COUNCIL *on*
FOREIGN
RELATIONS

The Future of Foreign Assistance Amid Global Economic and Financial Crisis

Advancing Global Health in the U.S. Development Agenda

Laurie A. Garrett
January 2009

This initiative was made possible through the generous support of the Bill & Melinda Gates Foundation, CFR's Program on International Institutions and Global Governance, Merck & Co., Inc., the Robina Foundation, and the Rockefeller Foundation.

The Council on Foreign Relations (CFR) is an independent, nonpartisan membership organization, think tank, and publisher dedicated to being a resource for its members, government officials, business executives, journalists, educators and students, civic and religious leaders, and other interested citizens in order to help them better understand the world and the foreign policy choices facing the United States and other countries. Founded in 1921, CFR carries out its mission by maintaining a diverse membership, with special programs to promote interest and develop expertise in the next generation of foreign policy leaders; convening meetings at its headquarters in New York and in Washington, DC, and other cities where senior government officials, members of Congress, global leaders, and prominent thinkers come together with CFR members to discuss and debate major international issues; supporting a Studies Program that fosters independent research, enabling CFR scholars to produce articles, reports, and books and hold roundtables that analyze foreign policy issues and make concrete policy recommendations; publishing Foreign Affairs, the preeminent journal on international affairs and U.S. foreign policy; sponsoring Independent Task Forces that produce reports with both findings and policy prescriptions on the most important foreign policy topics; and providing up-to-date information and analysis about world events and American foreign policy on its website, CFR.org.

The Council on Foreign Relations takes no institutional position on policy issues and has no affiliation with the U.S. government. All statements of fact and expressions of opinion contained in its publications are the sole responsibility of the author or authors.

For further information about CFR or this paper, please write to the Council on Foreign Relations, 58 East 68th Street, New York, NY 10065, or call the Director of Communications at 212.434.9400. Visit CFR's website, www.cfr.org.

Executive Summary

Though the United States of America faces its toughest budgetary and economic challenges since the Great Depression, it cannot afford to eliminate, or even reduce, its foreign assistance spending. For clear reasons of political influence, national security, global stability, and humanitarian concern the United States must, at a minimum, stay the course in its commitments to global health and development, as well as basic humanitarian relief. The Bush administration sought not only to increase some aspects of foreign assistance, targeting key countries (Iraq and Afghanistan) and specific health targets, such as the President's Emergency Plan for AIDS Relief (PEPFAR) and the President's Malaria Initiative (PMI), but also executed an array of programmatic and structural changes in U.S. aid efforts. By 2008, it was obvious to most participants and observers that too many agencies were engaged in foreign assistance, and that programs lacked coherence and strategy. Well before the financial crisis of fall 2008, there was a strong bipartisan call for foreign assistance reform, allowing greater efficiency and credibility to U.S. efforts, enhancing engagement in multilateral institutions and programs, and improving institutional relations between U.S. agencies and their partners, including nongovernmental organizations (NGOs), recipient governments, corporate and business sector stakeholders, faith-based organizations (FBOs), academic-based implementers and researchers, foundations and private donors, United Nations (UN) agencies, and other donor nations.[1]

This report describes:

- A brief lay of the foreign assistance landscape, outlining the current status of U.S. investment in health and development, the global donor panorama, basic needs assessment for poor countries, and forecast needs levels for 2009 to 2015;
- The rationale for continued, robust American engagement in foreign assistance, not just in spite of the economic downturn, but *because* of it;
- A consensus view of what works, what needs to be improved, and what still needs to be examined regarding how the U.S. planned and executed foreign assistance in fiscal year 2007 to fiscal year 2008;
- Consensus recommendations for the future of foreign aid under a new presidential administration and Congress.

Introduction: The Foreign Assistance Landscape and Needs Forecast for 2009–2015

The world is in an unparalleled time of economic crisis, experienced with acute pain by its poorest populations. Fearfulness and uncertainty abound. As the global marketplace retrenches, there is great danger that the poorest billion people will be abandoned, their hopes for escaping poverty and disease forgotten by all but themselves. They have turned their eyes to the United States, hoping for leadership that can both resolve the economic catastrophe and commit the wealthy to ensure that the developing world does not pay the price of global recovery with its people's health, welfare, safety, and lives.

There are many ways of assessing the impact any wealthy nation has on the global landscape, especially in terms of lifting other nations and peoples out of dire poverty, disease, and despair. By nearly all metrics, the U.S. government has long been the most influential donor, and in absolute dollars the most generous. When public and private American support for global health, development, and humanitarian assistance are combined, the United States ranks at about the middle range among donor nations for the EU target of giving 0.7 percent of its GDP for ODA.

More significant than the monetary figure is the policy impact of American giving. U.S. contributions to overseas health and development over the last century have put the country's imprint—for both good and ill—on the policies and priorities underlining concepts of global equity, security, and forward-moving change. The United States has consistently seized moments of earth-shaking change in the world, leading bold initiatives on behalf of the poor and needy. The world awaits America's leadership.

In the post–World War I tradition of Woodrow Wilson, the United States engaged in combating disease all over the world, and sought to use early schemes of foreign assistance to advance world peace and stability. Following in that tradition in the private sector, John D. Rockefeller set out, through his foundation, to scientifically understand and eradicate a long list of infectious diseases from the Americas. Following World War II, the United States signaled, again, a willingness to generously support reconstruction and economic stability through the Marshall Plan and Bretton Woods agreements. Important features of that era were the creation of the World Health Organization (WHO) and the U.S. Centers for Disease Control (CDC), both of which enjoyed strong U.S. support, particularly for successful campaigns to eradicate malaria, polio, smallpox, diphtheria, typhoid fever, and measles from Western Europe, the Americas, and Japan.

As the Cold War came to dominate the international landscape, John F. Kennedy ushered the formal age of overseas aid, creating the 1961 Foreign Assistance Act (FA Act), the United States Agency for International Development (USAID), the Peace Corps, and a powerful American commitment that by 1962 represented 3 percent of the entire federal budget. Though the worldwide ideological and military conflict between forces of communism and capitalism formed the backdrop to the congressional discourse over

foreign assistance in 1961, Congress in its great wisdom stipulated that the reason for taking part in overseas health and development programs was obvious and entirely separate from military motivations:

> The Congress finds that fundamental political, economic, and technological changes have resulted in the interdependence of nations. The Congress declares that the individual liberties, economic prosperity, and security of the people of the United States are best sustained and enhanced in a community of nations which respect individual civil and economic rights and freedoms and which work together to use wisely the world's limited resources in an open and equitable international economic system. Furthermore, the Congress reaffirms the traditional humanitarian ideals of the American people and renews its commitment to assist people in developing countries to eliminate hunger, poverty, illness, and ignorance. Therefore, the Congress declares that a principal objective of the foreign policy of the United States is the encouragement and sustained support of the people of developing countries in their efforts to acquire the knowledge and resources essential to development and to build the economic, political, and social institutions which will improve the quality of their lives.[2]

In the twenty years since the fall of the Berlin Wall, political leaders in Washington, and in other donor nations, have struggled to identify agreed-upon rationales for foreign assistance as well as strategic priorities. As globalization and open markets have increased prosperity in much of Asia and Latin America, sub-Saharan Africa's desperate struggles with old obstacles to development have been exacerbated by rising national debts, wars, the HIV/AIDS pandemic, resurgent malaria, and widespread famine and malnutrition. Africa has become the gravitational pull for much of the world's foreign assistance efforts, especially those related to health.

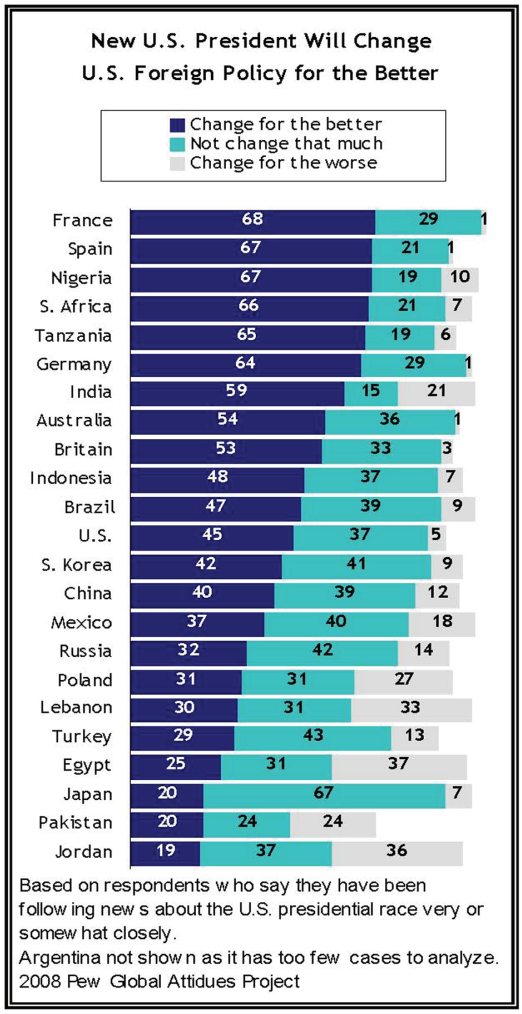
From a strategic point of view, over the past twenty years there has been no straightforward approach to aid, either on the part of the United States or on the multilateral stage. The period has been marked by shifting priorities and donation streams, largely reflecting the domestic political and cultural tensions inside the donor nations, rather than the needs of poorer countries. Inside the U.S. government these tensions have often grown from variant views of the purposes and strategies of overall American foreign policy that predate twenty-first-century issues, mirroring debates over multilateralism, the role of the United Nations, abortion, population growth, world trade agreements, and definitions of "national security."

