recommendations

1. Commit to the replenishment, subject to continued progress.

The Obama administration, in concert with bipartisan leadership in Congress, should make a robust long-term commitment during the 2014 GAVI replenishment. It should explicitly tie the work of the GAVI Alliance to the continued U.S. policy priority of ending childhood preventable diseases. Increased and longer-term support should be connected to GAVI's progress in improving the quality of data, incentives for partner governments, and assessment of new vaccines.

2. Improve data quality.

Through its GAVI board participation, continued work with WHO and UNICEF, and expanded assignment of CDC technical experts, the United States should champion the improvement of the quality of data that GAVI relies upon to track the delivery of vaccines and health impacts. In those countries where both GAVI and the United States have substantial health programs, there should be a concerted effort to draw upon U.S. technical expertise to improve the measurement of GAVI's coverage and impact.

3. Use cash-based assistance to focus on effective coverage.

The Secretariat and the GAVI board should focus on how its cash-based resources to countries, and the provision of technical assistance by partners, can more effectively improve the coverage and equity of immunization in the next two years. The new performance-based scheme should work alongside efforts to improve data quality in order to get the incentives right for higher coverage, while equity improvements should also be rewarded.

4. Use more rigorous economic evaluation methods to select new vaccines.

As a member of the GAVI Alliance, the United States should actively engage in developing the new vaccine investment strategy and designate an expert to participate in deliberations aimed at developing and deploying a standardized and rigorous approach to economic evaluation and affordability of new vaccines. This approach will deepen GAVI's understanding of the relative priority and affordability of each type of vaccine in each of the GAVI-eligible countries; it will also inform price negotiations with industry in order to obtain a fair price that reflects the value of a vaccine in a particular country setting.

41. Amanda Glassman et al., *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*, Working Paper 270 (Washington, D.C.: Center for Global Development, October 2011), http://www.cgdev.org/files/1425581_file_Glassman_Duran_Sumner_MIC_global_health_FINAL.pdf.

5. Assess alternatives for graduating countries.

The United States should support the Alliance's efforts to work with WHO to assess lower-middle-income countries' preparedness and political will to take on greater shares of financing their national immunization programs, considering country budget cycles and governance conditions. The new Office of Global Health Diplomacy should establish an interagency task force with a mandate to deliver analyses, conduct systematic outreach, and develop policy options that can raise the political will of GAVI countries to pay for vaccines. That should be part of a larger effort to examine how this problem emerges and can be addressed across a range of multilateral institutions. The results of the task force can provide input to the GAVI board on alternative scenarios and options for the future.

UNAIDS

By J. Stephen Morrison and Alisha Kramer[42]

Key Assets that Align with U.S. Interests

UNAIDS was launched in 1996 with a mandate to strengthen the United Nations' response to the HIV/AIDS epidemic, calling upon diverse skill sets and expertise within the UN family. UNAIDS is a partnership of 11 cosponsors.[43] The United States is the largest donor to UNAIDS, providing $45 million of UNAIDS' annual budget of $230 million.[44] The United States also plays a pivotal role on the UNAIDS' Program Coordinating Board[45] that sets the organization's overall strategic direction and monitors program implementation and impact.

UNAIDS aligns strongly with U.S. interests in combating HIV/AIDS. UNAIDS generates timely quality data on the global HIV/AIDS epidemic; tracks epidemiological, programmatic, and policy trends; provides leadership on human rights, most-at-risk populations (MARPs), pediatric AIDS, and reducing stigma and discrimination; builds outreach to civil society organizations; prioritizes effective HIV prevention and pushes national investments toward proven, high-impact programs; and engages in high-level dialogue with heads of state of impacted countries to secure higher political and financial leadership.

Policy Developments under the First Obama Administration

Increased Collaboration. Over the last four years, UNAIDS has worked with its partners to increase the effectiveness of its collaborations. Joint planning by the U.S. Office of the Global AIDS Coordinator and UNAIDS, for example, resulted in the *Global Plan towards the Elimination of New HIV Infections among Children by 2015 and Keeping their Mothers Alive*.[46] The *Global Plan* was launched by Michel Sidibé, executive director of UNAIDS, and Eric Goosby, U.S. global AIDS coordinator, among others, at the 2011 UN High Level Meeting on AIDS. In response to the Glob-

42. J. Stephen Morrison is senior vice president and director of the Global Health Policy Center at CSIS. Alisha Kramer is program coordinator and research assistant with the Global Health Policy Center.

43. The cosponsors include the Office of the United Nations High Commissioner for Refugees (UNHCR), United Nations Children's Fund (UNICEF), World Food Programme (WFP), United Nations Development Programme (UNDP), United Nations Population Fund (UNFPA), United Nations Office on Drugs and Crime (UNODC), UN Women, International Labour Organization (ILO), United Nations Educational, Scientific and Cultural Organization (UNESCO), World Health Organization (WHO), and World Bank.

44. UNAIDS, "Total contributions 2011," http://www.unaids.org/en/media/unaids/contentassets/documents/document/2012/2011-donor-total-contributions_en.pdf.

45. UNAIDS Program Coordinating Board includes representatives of 22 governments, the UNAIDS cosponsors, and give representatives of non-governmental organizations.

46. UNAIDS, *Countdown to Zero: Believe It, Do It: Global Plan towards the Elimination of New HIV Infections among Children by 2015 and Keeping their Mothers Alive* (Geneva: UNAIDS, 2011), http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/20110609_JC2137_Global-Plan-elimination-HIv-Children_en.pdf.

al Plan's call to action, the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) pledged an additional $75 million toward preventing mother-to-child transmission of HIV.[47]

World leaders at the UN High Level Meeting also set clear, measurable global AIDS targets for 2015, which were adopted in the "Political Declaration on HIV/AIDS: Intensifying our Efforts to eliminate HIV/AIDS."[48] The Declaration calls on countries to focus more intensely on populations at higher risk for HIV infection—sex workers, men who have sex with men, and people who inject drugs—and to base national strategies on epidemiological and national contexts.[49] HIV prevention in these key populations[50] continues to be a top priority for UNAIDS.

A joint effort with the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and PEPFAR is under way to work with highly impacted countries to pilot the new investment case approach, and Secretary of State Hillary Clinton recently commended the African Union's "Shared Responsibility Roadmap" that sets a course for greater national ownership and investment.

UNAIDS, in a June 2011 *Lancet* article[51] provided a framework to guide investments in prevention activities that are cost effective and produce maximum impact. This framework has helped inform PEPFAR strategies and guidance documents. A subsequent UNAIDS document issued in 2012 provides guidance on how to implement the investment framework.

More Rigorous Evaluation and Reform. In December 2007, UNAIDS commissioned its second external review.[52] That effort resulted in a new budgeting, accountability, and results framework, which aims to better demonstrate how finances are tied to goals and concrete outcomes. The first full reporting, based on that framework, will become available in June 2013. Sidibé also launched an internal restructuring in 2011, which reduced UNAIDS aggregate staffing as of 2012 by 100 (from 930 to 830); redeployed a number of staff from its Geneva headquarters to field posts (achieving a 30/70 split between Geneva and country offices); and increased the concentration of personnel deployed to high impact countries with the greatest disease burden and need, where UNAIDS can make the greatest difference.

Greater Engagement with Africa. Sidibé launched a major initiative with the African Union to achieve greater political, financial, and personnel commitments to national HIV/AIDS efforts. In July 2012, African heads of state and government adopted the *Roadmap on Shared Responsibility and Global Solidarity*, which calls on African governments and development partners to "fill…

47. UNAIDS, "World leaders launch plan to eliminate new HIV infections among children by 2015," press release, June 9, 2011, http://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2011/june/20110609prglobalplanchildren/.