This action plan is focused on the global health portion of foreign assistance, which has been a legislated component of foreign aid since 1961.[3] But it has long been acknowledged that no question of disease, survival, or longevity can be separated entirely from larger development issues, food security, or humanitarian crises. In fiscal year 2007 (FY07), health commanded 7.6 percent of U.S. foreign assistance spending and most disease and medical programs were hampered by the same range of obstacles and bureaucratic mires that impede effective implementation of all foreign assistance aspirations. Health programs have benefited, however, from heightened empathy and concern among donor nation populations, sparked in large part by the pandemic of HIV and AIDS.

Worldwide expectations run high.

The forty-fourth president of the United States and the 111th Congress face a unique opportunity to redefine the mission:

- Why does America send money, talent, resources, and food to poor countries all over the world?
- What are the strategic objectives behind this exercise?
- How should success or failure in these efforts be measured?
- In this time of grave economic uncertainty, can the president and Congress share the scale of vision and courage realized by their predecessors in 1961?



THE GLOBAL FINANCIAL CRISIS AND THE FUTURE OF U.S. FOREIGN ASSISTANCE

Since the credit crisis of 2008 unfolded, $6.9 trillion has disappeared from the global economy, according to the World Bank's final December estimate. Countries and small companies in the developing world have found it more difficult to obtain loans for programs such as road construction and business development and to offset declining revenue streams to cover the costs of essential public goods. According to the World Bank, global trade grew 9.8 percent in 2006; it will contract by 2.1 percent in 2009. The most severe contractions will be in trade and investment for developing countries, falling from about $1 trillion in 2007 to merely $530 billion in 2009. Even China, the fastest-growing economy on Earth, will witness sluggish movement, falling from a nearly 12 percent rate of economic growth in 2007 to 6.6 percent in 2009, according to Deutsche Bank forecasters.

In October 2008, World Bank president Robert Zoellick warned, "While people in the developed world are focused on the financial crisis, many forget that a human crisis is rapidly unfolding in developing countries. It is pushing poor people to the brink of survival." Several countries have experienced double-digit

food inflation, contributing to a global increase in malnourished people from 44 million to 967 million in 2008.[4]

The World Bank and the United Nations AIDS Programme (UNAIDS) issued stark warnings to African nations regarding external support for their HIV/AIDS treatment programs. World Bank representatives have told the most affected nations that they must work hard to reduce the annual incidence of HIV through aggressive prevention programs, as there is no assurance that economically reeling wealthier nations will continue supporting expansion of HIV treatment efforts. Similarly, when the Ugandan government announced that it "expected" donors would come through with their promised $2 billion over five years in support of the country's HIV prevention and treatment programs, UNAIDS warned that the emphasis had better be on prevention, as treatment funding might not be supplied at promised levels.[5]

American political leadership has reacted to the potentially catastrophic impact of the global financial crisis on developing countries with mixed, confusing signals. In 2007, then senator Barack Obama (D-IL) and senators Chuck Hagel (R-NE) and Maria Cantwell (D-WA) introduced the Global Poverty Act of 2007 (S. 2433), which was amended in April 2008 by then senator Joseph R. Biden Jr. (D-DE). The act called upon the Bush administration to develop a strategy for meeting the poverty-elimination component of the Millennium Development Goals (MDGs). At that time, presidential candidates Obama and Biden were both committed to doubling the size of the U.S. foreign assistance budget and supported a target of $50 billion in spending over five years for HIV/AIDS, malaria, and tuberculosis programs. But as the economy worsened in fall 2008, these political leaders and counterparts throughout Capitol Hill appeared to retreat from those commitments.

In December 2008, the House Foreign Affairs Committee's ranking Republican, Ileana Ros-Lehtinen of Florida, circulated a letter signed by eleven other Republican House members that called for freezing all foreign assistance spending at FY08 levels until FY11. Four Bush-appointed members of the board of the Millennium Challenge Corporation (MCC) published an editorial in mid-December 2008 arguing that the Obama administration should extend the MCC's seventeen "indicators of democracy," used to determine which countries may qualify for that agency's support, to all foreign assistance.[6]

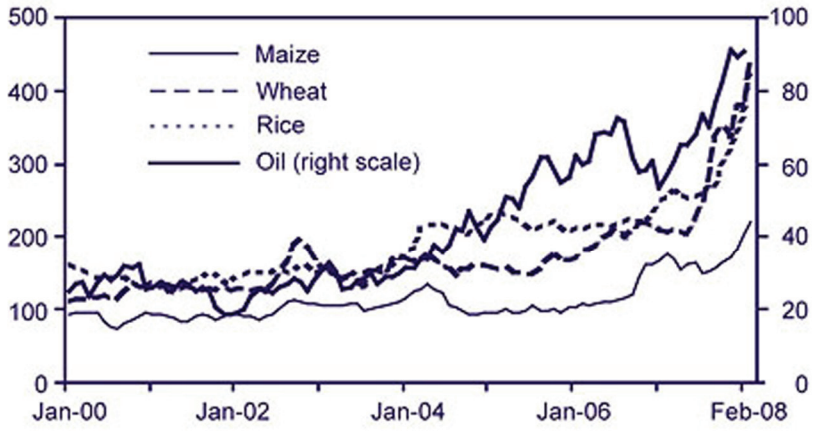
In contrast, Obama science adviser Harold Varmus chaired an Institute of Medicine (IOM) committee that asserted in a December 2008 report that spending on global health alone should increase steadily, doubling to $15 billion annually by 2012. And House leadership is pushing an FY09 omnibus spending bill that allots $36 billion to the 150 Account (the international affairs budget) for foreign assistance spending and seeks to bolster USAID, State Department, and PEPFAR staffing.

FORMIDABLE PROBLEMS FACING DEVELOPMENT AND GLOBAL HEALTH ASSISTANCE

The effects of the international financial crisis appear to be compounding other worsening trends in much of the developing world that began inflating health and development costs prior to fall 2008. For example, the regions of the world in which development might make the greatest difference in terms of stability and support for U.S. policy and business interests have become extremely dangerous places for civilian aid workers to attempt building schools, clinics, roads, and housing. The costs of executing such programs are rising, both in human and monetary terms. This disturbing trend reflects, in part, the loss of recognized neutrality, a complete lack of respect for the 1949 Geneva Conventions and their additional protocols, and the apparent increase in rogue states or pockets of nations that lack conventional rule of law.[7]

Foreign assistance efforts are also becoming more expensive due to rising or fluctuating fuel, transport, food, and commodities prices. It is a cruel formula: having focused the past several decades almost exclusively on providing food aid, the United States has not spent time building serious agricultural development programs that can sustain millions of farms and lives worldwide in what promises to be a brutal 2009, amid inflating seed, fertilizer, energy, and food costs.[8] With every global economic shock, weather-related catastrophe, or pestilence, countries are once again forced to turn to the United States and other donors for food because those same donors failed to invest in resilient local agricultural systems development.[9]

World Commodity Prices, January 2000–February 2008 (U.S.$/metric ton)



Sources: FAO international commodity prices database 2008, and IMF world economic outlook database 2007.

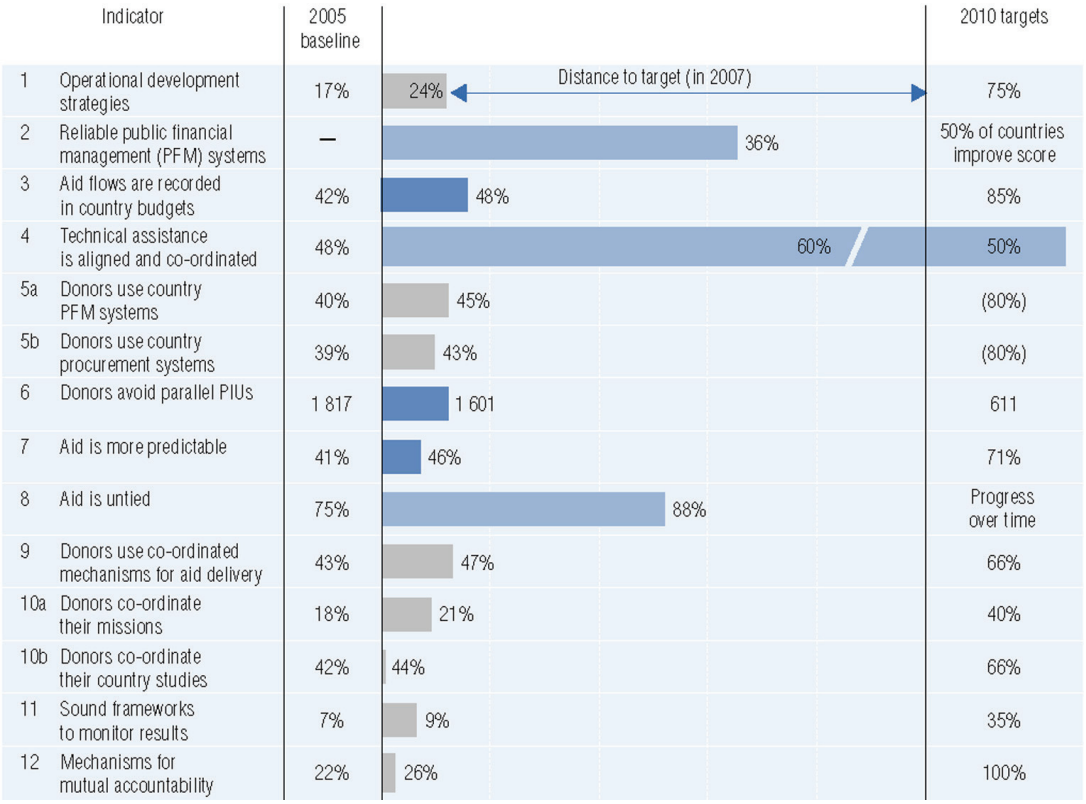
Despite a late 2008 decline in most commodities pricings, neither food nor energy costs settled back to pre-2007 levels, and the costs of basic agricultural products (seed, fertilizer, harvest transport) remain excessively high in poor countries. At the same time, downturns in the value of the dollar mean that less—of *everything*—can be purchased with the same amount of U.S. official development assistance (ODA). By the end of 2008, the U.S. dollar and UK pound had suffered enormous losses. Against the yen, the dollar lost 23 percent of its value, and the currency exchange traded $1.39 to one euro. The British pound lost a quarter of its value against the euro in 2008. Since the two primary currencies of ODA are dollars and pounds, the net impact for poor countries was devastating.

Further, with the governments of recipient nations feeling overwhelmed by the volume of organizations seeking to execute health and development programs inside their countries, and the reporting and fiscal monitoring requirements imposed by donors, it was clear by 2004 that donors, contractors, NGOs, and recipient governments needed to change the way they were doing the business of health and development. In March 2005, the Paris Declaration on Aid Effectiveness was reached, with the United States among the first signatories.

Accountability to the Paris Declaration is monitored by the Organization for Economic Cooperation and Development (OECD). Few donors are currently on track to meet the Paris Declaration commitments. In 2006 the Bush administration issued its plan for aid harmonization, placing emphasis on USAID and Millennium Challenge Corporation activities.[10] Under the U.S. Action Plan on Harmonization, the

administration promised to work closely with other donors and recipient governments to ensure that USAID activities serve to complement the actions of other providers, achieving shared goals for the benefit of poor countries. But the Action Plan makes no mention of PEPFAR, Department of Defense (DOD) programs, or the activities of the more than twenty-two other agencies and U.S. programs that currently execute foreign assistance. Further, it makes no commitment to provide greater *internal* harmony—that between U.S. government programs.

2007 Progress on Paris Declaration Indicators



Source: "Survey on Monitoring the Paris Declaration: Effective Aid by 2010: What it Will Take," OECD, 2008.

Poor countries are also facing a new threat: climate change. The health and development repercussions of climate change–related severe storm events, droughts, rising seas, and fishery depletions will be overwhelming. As poor countries try to adapt to the effects of rising atmospheric CO^2 levels, the acute need for sophisticated scientific analysis, exceeding local capacities, becomes dire. Countries with ecologies as divergent as Pacific atolls, Saharan deserts, rain forests, and Himalayan mountains are all increasingly in need of detailed forecasting that can guide investments of precious resources, aimed at minimizing the agricultural and human tolls of related catastrophic events.

Compounding all of these worrying trends has been a series of difficult outbreaks in 2008 that have taxed both local and humanitarian capacities. Cholera, Ebola, and extremely drug-resistant forms of tuberculosis emerged in eastern and southern Africa; bird flu outbreaks continued to tax agricultural development in southeastern Asian nations; yellow fever reemerged in human beings in three Latin American countries for the first time since construction of the Panama Canal; the mosquito-born Chikungunya virus

spread from the Seychelles to southern Europe, the Indian subcontinent, and parts of southeast Asia; hand, foot, and mouth disease swept across pediatric populations of China; multidrug-resistant forms of *Clostridium difficile* and *Staphylococcus* plagued hospitals across the United States and Europe; contaminated heparin and milk products from China caused deaths and injuries in people all over the world; and drug-resistant forms of seasonal influenza emerged in the United States and Europe.

THE PROMISE: UNPRECEDENTED INCREASES IN GLOBAL HEALTH SPENDING

Since the dawn of the twenty-first century, public and private spending for achievement of MDGs, the Gleneagles G8 commitments, universal access to anti-HIV treatment, and stability improvement in some of the world's hot zones has skyrocketed. New players on this field have become leaders in the wars on poverty and disease: the Bill and Melinda Gates Foundation, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), Roll Back Malaria, the White Ribbon Alliance, and rock stars Bono and Bob Geldof, to name a few. A profound sea change occurred across the wealthy world as hundreds of millions of young people embraced global issues of poverty, disease, climate change, and economic development. Since 2000, when Nobel Peace Prize winner Nelson Mandela issued the call in Durban, South Africa, for global equity in access to affordable treatment for HIV, a new paradigm in global notions of economic and social change has emerged—slowly, but in nearly all tiers of society.

Between 2000 and 2006, estimated spending from all sources on global health efforts alone rose from $15 billion to $45 billion, comprising the lion's share of an overall increase in ODA.[11] Estimated total ODA commitment rose from $53.7 in 2000 to $103.7 billion in 2007. On average, sub-Saharan African governments also increased spending on the health of their populations. According to the World Bank, in 1990 the average sub-Saharan government spent $6 per capita annually on health, with spending ranging across the region from a low of $2.27 per capita to $21 per capita.[12] Fifteen years later, Abt Associates found that per capita government spending on health in the region averaged $16 to $20 annually, with high-end spending reaching $40.[13]

Many of the United States' largest corporations, in addition to financing the health of their own employees, back health and development programs overseas, seeing them as essential components of company goodwill.[14] In addition to the $22 billion in ODA provided by the federal government, private U.S. philanthropic donors give more than $13 billion a year to overseas efforts, bringing the nation's contribution to international development close to $35 billion, or roughly 0.25 percent of total U.S. GDP for 2007 ($13.7 trillion). The European Union has committed to a 2013 target of 0.7 percent of GDP foreign assistance spending.

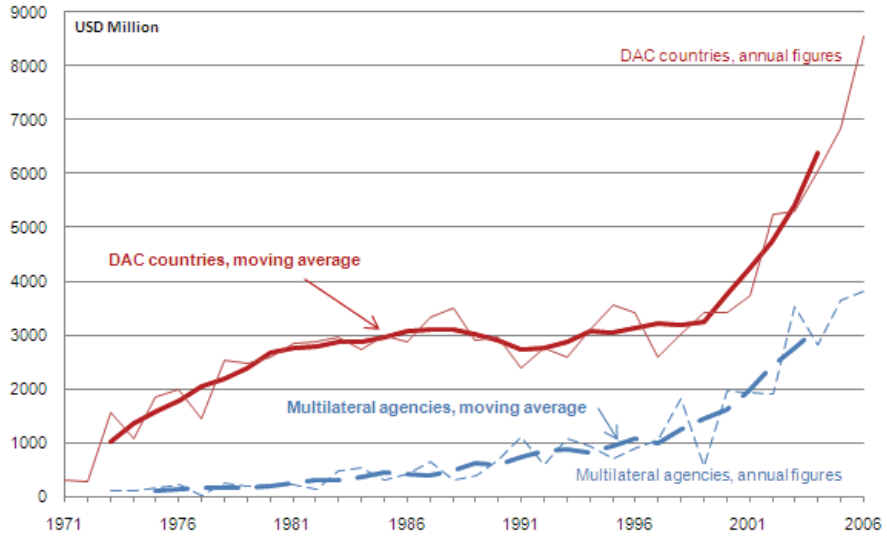
Since 2000, amid this surge in donor support, great achievements have been made. For example, thanks to combined UN and Global Alliance for Vaccines and Immunization (GAVI) campaigns, tremendous achievements have been realized in reducing vaccine-preventable child illness and death rates. In 2000, about 750,000 children died of measles; by 2007, that death toll had dropped 74 percent, to 197,000.

The Global Fund to Fight AIDS, Tuberculosis and Malaria was launched in 2002, and by October 2008 had disbursed $6.4 billion worth of grants for country-designed programs in a mechanism that is both without precedent and empirically demonstrably successful in achieving its targets some 80 percent of the time.[15] PEPFAR had by March 31, 2008, started 1.73 million people on antiretroviral treatment for HIV infection and provided antiretroviral prophylaxis for more than one million pregnant women to prevent

infant in utero infection.[16] The combined donor, GFATM, and UN efforts to tackle malaria had, by the end of 2008, pushed down deaths due to malaria by 50 percent in crucial African and Asian countries, in large part due to disbursements of pesticide-treated mosquito nets and insecticide-spraying campaigns.[17]

According to UNAIDS, global contributions in support of HIV prevention and treatment increased six-fold between 2001 and 2007. The U.S. PEPFAR program was the key to that surge in support. Over that period, three million people living in poor and middle-income countries started anti-HIV treatments, and the number of people dying from AIDS declined for the first time since the epidemic commenced in 1981.