48. UN General Assembly, "Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV, and AIDS," June 10, 2011, http://www.unaids.org/en/media/unaids/contentassets/documents/document/2011/06/20110610_un_a-res-65-277_en.pdf.

49. UNAIDS, "Bold new AIDS targets set by world leaders for 2015," press release, June 10, 2011, http://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2011/june/20110610psdeclaration/.

50. UNAIDS defines key populations as those "disproportionately impacted by HIV when compared with the general population. While this may vary according to local epidemic dynamics, principally this describes gay men and other men who have sex with men, women and men who inject drugs, sex workers and transgender people."

51. Bernhard Schwartländer et al., "Towards an Improved Investment Approach for an Effective Response to HIV/AIDS," *The Lancet* 377, issue 9782 (June 11, 2011): 2031–2041.

52. UNAIDS, "Second Independent Evaluation of UNAIDS," http://www.unaids.org/en/ourwork/managementandgovernance/dxdmanagementandgovernance/secondindependentevaluationofunaids/.

funding gaps together, investing their 'fair share' based on ability and prior commitments."[53] Secretary of State Hillary Clinton commended the *Roadmap*.

In recent years, some African countries have introduced policies that criminalize and severely punish homosexuality. These regressive human rights policies threaten HIV/AIDS response efforts. Sidibé has made it a priority to use UNAIDS' good offices systematically to address these egregious policies.

Ongoing Challenges

UNAIDS faces a range of challenges:

Coordination. UNAIDS-GFATM coordination has in the past been problematic—protracted tension and uneven cooperation—but the level of trust and confidence between the two organizations has increased, and UNAIDS is more actively participating in GFATM joint technical committees and reviews. The challenge ahead is to keep a priority focus upon further strengthening concrete alignment of plans, programs, and policies with the Global Fund. More progress is still warranted. UNAIDS has been far less effective coordinating its work with WHO and the other UNAIDS cosponsoring agencies. That has proven to be problematic, and progress in this area will require a concerted effort.

Staffing. UNAIDS also needs to justify its large staff count, demonstrate that it is delivering consistent quality in its personnel where they are needed most and in achieving concrete impact. Though UNAIDS trimmed its staff, it still employs 830 people, a sizeable number, and there is continued uncertainty about what the optimal size is for UNAIDS, given its mandate. The quality of technical assistance in country remains inconsistent, and donor concern over appropriate and balanced distribution of personnel remains. A tough budget climate will require UNAIDS to continue to find efficiencies both in size and distribution of its staff.

Post-2015 Role. The evolving Millennium Development Goal (MDG) landscape requires that UNAIDS clearly explain its future role. As the HIV-prevention agenda continues to evolve rapidly based on new science, UNAIDS will need to better help countries and international service providers stay ahead of these changes with optimized and focused national strategies. The MDGs established in 2000 will reach their target completion date in 2015. MDG 6 set out targets to combat HIV/AIDS, malaria, and other diseases. By 2015, MDG 6 calls for the halt and reversal of the spread of HIV/AIDS and to have achieved universal access to HIV/AIDS treatment by 2010. UNAIDS rallied around these two targets and campaigned to reach them by devising strategy documents, reporting on progress, and advocating on behalf of human rights and increased resources. The Post-2015 MDG agenda is unlikely to include a specific goal related to HIV/AIDS.

Confronting Governments. UNAIDS is inherently constrained in what political leverage it can bring against regressive national human rights policies. UNAIDS has been outspoken against policies that inhibit the human rights of sex workers, men who have sex with men, and injection drug users. However UNAIDS must walk a tight line to address policies that threaten human rights and an individual's ability to access health services, while maintaining cordial and cooperative rela-

53. UNAIDS, "African Union adopts new roadmap to accelerate progress in HIV, TB and malaria responses," press release, July 16, 2012, http://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2012/july/20120716aprausummit/.

tionships with country governments. Given this reality, UNAIDS' voice and influence, to be really effective, have to be closely harnessed to the efforts of other like-minded governments and multilateral institutions, including most importantly the United States.

Policy Recommendations

To address these challenges, the Obama administration and Congress should adopt the following priority policy options:

1. Maintain funding, contingent on continued reform.

The United States should sustain its current funding levels to UNAIDS, but make it contingent upon continued efforts to more clearly define the UNAIDS mission, guarantee high quality of its technical expertise, and achieve greater efficiencies in staffing. The quantity, quality, and distribution of staff must remain a priority area of reform and should be the subject of an independent expert review.

2. Focus on national strategies.

The United States should press UNAIDS to help and as needed push countries to develop and maintain optimized national HIV/AIDS strategies. UNAIDS' role as a global advocate remains important, but it should resist the temptation to launch new public campaigns and instead focus more on the basics: getting more people treated and reducing the number of new infections.

3. High-level leadership and collaboration.

The United States should give high priority to collaborating with UNAIDS leadership to build country ownership in Africa and address regressive human rights policies against sex workers, men who have sex with men, and injection drug users. UNAIDS should continue to work with country leaders to eliminate pediatric AIDS and develop clear investment cases to help guide national governments and donor programs.

THE WORLD BANK GROUP

By J. Stephen Morrison and Nellie Bristol[54]

Key Assets that Align with U.S. Interests

As low- and middle-income countries and the international community begin to focus on more comprehensive health service delivery and self-sustaining financing, the World Bank Group has special strengths to offer in both the public and private sectors. It has the knowledge and the capital to foster strong health systems and the expertise and cross-sectoral connections in finance and health to aid in developing innovative ways to provide financial risk protection for health services. In order to assume this pivotal role, the Bank needs to systematically bolster its health portfolio and take a more strategic approach. It currently gives relatively modest priority to its health programs, a situation stemming from leadership priorities and competition from other sectors including agriculture, energy and mining, transportation, education, climate change, labor, and social protection. In addition, during the past decade ample, far more concessionary bilateral and multilateral health resources have become available from other sources, including the President's Emergency Plan for AIDS Relief (PEPFAR), the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the GAVI Alliance. But these circumstances are shifting in the face of flat or declining global health resources. In addition, there is an ever-louder call for creating sustainable, country-owned health systems that move away from disease-specific approaches to address a broad disease burden, including, increasingly, noncommunicable conditions such as heart disease, diabetes, and cancer. Such a change would rest upon co-financing that allows individuals and families access to services without the risk of financial catastrophe.

With its new president, Dr. Jim Yong Kim, a well-known and highly respected innovator in global health appointed in July 2012, the Bank is positioned to step up its health presence. Kim quickly initiated a promising reorientation of the Bank's mission, including a focus on better addressing extreme poverty and improving implementation programs—the "science of delivery"—that could have important health dimensions. As the Bank's mission and future priorities are actively debated in the coming months through the 17th replenishment of the International Development Association, there is a timely opening for the United States and other like-minded governments to steer the Bank's approach to health in directions that help achieve U.S global priorities.

Since its creation in 1944, the World Bank has taken a leadership role, intellectually, analytically, and financially, in advancing strategies to alleviate poverty and achieve economic development. To that end, it provides concessionary loans and grants to developing countries through three mechanisms: the International Bank for Reconstruction and Development (IBRD), the International Development Association (IDA), and the International Finance Corporation (IFC), the latter focusing solely on the private sector in developing countries.