Trends in Aid to Health[18]
(1973–2005, 5-year moving averages and annual figures, constant 2006 prices)

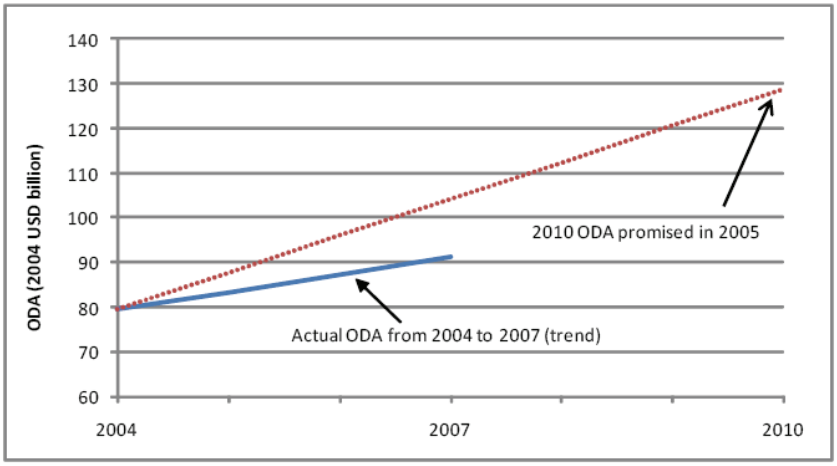


RECENT INITIATIVES ON DEVELOPMENT ASSISTANCE LEAVE THE FUTURE UNCERTAIN

Despite these notable achievements, much of the formally committed ODA has not, as of December 2008, materialized. G8 commitments to African development, the MDGs, and the Gleneagles promises for global health have largely been ignored by donors. G8 countries have only delivered 14 percent of the promised $21.8 billion.[19]

Well before the impact of the financial meltdown was felt, donor support had declined. Aid dropped 8.4 percent in 2007, after a 4.7 percent drop in 2006. "We are running out of time," warned UN secretary-general Ban Ki-moon.[20] On September 5, 2008, the Office of the Secretary-General concluded that both funding and program development were falling far short of that needed to reach the 2015 MDGs, and at least six of the eight targets were on course to fail. In particular, MDG 5—maternal survival—has not shown significant improvement in any poor, or most emerging market, countries, and movement has been sluggish on the three other MDGs related to global health.

Performance Against 2005 Gleaneagles ODA Projection[21]



Note: This chart does not show actual ODA for 2005 and 2006, which was affected by exceptional debt relief.

On November 11, 2008, as the global economy went into a tailspin, the World Bank announced that it would double its foreign aid budget to developing countries, totaling about $100 billion "over the next few years."[22] A month later, the bank announced the creation of a fast-track facility that will speed delivery of loans and subsidies to poor countries. Dubbed the International Development Association (IDA) Financial Crisis Response Fast-Track Facility, the novel system is empowered to disperse $2 billion to poor countries for social safety nets, infrastructure, education, and health. It is not clear at this time which, if any, of these loans will support global health efforts.

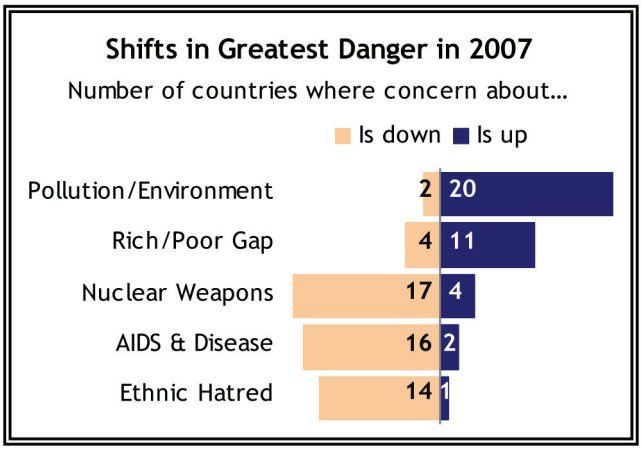
The UK government of Prime Minister Gordon Brown reaffirmed its commitment to increase ODA from its 2007 level of 0.36 percent of the British budget to 0.7 percent in 2013, two years ahead of the EU schedule for reaching that donor target.[23] The G20 will convene in London on April 2, 2009, and Brown has vowed, as host of the summit, to push for economic policies that include food support, poverty alleviation, and health infrastructure financing for developing countries.

Similarly, in Germany, the Bundestag recently approved a 2009 foreign assistance expenditure of 800 million euros (roughly $1.2 billion, based on December 2008 currency valuations), marking a 12 percent increase from Germany's 2008 budget. About a quarter of this spending is realized through a carbon-trading mechanism.[24]

Unfortunately, these encouraging efforts from the UK and Germany have not been mirrored across the G8. Indeed, the Italian parliament responded to the global economic crisis by cutting 2009 ODA by 170 million euros, and projecting further reductions through 2011 that will mean that Italy's ODA will be reduced by more than 50 percent compared to its 2007 contributions. Prime Minister Silvio Berlusconi is scheduled to host the next annual gathering of the G8 leaders, in July 2009 in Sardinia.[25]

In November 2008, the OECD called upon all of its member states—which include the United States—to take an "aid pledge," promising to fulfill all foreign assistance commitments, despite the worsening global economy.[26] OECD secretary-general Angel Gurría warned, "Unless we act decisively now, we may not be able to prevent the financial crisis from generating an aid crisis. Let us not repeat the mistakes we made following the recession of the early 1990s when many OECD governments let aid efforts decline, with the

consequent impacts on developing countries in such areas as agricultural production, infrastructure, social welfare and political stability."[27]



"Assessments of the greatest dangers to the world have shifted in recent years. The gap between rich and poor countries appeared more menacing in 2007 than in 2002, as did pollution and other environmental problems. In 2002, AIDS was selected by 17 countries, while the gap between rich and poor was the choice of five countries and pollution of only four."
—Pew Global Attitudes Project, December 18, 2008

Concern about HIV/AIDS and other diseases has apparently declined over recent months, both within donor nations and among the world's poor populations. Decoupling "disease" from "poverty" in the face of global economic catastrophe risks allowing immediate pocketbook worries to subvert support for programs aimed at controlling, or eliminating, health crises. The result could be devastating, both in loss of human lives and in ultimately exacerbating the very financial crisis that prompted diversion of attention to, and financing from, health.

The failure of G8 nations to fulfill years of promised development and health support for poor countries, coupled with the rising stature of the G20, threatens the institution's credibility. Though London will officially host the April 2009 G20 summit, the tone will be set by how the Obama administration balances the needs of its domestic population against those aimed at softening the blows of the world financial crisis in poorer parts of the world.

Clearly, it is the United States that is expected to lead the world out of this crisis, and to do so in a manner that prevents widespread famine, disease, and instability in the most economically challenged nations.

The global health and development community is not naïve regarding the budgetary pressures facing America's political leadership. It fully recognizes the enormity of the global financial meltdown, credit crisis, U.S. debt, and the budgetary deficit. And it appreciates that in times of economic catastrophe, political leaders, cognizant of the pressing need to reduce spending, seek to eliminate or trim programs that lack clear domestic constituency support. It is also mindful of looming additional crises in U.S. entitlement spending and domestic healthcare reform.

Yet since the 1961 passage of the Foreign Assistance Act, the U.S. government has generously supported humanitarian, health, and development schemes worldwide, recognizing that such efforts bought goodwill, stability, and human growth at a very small price. Over the decades, however, commitment to the FA Act has actually declined. At its peak level of support in 1962, foreign assistance spending represented 3 percent of the U.S. budget. However, over the past twenty years it has never garnered more than 1 percent. The United States currently ranks at number seventeen out of twenty-two high-income countries in its promotion of polices that foster prosperity in developing countries, according to the Center for Global Development's 2008 Commitment to Development Index.[28] Prior to the financial crisis, there was strong bipartisan support for increasing the size of the foreign assistance commitment and nearly tripling the

budget of PEPFAR, which was reauthorized at $48 billion in August 2008, to be spent over the next five years.

THE CASE FOR ROBUST U.S. DEVELOPMENT AND GLOBAL HEALTH ASSISTANCE

Congress should, at the least, appropriate global health and development funding at levels that were previously authorized, if not in fact aim for the oft-stated goal of doubling ODA spending to reach $44 billion for FY10. Further, the full foreign assistance package, which was about $36 billion in FY08, including special supplementals, should be doubled by FY10, reaching $72 billion.

As John Danilovich, CEO of the Millennium Challenge Corporation, stated, "While current economic uncertainty rages—focusing on the connection between Wall Street and Main Street—we must not overlook the connection to those places in the world where the streets have yet to be paved. Ignoring, and thereby marginalizing, the impact of this unprecedented crisis in those poorest corners of the world weakens our ability to resolve effectively the turmoil we face at home. After all, Americans are a compassionate and generous people and helping those in need remains a deeply-held American value. Just because times are difficult for us now does not mean that we check our values at the door."[29]

Total U.S. federal budget spending in FY07 was $2.7 trillion. U.S. GDP was $13.7 trillion.

FY07 U.S. ODA spending was $22 billion, or 0.16 percent of total U.S. GDP.

Total U.S. foreign assistance spending was $36 billion in FY07, or 0.26 percent of total U.S. GDP.

The popularity of the ONE Campaign[30] demonstrates that the American people see that it is in their interest, as well as a matter of basic human decency and morality, for the United States to maintain a robust commitment to the survival, health, education, and economic development of the "bottom billion" poorest people on Earth.[31] The American people are generous. Millions of Americans have personally donated money and time to such efforts as malaria bed-net distribution, treating people infected with HIV, expanding girls' education in poor countries, and providing food aid. For many churches across the country, supporting these programs has become an expression of faith.[32]

ADVANCING ACTIVE SECURITY: PREVENTING CONFLICT AND BUILDING RESILIENCE AND STABILITY IN THE INTERNATIONAL SYSTEM

Whether it is the threat of pandemic influenza, al-Qaeda–inspired terrorism, mass migration due to the impacts of climate change, or regional instability brought by severe resource scarcities, Americans favor

preemptive, mitigating interventions. Global health interventions, in particular, and development support generally have demonstrated positive, mitigating impacts on several aspects of global and national security, though it may not always be possible to prove a "negative." If an epidemic never occurs, proving that years of disease control efforts were essential to its deterrence may never be specifically doable. Americans realize that their tap water is safe to drink, thanks to public hygiene programs, but they may not be able to appreciate the millions of lives saved and hospitalizations prevented by clean water provisions. Highly effective disease interventions, such as widespread polio vaccination or water filtration, render the relevant microbes' threats to humanity so minimal as to invite complacence.