The IBRD, which raises most of its funds via financial markets, has 188 member countries and provides loans and advice to middle-income and "credit worthy" low- income countries.[55] IDA

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55. World Bank, "International Bank for Reconstruction and Development," http://web.worldbank.org/WBSITE/EXTERNAL/EXTABOUTUS/EXTIBRD/0,,menuPK:3046081~pagePK:64168427~piPK:64168435~theSitePK:3046012,00.html.

distributes grants and concessional loans—with zero or low interest paid over 25–40 years—to the 81 poorest countries, 39 of which are in Africa.[56] These funds provide support for health, part of a broader category of funding for health, nutrition, and population (HNP). For fiscal years 2009–2012, IDA committed $4.2 billion to health, about 7 percent of its total resources. IBRD lending for health during the period amounted to $8.3 billion, roughly 6.7 percent of IBRD resources.[57]

Nearly 65 percent of IDA funding comes from the governments of its 172 member countries. Every three years, donors meet to replenish IDA resources and review its policy framework. The 16th and most recent replenishment, finalized in 2010, resulted in pledges totaling $49.3 billion dedicated to projects approved during the three-year period ending June 30, 2014. The United States is the largest and most influential World Bank shareholder; its $4.1 billion pledge to IDA 16 accounted for 16 percent of the total. Negotiations on the 17th replenishment will unfold and be concluded over the course of 2013.

The International Finance Corporation (IFC) has expanded its investments in health since 2007. IFC committed almost $2 billion to health projects in 2007-2012, up from $474 million in 2001-2006. In sub-Saharan Africa, IFC commitments grew from $12 million in 2001-2006 to $300 million in 2007-2012.[58] The increase followed an analysis that showed that approximately 50% of health services in the region were provided by the private sector.

Unlike most other development multilateral institutions, the World Bank Group reaches across a broad spectrum of both low- and middle-income countries. Its multisectoral approach to development and poverty alleviation encompasses finance, health, education, transport, and agriculture, among others, which gives the Bank a unique bully pulpit and a special capacity to integrate planning. With its wide-ranging access to heads of state, finance ministers, and other cabinet officers, along with the private sector and increasingly civil-society groups, it can shape countries' choices, encouraging low- and middle-income countries to give health a visibly higher priority, and to make significant, long-term commitments to creating effective health systems. It is able to draw on its expertise in health financing, pensions, taxation, public/private insurance schemes, supply chains, and data management to track investments against the delivery of health services and actual health impacts.

The Bank can point to considerable expertise gained through partnerships in such countries as Mexico, Thailand, Brazil, Turkey, and more recently Rwanda and Burundi, which focused on sustainable health financing, effective and affordable delivery of core health services, and building the systems for ensuring accountability and impacts.

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56. World Bank, "International Development Association: The World Bank's Fund for the Poorest," http://www.worldbank.org/ida/what-is-ida/fund-for-the-poorest.pdf.

57. Author communication with Melanie Mayhew, Communications Officer, World Bank, January 24, 2013.

58. Author communication with Melanie Mayhew, Communications Officer, World Bank, February 2, 2013.

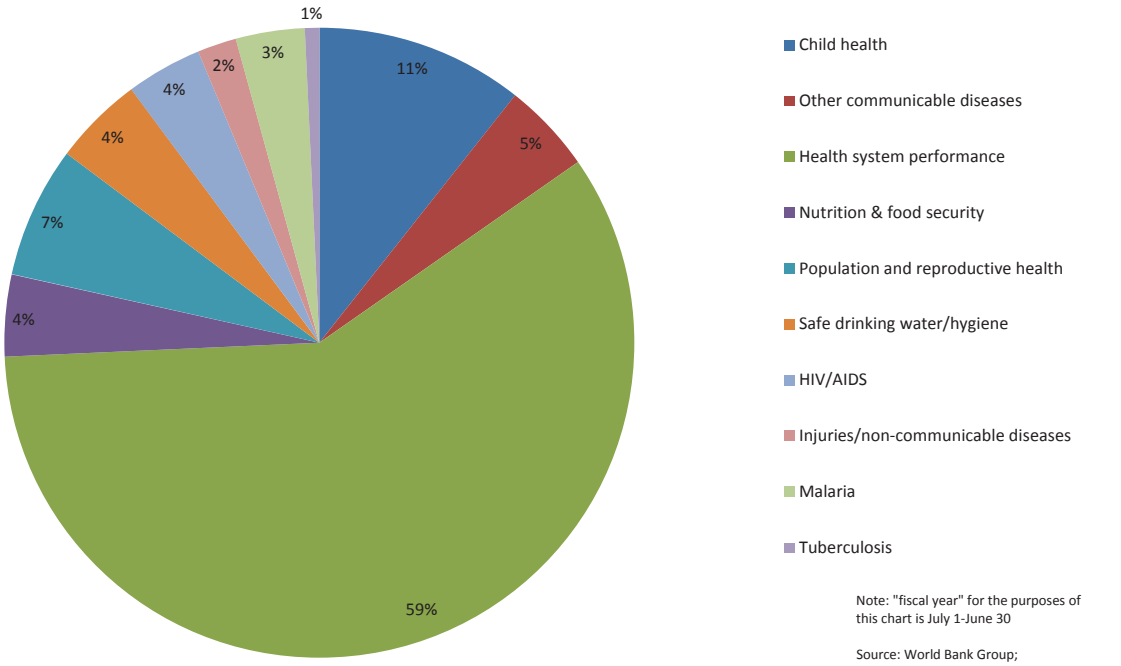
Policy Developments under the First Obama Administration

As the first Obama term unfolded, the Bank was in the early stages of implementing its 10-year health program, "Healthy Development: The World Bank Strategy for Health, Nutrition and Population Results," launched in 2007.[59] The strategy focuses on preventing poverty as a result of illness and supporting country efforts to develop well-organized, sustainable health systems. It acknowledges the change in the global health architecture in the first decade of the 2000s, noting the proliferation of multilateral organizations, initiatives, and foundations that began financing health programs during the period.

Much of the funding from outside the Bank, it notes, prioritizes specific diseases such as malaria, tuberculosis, and HIV/AIDS, with less focus on broader categories such as health systems and maternal and child health. The Bank stakes out a comparative advantage in strengthening health systems along with health financing and economics and supporting government leadership. While emphasizing system strengthening, the strategy also notes the need for measured outcomes.

Bank commitments over 2009–2012 reflect the strategy's emphasis on systems, with nearly 60 percent of lending devoted to health through the IDA and IBRD focused on "health system performance" (see chart). In line with the three health-specific Millennium Development Goals (MDGs), the Bank has prioritized access to providing reproductive health services; scaling up support for early childhood nutrition; and preventing HIV/AIDS and other communicable diseases.[60]

World Bank Funding Commitments for Health, Nutrition and Population (FY09-FY12)



59. World Bank, "Healthy Development: the World Bank Strategy for Health, Nutrition, and Population Results," April 24, 2007, http://siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Resources/281627-1154048816360/HNPStrategyFINALApril302007.pdf.

60. Author communication with Melanie Mayhew, Communications Officer, World Bank, January 11, 2013.

One central facet of the health development strategy is results-based financing (RBF), a strategy to improve the quality, reliability, and reach of health services in the poorest countries by linking finance to concrete proof of results. RBF focuses on paying for health outcomes (e.g., increasing the percentage of women receiving antenatal care and delivering their children by a trained health worker) as opposed to financing simply inputs or processes, such as salaries, training, or medicines.

In addition, the Bank has committed in recent years to collaborate more closely with the UNAIDS Joint Program (where it is a cosponsoring organization), the Global Fund (where the Bank is the financial trustee), the Office of the U.S. Global AIDS Coordinator, and the President's Malaria Initiative, with a special focus on accelerating progress on HIV/AIDS, tuberculosis, and malaria (MDG 6) in high-burden countries. In late 2012, Bank President Kim and USAID Administrator Rajiv Shah agreed to launch a pilot in four priority countries to intensify their health collaborations.