Congress has, however, long recognized the global and national security threats posed by a pandemic of virulent influenza or other highly contagious organisms. The severe acute respiratory syndrome (SARS) epidemic of 2003 demonstrated how rapidly a previously unknown, deadly organism can spread in the globalized world. Agricultural diseases, such as bovine and ovine foot-and-mouth, "mad cow" prion disease, and crop pestilence have over the past decade prompted profound economic and social shocks, with regional and global force. In 2008, several Asian countries ranked the ongoing H5N1 bird flu pandemic in the top three causes of their economic woes.

As bird flu continues its evolution and spread, the United States must continue to sustain influenza surveillance and control measures or face the dire possibility of being caught off guard by a virulent pandemic.[33] On November 7, 2008, the U.S. General Accounting Office (GAO) released a list of thirteen issues urgently requiring the attention of the Obama transition team. Among them were pandemic preparedness and food safety. Both issues require considerable investment in and coordination of international surveillance and response activities.

As the costs and risks of doing the business of humanitarian aid in the world increase, so must U.S. financial support; otherwise, the American people face the continued dangers posed by alienation and anti-American anger in unstable, impoverished parts of the world. The Indonesian government's refusal to share samples of H5N1 viruses that have infected people in that country, on the grounds that vaccines and drugs derived from those strains will not be made available to poor nations, illustrates how trade and political issues threaten the viability of global disease surveillance. Only committed foreign assistance, coupled with U.S. trade strategies, can overcome such hostility and make the world a safer place for everyone, including Americans.

The massive HIV/AIDS pandemic, which had by December 2007 claimed nearly thirty million lives, demonstrates the folly of decoupling a disease outbreak from the notions of global solidarity and shared risk. By failing to react with an early and powerful response to the epidemic in the 1980s, largely because of the view that the virus would only afflict small minority populations that were of little concern to the majority populations, the twenty-first-century world is saddled with a disease catastrophe unlike any seen since the Great Plague of the fourteenth century. In 2007, twelve million children were orphaned by their parents' deaths to AIDS and about two million people died of AIDS. The National Intelligence Council (NIC) estimates that if treatment and prevention strategies for the AIDS pandemic remain roughly status quo until 2025, some fifty million people will be living with the disease, and about thirty million of them will require daily treatment with antiviral drugs.[34]

Provision of anti-HIV drugs cannot cease, as countries lack the capacity to purchase these medicines on their own, and the individuals will almost certainly die within weeks, at best months, of cessation of medication. Were the United States to cut off support of HIV treatment without ensuring other mechanisms

were in place to maintain medication, America would face great hostility, and accusations of mass-scale medical malpractice.

Amid a global crisis in the emergence of drug resistant microbes—especially untreatable forms of tuberculosis—the United States cannot afford to reduce efforts to control and treat bacterial diseases properly. The rapid global spread of XDR-TB—a nearly incurable form of highly drug-resistant tuberculosis—offers clear evidence of the risks America shares with the rest of the world.

Support for disease surveillance activities aimed at early detection of outbreaks is an obvious first step. But the World Health Organization and Bush administration have discovered that even when the microbe's identity is clear, as in the case of H5N1 influenza, surveillance, laboratory confirmation, reporting, and response are difficult, if not impossible, in countries that lack scientific and public health development. Prevention of contagious disease inside the United States requires, among other things, sustained support of robust laboratory, surveillance, veterinary, medical, and public health capacities in poor countries all over the world.

In its 2025 forecast, the National Intelligence Council ranked a global pandemic among its leading security concerns, noting that the emergence of a killer virus "will first occur in an area marked by high population density and close association between humans and animals, such as many areas of China and Southeast Asia." The NIC 2025 predicts that such an outbreak would spread worldwide, unimpeded for precious weeks, due to "inadequate health-monitoring capability within the nation of origin," and that "slow public health response would delay the realization that a highly transmissible pathogen had emerged."[35]

A similar twenty-first-century national security forecast compiled for the UK government ranks disease emergence among the thirteen future threats to global stability. As the anthrax mailings of 2001 illustrated, even a very small bioterrorist episode that claims few lives can have enormous economic and social consequences for the entire world, the UK report notes. In particular, this Institute of Public Policy Research (IPPR) analysis warns:

- New innovations in biotechnology "could be put to deadly purposes and would have terrifying implications";
- Al-Qaeda and other terrorist organizations remain active, but so do "lone individuals with relevant expertise and access to the necessary technological infrastructure. … Insufficiently secure government laboratories around the world remain a particular worry in relation to bioterrorism";
- "Humanity is increasingly vulnerable to infectious disease and to the possibility of new and devastating global pandemics."[36]

A December 2008 collaborative Central Intelligence Agency (CIA)/Defense Intelligence Agency (DIA)/National Center for Medical Intelligence (NCMI) assessment agreed with the NIC and IPPR concerns regarding infectious diseases, adding layers of national security concerns that are based on rising levels of chronic disease and health disparity in poor countries.[37] The CIA asserts that U.S. efforts to improve standards of health throughout the world, especially in Muslim countries, "could play a role in easing frictions between the West and the Islamic world."

Former UN secretary-general Kofi Annan recently warned that "failure to honor aid commitments would be a breach of faith and potentially disastrous for the ability of Africa to achieve the Millennium Development Goals. For richer countries, this is not about charity. It is about self-interest. By helping Africa to build roads and railways, power plants, and irrigation and water treatment systems, donors will increase capital exports to Africa at a time when their own industries are facing a collapse of demand. … Develop-

ment assistance can also contribute to global security. Problems in one country, let alone one continent, cannot be contained within borders. If African countries cannot overcome the many social and economic challenges they face, these problems will spill over rapidly."[38]

Failed and unstable states pose a special challenge for global security. Lacking governance and public goods, these sites can become places in which problems fester, spilling over to neighboring states and having regional repercussions. The now fourteen-year conflict in eastern Congo offers ample evidence of this effect, with the war having spilled in various forms into Uganda, Rwanda, Tanzania, Zimbabwe, southern Sudan, and Burundi. For the peoples of the region, the ongoing conflict has devastated roads, schools, hospitals, clinics, churches, businesses, and virtually every other aspect of healthy life. It has also sparked disease, including at least three outbreaks of cholera, several Ebola virus outbreaks, monkey pox, shigella dysentery, and several epidemics of vaccine-preventable diseases. It is in the U.S. interest to seek an end to such conflicts, build viable governance in failed regions, and provide services that can mitigate the impacts of such conflict on regional poverty and disease. It makes little sense to invest heavily in health and development in one state while its neighboring region remains a festering wound, spewing disease, refugees, and chaos. Both the stable and failed states must be targets for health and development efforts, though the nature of U.S. interventions will necessarily differ in the two settings.

It is no coincidence that so many leaders on the stage of humanitarian crisis intervention and foreign policy are physicians, as the experiences of medical responders in Rwanda, the Balkans, Zimbabwe, Somalia, Darfur, and dozens of other crisis points have provoked outrage and indignation in their ranks. The large epidemic of drug-resistant cholera and shigella dysentery that arose among victims of the 1994 Rwandan genocide and the long siege of Sarajevo offered special insight for responding physicians. They came to believe that their actions were frustrated by larger political forces. And the illnesses and deaths they witnessed were preventable through those same channels—not by medical intervention. The humanitarian responses, in this algorithm, are simply Band-aids placed on deep wounds that have roots in political and economic issues that can be mitigated through political diplomacy and well-conceived development and health interventions aimed at preventing conflict.[39]

The concept of "health diplomacy" has perhaps been best realized by Cuba and Venezuela within Latin America and the Caribbean. By deploying thousands of physicians and nurses to treat the poorest citizens of the region, and by opening Cuba's medical schools to train legions of Latin American doctors, the two countries have garnered outsized allegiance. Medical and public health diplomacy were once critical features of U.S. activities in Latin America and the Caribbean, and foci of activities for the U.S. Armed Forces, Peace Corps, and USAID personnel working in the region. The successful eliminations of yellow fever, malaria, and polio, to name a few, from most areas stemmed largely from close U.S. collaboration with counterparts in the region.

STRENGTHENING U.S. POLITICAL INFLUENCE AND GLOBAL LEADERSHIP IN A MULTIPOLAR WORLD

Frequent travelers and members of the U.S. corporate community are well aware of the hostility that greets America, as a nation, and Americans, as individuals, in much of the world. Anti-American fervor can, in extreme cases, impel violent action against individuals and institutions believed to represent U.S. interests. While such sentiments can never be fully erased, effective foreign assistance and multilateral engagement can soften the American image—even win friends. Surveys conducted by a variety of polling services dem-

onstrate strong support among American citizens for activities aimed at changing the face of America in the world. Americans are deeply concerned about the decline in approval of the United States demonstrated in overseas polls.

Favorable Views of the U.S.