Since 2007, the World Bank has been the co-administrator, along with the World Health Organization, of the International Health Partnership (IHP+), which aims to unify donors, developing countries, and international agencies behind a single national health plan. IHP+ has helped generate in 20 countries a compact or similar partnership agreement to coordinate health aid.

In his first few months as head of the Bank in the second half of 2012, Kim began charting a course for the future. He indicated that the Bank should prioritize addressing extreme poverty, with a special emphasis on economic growth that generates new jobs: a "shared prosperity" that will benefit both private capital and the poor. He also identified climate change and fragile states as high priorities, and said that across all development sectors, the Bank should concentrate on the "science of delivery"—achieving better value for dollars invested by focusing assiduously on implementation.[61]

Despite concerns in some corners that Kim might deemphasize health to avoid the appearance of favoring an area in which he has so much experience, he has signaled his desire to reenergize the Bank's efforts to implement its Health, Nutrition, and Population strategy. At the July 2012 International AIDS Conference in Washington, D.C., he made a forceful case for greater global engagement in fighting the epidemic, and committed the World Bank to playing a leading role primarily through its systems-development work: "successful countries have tackled AIDS as a systems problem…. Building systems is what the World Bank does best."[62]

Across multiple areas, including health, Kim has begun to translate his strong interest in the science of delivery into pilot models in major "hubs." In late 2012, he swiftly concluded an agreement with then-incoming President Xi to partner in putting together on a six-month crash basis plans for managing the influx of an estimated 350 million persons into China's coastal urban

61. World Bank Group president Jim Yong Kim, "Remarks as Prepared for Delivery: World Bank Group President Jim Yong Kim at the Annual Meeting Plenary Session," Tokyo, Japan, October 11, 2012, http://www.worldbank.org/en/news/2012/10/12/remarks-world-bank-group-president-jim-yong-kim-annual-meeting-plenary-session. See also World Bank Group President Jim Yong Kim, "Make climate change a priority," *Washington Post*, January 24, 2013, http://www.washingtonpost.com/opinions/make-climate-change-a-priority/2013/01/24/6c5c2b66-65b1-11e2-9e1b-07db1d2ccd5b_story.html.

62. World Bank Group, "World Bank Group President Jim Yong Kim Remarks at the Opening Plenary of the International AIDS Conference," July 22, 2012, http://www.worldbank.org/en/news/2012/07/22/world-bank-group-president-jim-yong-kim-remarks-at-the-opening-plenary-international-aids-conference-2012.

centers in the next 10–15 years. The multisectoral approach will address food security, education, infrastructure, and health. Similar pilots, each with a varying focus based on the country's priorities, are expected to be launched in South Africa, Brazil, and one to two other hubs in the coming year.

Ongoing Challenges

The Bank faces several obstacles to taking on a more strategic, robust approach to health in low- and middle-income countries.

First, over the past decade, developing countries have had comparatively weak incentives to utilize their borrowing capacity with the Bank when the Global Fund, the GAVI Alliance, the U.S. bilateral HIV/AIDS and malaria programs, along with other donor funding facilities, have offered ample concessionary grants, including in support of strengthening health systems. Increasingly, however, as resources from these funders have flattened or declined, that mix of incentives and disincentives has begun to shift.

Second, health competes against other of the Bank's sectoral priorities, including agriculture, education, climate change, transportation, labor, and social protection. Demand on these other priorities has grown in the midst of the protracted global recession. If Bank President Kim is to do more on health, he will almost certainly need to do less in one or more of these sectors, and to carefully rally his senior management and the executive directors on his governing board behind any such a strategy. Moreover, he will need to do that as new leadership is transitioning into place charged with directing the Bank's health, nutrition, and population programs.

Third, the Bank's policy and programmatic alignment and coordination with the Global Fund, the GAVI Alliance, UNAIDS, and U.S. bilateral HIV/AIDS and malaria efforts remains at an early point. Much more aggressive action in this area is warranted, if the efficiencies of integration are to be realized, and if there is to be clearer specialization across these institutions.

Fourth, many countries are projected to graduate in the next decade out of low-income status, as they attain annual incomes of $1,500 per capita. As this transition unfolds, the pool of IDA-eligible countries will steadily diminish, at the same time that the pool of lower-middle-income countries—countries with considerable impoverished populations and high disease burdens but which are *not IDA-eligible*—expands.

Finally, at a macro level, the Bank is constrained in the depth of its expert pool and its budgetary flexibility.[63] Internal reforms could dominate the Bank's agenda in 2013.[64]

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63. Through a "diagnostic" organized through the 1818 Society, former Bank officials concluded that the Bank is "under-performing" and saddled with a "very cumbersome inefficient internal structure." The report highlights weak Bank human resource strategies that have resulted in depleting its core of experts and left the Bank "excessively decentralized to the point that the budget is a serious and growing constraint." "The World Bank's competitive advantage as a provider of integrated financial and advisory services is falling behind, largely because of internal failures," it concludes. Danny Leipziger et al., "The Key Challenges Facing the World Bank President: An Independent Diagnostic," The 1818 Society World Bank Group Alumni, April 16, 2012, http://siteresources.worldbank.org/1818SOCIETY/Resources/World_Bank_Diagnostic_Exercise.pdf.

64. Udani Samarasekera, "Jim Kim Takes the Helm at the World Bank," *Lancet*, July 7, 2012, vol. 380, 15–17.

Policy Recommendations

1. Urge the World Bank Group to strengthen and expand its global health focus.

In 2013 discussions over the IDA 17th replenishment, and during this promising period of reappraisal under Kim's new leadership, the Obama administration should press the World Bank to use its influence more strategically in the area of health for coordinating lending and grants programs for both the public and private sectors. The administration should make clear its strong preference that the Bank lead more aggressively in public administration and accountability systems for health financing and improving health data collection and supply chains, tied to the "science of delivery." The Bank can provide expertise on public/private options for pension and health insurance schemes; taxation and other measures to reduce tobacco consumption; and how to lower the long-term burden of noncommunicable diseases (NCDs).

2. Encourage the World Bank to update its health strategy for public- and private-sector development.

The administration should press the Bank to measure progress on its HNP strategy, and to formulate an updated version that reflects clear goals and spells out how investments in health are to fit with broader efforts to alleviate extreme poverty, generate economic growth and new jobs, stabilize fragile states, and strengthen the "science of delivery" to derive higher value for every dollar invested. Furthermore, the administration should press the Bank and its private-sector development arm, the International Finance Corporation (IFC), to aggressively support an expanded portfolio of investments in the private health sector that brings improved health benefits to the impoverished majority through greater access to affordable loans and other financial services.

3. Better integrate U.S. policies and programs with the World Bank.

Where feasible, the administration should shape its health diplomacy to support the World Bank's pilot "hubs" in China, South Africa, Brazil, and elsewhere, and give priority to better aligning the work of U.S. bilateral programs, the Global Fund, the GAVI Alliance, the World Bank, and other UN agencies involved in health, including UNAIDS. The newly established Office of Global Health Diplomacy at the State Department should formulate a strategy in 2013, in concert with the Department of the Treasury and the White House, that spells out the concrete steps the United States will pursue, in league with like-minded governments, to strengthen the Bank's health engagement in the coming four years.

4. Better align with other funding and technical partners.

The Global Fund, the GAVI Alliance, and U.S. bilateral health programs have had to invest significant resources to address deficient health systems. Over the long term, this responsibility is better undertaken by the World Bank, which has a clear comparative advantage in this area and the technical and financial resources to be successful. The Bank should also increase its efforts to build more sustainable health-financing mechanisms—social-insurance schemes, special taxes, innovative financing arrangements—in developing countries, decreasing dependence on outside donors to cover long-term commitments such as for AIDS treatment and replacement of bed nets.