	1999/2000	2002	2003	2004	2005	2006	2007	2008
	%	%	%	%	%	%	%	%
Britain	83	75	70	58	55	56	51	53
France	62	62	42	37	43	39	39	42
Spain	50	--	38	--	41	23	34	33
Germany	78	60	45	38	42	37	30	31
Poland	86	79	--	--	62	--	61	68
Russia	37	61	37	46	52	43	41	46
Turkey	52	30	15	30	23	12	9	12
Lebanon	--	36	27	--	42	--	47	51
Egypt	--	--	--	--	--	30	21	22
Jordan	--	25	1	5	21	15	20	19
South Korea	58	52	46	--	--	--	58	70
India	--	66	--	--	71	56	59	66
Japan	77	72	--	--	--	63	61	50
Australia	--	--	59	--	--	--	--	46
China	--	--	--	--	42	47	34	41
Indonesia	75	61	15	--	38	30	29	37
Pakistan	23	10	13	21	23	27	15	19
Brazil	56	51	35	--	--	--	44	47
Mexico	68	64	--	--	--	--	56	47
Argentina	50	34	--	--	--	--	16	22
Tanzania	--	53	--	--	--	--	46	65
Nigeria	46	76	61	--	--	62	70	64
South Africa	--	65	--	--	--	--	--	60

1999/2000 survey trends provided by the Office of Research, U.S. Department of State.

"I think the new president has to realize that the world looks to America for leadership," General Colin Powell recently said on NBC's *Meet the Press*. He continued:

"I think we have to do a lot more with respect to poverty alleviation and helping the needy people of the world. We need to increase the amount of resources we put into our development programs to help the rest of the world. We have not explained ourselves well enough. And we, unfortunately, have left an impression with the world that is not a good one. And the new president is going to have to fix the reputation that we've left with the rest of the world."
—*Meet the Press*, October 19, 2008

The table to the left is from the Pew Global Attitudes Survey, December 18, 2008. The 2008 uptick in positive attitudes in many countries reflects survey results following the election of Barack Obama to president.

Though the United States may no longer be the global hegemonic power, and economic and political influence gravitates toward many poles today, the world is hungry for leadership. The enthusiasm worldwide that greeted Barack Obama's election indicates the deep longing for an America that captains the nations, for realization of broad social and economic improvements, peace and stability.

In the end, a remarkably small investment put toward saving lives in other parts of the world is among the most cost-effective and wise U.S. budgetary expenditures.

EXPANDING ECONOMIC WELL-BEING IN A GLOBALIZED MARKET

American companies want the world to be a safe and predictable place for commerce. Anti-American sentiments often target U.S.-identified companies overseas. Many U.S. corporations seek to offset such senti-

ments with development and health-related programs, such as HIV treatment efforts (Merck, Pfizer), river blindness elimination (Merck), malaria prevention (Exxon), health messages for adolescents (M.A.C., Viacom/MTV), and nutrition campaigns (PepsiCo). In a less specific sense, some businesses see development and anti-poverty campaigns as effective efforts in American interests that enhance stability and can generate consumer wealth.

Building viable businesses in developing countries is a critical element of sustainable growth. Ideally, business models should include the health sector, offer the possibility of a U.S. engagement endgame, and leave behind lasting employment and economic growth. In general, U.S. agencies engaged in ODA and global health, specifically, have done a poor job collaborating with corporate enterprises and building business models in developing countries. Though many private companies have carried out assistance programs as contractors, corporations generally complain that NGOs and U.S. government agencies fail to capitalize on their core competencies in efforts to execute smarter, sophisticated programs.

As the United States rebuilds its economy, it must recognize the globalized nature of modern marketing, production, and distribution. It would be a tragic loss of opportunity if 2009–2010 U.S. recovery plans failed to incorporate exciting potentials in developing countries, especially those related to pharmaceutical, medical, and general public health products and businesses.

THE HUMAN DIGNITY AGENDA: SOLIDARITY THROUGH HUMANITARIANISM

Political leaders should not be under the misapprehension that protecting foreign aid programs will result in serious election repercussions in their home constituencies. Though America is now in a more isolationist mood, sparked by the gloomy economic situation, wise leadership can, and should, underscore the urgent need to repair the global image of United States and fulfill longstanding promises to the poorest, neediest citizens of the world.

Whether motivated by religious, moral, political, empathetic, or combined concerns, Americans care about the suffering of others and are deeply moved by humanitarian crises, such as the 2004 tsunami and the 2008 cyclone Nargis. For example, World Vision, a Christian organization providing foreign aid in nearly one hundred countries, enjoys enormous support in the United States, and sees its mission as one dedicated to facilitating "engagement between the poor and the affluent that opens both to transformation," according to its mission statement. "Together we share a quest for justice, peace, reconciliation, and healing in a broken world."

Philanthropists Bill and Melinda Gates have often spoken of what motivated them to commit the majority of their personal wealth to tackling health, poverty, and education issues worldwide: equity. A striking trend of the post–World War II era has been rapid increases in the life expectancies of most Europeans, northern Asians, Latin Americans, and North Americans, but stagnated, even declining life spans in the poorest nations, particularly in sub-Saharan Africa. A gap in life expectancy appeared and then widened steadily over the decades, now exceeding forty years between the longest and shortest-lived societies. For the Gateses and many other Americans, this is an appalling state of affairs.

Investing in the world's poor and protecting them from disease and famine are simply the right things to do.

The Way Forward: Recommendations for U.S. Development Assistance and Global Health Commitments

ROOT-AND-BRANCH REFORM OF U.S. FOREIGN ASSISTANCE ARCHITECTURE, LEGAL AUTHORITIES, AND CAPABILITIES

At least twenty-two different agencies and programs of the U.S. government play a direct role in foreign assistance, receiving support from the congressional 150 Account and special allocations for targeted programs. There is little coordination or coherence between these programs, and at times their efforts appear to be at odds, competing for resources and attention on the ground. Many of these agencies work bilaterally in countries where nearly all other donor support proceeds through multilateral or collaborative channels. Some programs are administered out of U.S. embassies and may be directly overseen by the ambassador or consular staff. Others, in stark contrast, are executed by NGOs that avoid any overt in-country connections to the U.S. government.

The United States theoretically executes foreign assistance under the terms of the 1961 Foreign Assistance Act, which was partially rewritten and reauthorized in 1985. As originally conceived during the Kennedy administration, the FA Act was less than one hundred pages long and represented a fairly straightforward strategic mission. Over the subsequent half-century, the FA Act has been amended so many times that it is now an incoherent document two thousand pages long, with at least thirty-three different goals, seventy-five "priority areas," and 247 directives, and is executed by twenty-two implementing agencies that operate without any overarching strategic vision. It is an unwieldy piece of legislation that is frankly impossible to implement in its current form. The many amendments of the FA Act over the forty-seven years of its authorization have typically reflected the variant policies of different U.S. presidents and congressional leaders, not shifts in overseas needs and conditions.

Among stakeholders in the foreign assistance community, former USAID administrators, and members of the congressional foreign affairs committees, there is nearly unanimous agreement that the FA Act cannot be transformed into a meaningful, strategic document through further amendment. It must be rewritten.

The congressional process of recrafting the FA Act should reflect a twenty-first-century strategic vision of why the United States engages in this exercise and to what end. Reorganizing how foreign assistance is administered, which agencies properly play a role, and which health and development issues and world regions it targets cannot be done properly until the very purpose of foreign assistance is determined. Writing in the November/December 2008 issue of *Foreign Affairs,* three former USAID administrators made a strong case for both the expansion of foreign assistance, and the reorganization of ODA programs:

> To ensure that taxpayer dollars are well spent on a single, coherent foreign aid bureaucracy under one chain of command, the next president will have to push through major insti-

> tutional reforms. But … U.S. development efforts lack coherent policy guidance and are spread across myriad agencies with little coordination among them. Such a sad state of affairs did not always exist. We can testify to this from our own experience, having collectively run USAID for 16 years, under both Democratic and Republican administrations. We share the concern that our civilian capacities have eroded at a time when they are most needed. The United States cannot win the hearts and minds of the world's people with only an anemic USAID presence in the developing world. The situation will not improve without sensible presidential leadership to support an independent, vigorous, and restructured USAID or a new federal department devoted to development.[40]

During the Cold War, the United States took its foreign assistance efforts very seriously, building up a professional corps of health and development expertise that largely resided within USAID. By 1980, USAID had more than four thousand permanent employees, representing a range of skills that included engineering, hydrology, agronomy, financial management, logistics, and supplies planning and medicine. Today the agency is whittled down to merely 2,200 employees, most of whom spend their days managing an array of contractors and NGOs that, often at great cost, implement programs akin to those once done by government employees. To accommodate drastic cuts in its budgets every year, USAID has closed down offices in twenty-six countries and transformed into a bureaucratic management organization.[41]

The loss of professional expertise and funding for USAID has forced the agency to farm its work out to NGOs and companies that typically lack full transparency and accountability. PEPFAR has to some degree followed a similar model, often administering programs that are executed by contractors and grantees. It is not uncommon for such third-party programs to exact enormous overheads and operational costs, exceeding half of the agency's total costs.

Devaluing the USAID professional staff and eliminating fully half of all full-time jobs since 1980 has resulted in higher costs to tax payers, with, as the three former USAID administrators assert in their article, absolutely no evidence of improved performance.

Recognizing the lack of strategic direction for foreign assistance as well as its structural incoherence, the Bush administration tried to repair matters without confronting the legislative language of the FA Act. During the two terms of the Bush administration, U.S. foreign assistance underwent multiple changes, including the creation of a host of entirely new programs,[42] an enhanced role for the secretary of state, the merging of USAID under the direction of the Department of State in the "F process," and a striking increase in the role of the Department of Defense. The absolute dollar commitment has increased from $11.4 billion in 2001 to $27.5 billion in 2005.[43] The majority of that $10.2 billion increase went to Iraq, Afghanistan, and PEPFAR. And despite the increase in absolute dollar commitment to foreign assistance, the 150 Account's share of the total U.S. budget has not risen above 0.5 percent, and its apportionment has shifted radically:

1. In 2007, net ODA by the United States was $21.8 billion, representing a fall of 9.9 percent in real terms from 2006.[44]
2. In FY1998, the Department of Defense garnered about 3.5 percent of U.S. ODA; by FY05 about 22 percent of ODA was channeled through the DOD, second only to USAID, which provided 39 percent of ODA assistance in FY05.[45]
3. Between FY06 and FY08 the USAID budget was cut by 30 percent, with most of these funds being shifted from traditional development assistance accounts (DAA) to economic support funds (ESF), in-

tended to be used by the secretary of state to advance U.S. strategic objectives.[46],[47] Overall, USAID has experienced a 37 percent funding reduction since FY01.

4. Of total estimated spending on global health issues, the HIV/AIDS pandemic was the object of about $236.1 million of U.S. foreign assistance in FY00[48] (approximately 2 percent of FY00 foreign aid budget); by FY07 PEPFAR and HIV/AIDS programs were a primary target of all U.S. aid, receiving $3.3 billion, or about 15 percent of all U.S. foreign assistance and 60 percent of total U.S. funding for global health.
5. In 2000, Iraq and Afghanistan combined received less than one percent of U.S. ODA; by FY07 ODA for Iraq and Afghanistan exceeded 24 percent of the total U.S. ODA budget (not including traditional military expenditures).[49]
6. Since passage of the 1961 Foreign Assistance Act, each administration has tried to walk a careful tightrope with ODA, using it to win friends and stability in the world while striving to separate aid from U.S. national security and strategic foreign policy efforts. This separation was long considered essential not only for the safety of aid workers, but also as a moral principle. The creation of the Office of the U.S. Director for Foreign Assistance in the Department of State, however, led to the Strategic Framework for Foreign Assistance, a five-point plan, tightly linking provision of health, humanitarian, and development assistance to U.S. security interests.[50] There has been an overall shift in ODA toward narrowly targeted programs with clear, measurable goals (e.g., the number of people started on antiretroviral therapy for HIV), often at the expense of general support for infrastructure, human resources development, institution building, and longer-term country self-sufficiency. In its most extreme case, the PEPFAR treatment program has been characterized as entitlement expenditure, committing U.S. taxpayers to decades of spending on HIV treatment for individuals living in poor countries.[51]
7. U.S. foreign assistance under the Bush administration has been tightly linked to Christian principles, reflecting the interests of a constituency vital to the election of President George W. Bush. The upside of this has been a remarkable surge in both the numbers of faith-based organizations (FBOs) engaged in overseas assistance and in the acquired sophistication of their operations. The downside has been the insertion of controversial program guidelines that, critics charge, reflect religious values but are not empirically supportable. Concerns have also been raised about the use of taxpayer money to support religious advocacy abroad, the special tax status of faith-based institutions, and related transparency issues regarding scrutiny of how funds are used.

These controversies remain unresolved at this time, and some cannot be decided by the executive branch alone.

These changes have not solved the fundamental problems with ODA or foreign assistance. U.S. programs continue to operate through legislated stovepipes, putting resources and cash into efforts, regardless of—and often in opposition to—the primary needs on the ground in recipient countries. Few programs have built-in exit strategies, with final targets agreed to jointly by the United States and a recipient nation, or schemes in place to allow eventual full country ownership of the effort. All too often foreign assistance *increases* dependency, and aims at the wrong targets.

In Mozambique, for example, 98 percent of all funding for the country's HIV/AIDS programs comes from outside donors: 78 percent of it is from the U.S. PEPFAR program, despite glaring needs in other social/economic sectors. Similarly, Uganda is 95 percent dependent on external donors for financing of its HIV/AIDS programs: 73 percent of its outside support is from the U.S. PEPFAR program.[52] In both cases the nation's extraordinary dependence on external support—in particular, on the financing from U.S. taxpayers—begs questions regarding the efforts' sustainability, and country ownership and control.

Were the United States to suddenly cease underwriting these programs, AIDS patients would die by the thousands for lack of life-extending treatment. Knowing this, recipient governments are obliged to comply

with moral and programmatic designs for their health efforts that are created in the United States, or by U.S.-supported contractors.

Rwanda has, appropriately, been a major recipient of U.S. support, but the apportionment of U.S. funding does not appear to reflect Rwanda's needs: 63 percent of all ODA from the United States to Rwanda goes for HIV treatment and care programs, but Rwanda's HIV prevalence has never exceeded 3 percent of its general adult population, and is currently only 2.8 percent. In contrast, the lifetime chance of a woman in Rwanda dying as a result of childbirth-related complications is one in sixteen, ranking among the highest in the world, yet in 2007, maternal and child survival represented less than a fourth of total U.S. funding for health in Rwanda.[53]

Among the sharpest changes made by the Bush administration involve the dramatic increase in the role of the Department of Defense (DOD) in ODA and foreign assistance programs. In 2000, the DOD received 3.5 percent of the ODA budget, and by FY08 the DOD allotment increased to 22 percent. In addition to receiving 150 Account funds, DOD now also receives so-called Section 1206 funds for provision of security services, funds that previously were solely administered by the Secretary of State. In a further striking departure from the prior patterns of U.S. assistance, some military commands (particularly the U.S. Southern Command (SOUTHCOM) consider coordination of all U.S. ODA efforts in their region—civilian and military—to be part of their mission.

As the civilian side of U.S. foreign operations has been gutted, and its ranks of professionals depleted, the military has stepped into the vacuum, providing rapid logistic and operational support in response to catastrophic events, and education, health, and development support in dangerous areas. While the overwhelming majority of these activities have focused on Iraq and Afghanistan, U.S. military personnel have been engaged in health and development activities all over the world.

U.S. and Australian military personnel in Aceh, Indonesia, following the December 2004 tsunami.

Source: http://www.iabc.or.id/photos_aceh.htm.

As the military clearly demonstrated in its extraordinary mobilization to Aceh in response to the 2004 tsunami, DOD ability to move supplies and personnel anywhere in the world is unrivaled. No NGO or civilian agency has ever shown an equivalent capacity for rapid response to humanitarian catastrophe. But since September 11, 2001, the armed forces have tackled issues previously considered the exclusive domain of civilian agencies, prompting concern about what many NGOs and civilian agency personnel call the growing militarization of foreign aid.

Controversies regarding the appropriate roles for military personnel in humanitarian and development arenas are being debated all over the world, and are hardly exclusive to the U.S. discussion. Since the early 1990s, pressure has increased inside the United Nations and the European Union for military action to prevent genocide and famine. The Responsibility to Protect Doctrine, or R2P, has been cited as justification for placing military personnel in the Darfur refugee camps, and French foreign minister Bernard

Kouchner invoked R2P following Cyclone Nargis when calling for a massive international military intervention to bring food and medical supplies into Myanmar.[54] However, the UN Security Council has never endorsed an R2P intervention.

Some advocates would go further, calling for a sort of Responsibility to Prevent. In this view the militaries of the world must play a direct role in constructing the peace, engaging in a broad array of development efforts with the goal of undermining support for terrorism and oppression. Whether the military actually builds bridges or surrounds and protects civilian bridge-builders is almost immaterial. The reasoning, argue institutions and individuals as diverse as the World Bank, the UK's Department for International Development (DFID), and noted author Paul Collier, is that desperate poverty and genocidal oppression go hand in hand, and must be confronted simultaneously.[55] The Nobel Peace Prize–winning humanitarian aid organization Médecins Sans Frontiers (also known as Doctors Without Borders) counters that the increased presence of combat-ready armed forces personnel in humanitarian operations blurs the line between the civilian and military "foreigners" and therefore puts unarmed civilian actors at increased risk of violence.[56]

A U.S. civilian working with the Military Assistance Team, Iraqi Assistance Group, explains to engineers in the Iraqi Army's 6th Division the proper position for a mounting post for a solar light panel, June 19, 2008. The solar lights will reduce the strain on Baghdad's electrical system while lighting checkpoints.

Source: Department of Defense, http://www.defenselink.mil/dodcmsshare/newsstoryPhoto/2008-06/scr_080623-A-xxxxS-003.jpg.

The skill sets of the armed forces and civilian aid experts should be considered complementary. DOD's strengths are in logistics and security; the civilian forte is in long-term development planning and execution. Regrettably, however, over the last seven years little harmonization between the sectors has emerged.

General Anthony C. Zinni and Admiral Leighton W. Smith Jr. retired from the Marine Corps and the Navy, respectively, and are co-chairs of the Center for U.S. Global Engagement's national security advisory council. They argued in March 2008 in *USA Today* that "the U.S. cannot rely on military power alone to keep us safe from terrorism, infectious disease and other global threats that recognize no borders."[57]

Defense Secretary Robert Gates struck a similar chord in September 2008, saying, "funding for nonmilitary foreign affairs programs … remains disproportionately small relative to what we spend on the military. Why?" Gates continued, "Diplomacy simply does not have the built-in, domestic constituency of defense programs."[58]

The Obama administration should task the new leadership of U.S. foreign assistance with developing clear policy guidance regarding the appropriate role of armed forces personnel in global health and development efforts. The leadership should take seriously the analysis and recommendations forwarded by the Center for Strategic and International Studies in its January 2008 report on the matter.[59]

Building coherence in global health and development efforts should be embedded in the broader effort to reform U.S. foreign assistance, though disagreement persists as to whether this reform effort should take an incremental approach or consist of a full-frontal assault with major structural reforms.

The historic moment is ripe, and support for modernization of all aspects of foreign assistance and global health delivery is strong, both in the executive and legislative branches. Moreover, the architecture of ODA is changing all over the world. The United States should embrace the moment and play a strong leadership role in revamping the nuts and bolts of twenty-first-century wars on poverty, disease, instability, famine, and ignorance.

How should the design and administration of the 150 Account and general foreign assistance be executed?

America must move from repair work overseas to construction of fundamental change in developing countries. The main goal of change must be the creation of permanent systems and infrastructures, ultimately offering the American donor an exit strategy. Such aspirations cannot be realized without professionalism between foreign assistance administrators and implementers, clear strategic missions, and coherent leadership from the highest level.

Several of the major donor states have made radical changes in the structures of their operations: the most dramatic case is the United Kingdom and its Department for International Development. The United States can, and should, learn from the UK's DFID experience and seek to emulate some of the same innovations in strategic planning and implementation of foreign assistance. Among the core achievements of the twenty-first-century DFID model are:

- Under the 2002 International Development Act, DFID has a clearly defined strategic mission: poverty reduction
- DFID is, by law, required to dispense 90 percent of its funds to low income countries, and only 10 percent to middle income nations
- DFID allocations are locked in three-year cycles, allowing recipient programs ample time to unfold and build necessary infrastructures
- DFID is a cabinet-level agency in the UK government, viewed as a national security peer to defense and diplomacy
- DFID is a coherent implementer, controlling 84 percent of all of the UK's ODA.

Though DFID has succeeded in implementing organizational innovations and in improving harmony between once rival UK programs, its outcomes have yet to demonstrate sufficient grounds for excitement. The next vital innovation for DFID, as well as for U.S. foreign assistance efforts, will rest with the development of improved accountability, tightly linked to transparent measurements of both short- and long-term program outcomes. Nevertheless, the DFID consolidation of foreign assistance offers a model worthy of U.S. attention.

Strategically, the U.S. foreign assistance framework should focus on capacity building, reducing vulnerabilities, and playing to the United States' comparative advantages, such as its ability to work with private sector players, proven DOD ability to muster overnight humanitarian mobilization in response to immense natural disasters, and CDC rapid-response capabilities in the face of disease outbreaks. Implementation of such an approach requires an interagency strategic planning mechanism tied to budget and resources and clear, coordinating leadership, ideally nested inside the White House.

Foreign assistance must be dynamic and innovative, capable of mustering robust course corrections and responses to new crises, novel technologies, and regional shifts in climates—whether meteorological, economic, or political. The White House–based director of foreign assistance should have the flexibility to move resources and funds as exigencies require. Further, innovative research and development should be encouraged, with an agile USAID administrator capable of putting proven ideas into practice rapidly.

Though many advocates in this arena favor immediate creation of a U.S. cabinet department akin to the DFID model, this does not offer a satisfactory solution to the vast architectural and coherence problems of U.S. ODA and assistance efforts at this time. Though department creation may represent a suitable aspiration for long-term planning, far more rapid and fundamental improvements in foreign assistance can be achieved by creating an office within the National Security Council that both advocates on behalf of development, health, and humanitarian responses inside the NSC and has statutory authority to coordinate and oversee all ODA and assistance activities executed by federal agencies, including DOD. Critics of this proposal argue that the NSC would logically seek to link development and aid too tightly to U.S. national security concerns. The appropriate guidance from the president's office, coupled with congressional reexamination of the strategic goals of issues covered by the FA Act, can prevent inappropriate use of the foreign assistance apparatus for national security purposes.

A parallel civilian panel should also be established that has statutory advisory authority over all ODA activities, roughly in the manner that the Joint Chiefs of Staff oversees the branches of the armed forces. This authority—the McPherson/Atwood/Natsios Proposal—would be chaired by a senior Foreign Service officer, and comprises the leaderships of the USAID, U.S. Treasury, and the U.S. Trade Office.

The two leadership authorities described above should create forthright cooperation from the outset between the new administration and Congress in achieving broad agreement on the purposes of U.S. foreign aid. Further, they should consolidate at least some of the fragmented actors and aid streams (USAID, PEPFAR, and MCC, especially) under one roof.

RECOMMENDATIONS ON DEVELOPMENT ASSISTANCE

U.S. taxpayers have a right to expect cost-effective expenditure of their foreign assistance dollars, executed by a well-organized distribution and planning structure. Further, taxpayers who now face economic challenges on the home front deserve assurance that their dollars are being spent on programs that seek to prevent disease, conflict, famine, and poverty with the goal of rendering countries less dependent over time. Though U.S. agencies must be prepared to respond to crises, American aid should aim to prevent such disasters by building strong, sustained programs and institutions for preventing disease and strengthening economies.

Congress must now remove clear obstacles to these aspirations through legislation. The United States is the last wealthy nation to modernize its giving to meet twenty-first-century challenges. For example, amid rising transport and energy costs, most other donors have forsaken twentieth-century practices of shipping their products to meet program needs in favor of purchasing on the ground from local manufacturers and providers.

In the original 1961 FA Act, Congress found that "… the greatest potential for significantly expanding availability of food for people in rural areas and augmenting world food production at relatively low cost lies in increasing the productivity of small farmers who constitute a majority of the agricultural producers in developing countries. Increasing the emphasis on rural development and expanded food production in

the poorest nations of the developing world is a matter of social justice and a principal element contributing to broadly based economic growth, as well as an important factor in alleviating inflation in the industrialized countries."[60]

Over subsequent decades, however, Congress and various administrations have veered from this stated goal, preferring to meet dire food needs overseas through distribution of U.S. commodities. For global health experts, this failure to support long-term, predictable food production in many parts of the world is critical because poor nutrition contributes to growth stunting, vitamin and protein deficiencies, weakened immune responses to infectious diseases, bone and tooth loss, and lowered intellectual performance.

The 110th Congress and the Bush administration generously gave $16 billion in food aid from FY02 to FY07, and committed to providing another $5.5 billion for FY08 to FY09. But the United States is the last major donor in the world to still tie 100 percent of its food aid to distribution of U.S.-grown crops that are shipped at extraordinary cost via U.S. shippers. The cost of tied food aid is demonstrably higher—in many cases 30 to 50 percent higher—than alternative, non-tied sources of food aid.[61] According to OXFAM, some 40 percent of all U.S. food aid is eaten up by shipping and delivery costs. Moreover, donated food undermines regional markets for agricultural products, driving local farmers into deeper poverty.

The real goal of food aid should be building local agricultural capacities, bringing dependency to an end. Short-term famine relief efforts, including distribution of American and European grown crops, should be seen as emergency measures necessitated by failures in achievement of the larger goal, not as end in themselves.

The conservative Harper government of Canada recognized the low cost-effectiveness of tied aid in early 2008, when food prices inflated 300 percent in much of the poor world, and pushed through a bill in Ottawa that *untied* 100 percent of Canada's assistance. Today, Canada and most European nations support local agricultural development and food purchasing within troubled regions, bolstering local capacity in a cost-effective and sustainable manner. Despite Bush administration attempts to untie at least 25 percent of food aid, the 110th Congress stalwartly insisted that 100 percent of U.S. goods must be used. Therefore, the United States stands alone in choosing to give more money to American agricultural producers and American shipping companies at the direct cost of human lives in poor countries.[62]

What does this mean on the ground? After years of famine, the Malawi government, for example, decided in 2006 to underwrite seed and fertilizer costs for the nation's farmers. In 2007, the country had a record corn harvest. In a well-intended effort, the United States and World Food Programme backed school meals for 650,000 Malawian children, using U.S. corn that, after shipping, cost 2.5 times the price of local corn, and fed 400,000 fewer children than could have been sustained by simply purchasing from the locally grown bumper crop.[63]

Beyond the question of what America buys with taxpayer money in the name of foreign assistance, the U.S. presence on the ground is often confusing and chaotic. U.S. foreign aid is typically executed by a vast and bewildering array of private intermediaries, such as university scholars, NGOs, faith-based groups, private companies, contractors, financially backed UN players, and private foundations. Though most may receive their funds from a single or at least finite number of Washington agencies, in-country they each have separate identities, requiring individual agreements with recipient governments, separate sets of paperwork, varied goals and styles of work, and competing interests in relation to hiring local personnel and gaining good graces with important ministries. All too often local governments find keeping track of this array of well-intended American presence unmanageable and chaotic.

This confusion has negative impacts overseas and at home. For the governments of recipient countries the inability to keep track of the plethora of international players working on development and health inside their countries makes it nearly impossible to implement overarching strategic initiatives or ensure that all players are working in reasonable harmony. On the home front, the vast array of virtually unmanaged foreign assistance players exceeds any reasonable capacity for PEPFAR, USAID, or any other federal agency to tell Congress precisely how its funds are being spent, and with what outcomes. It is clear that the current system of ODA disbursement cannot always provide American taxpayers with a delineation of how monies are expended for U.S. NGO/FBO/contractor/university overhead versus on-the-ground programs; for prevention versus treatment efforts in the case of health programs; for hotel accommodations and meals for American citizens versus salaries and payments to local personnel; for purchase of costly American goods, shipped at great expense in a costly fuel environment, versus buying cheaper, locally made products; for executive salaries for the heads of U.S. contractors and NGOs versus on-the-ground salary support.

In sum, it is not possible, in most cases of U.S. foreign assistance, to provide members of Congress with a clear cost-effectiveness ratio for dollars spent, as the funding streams are neither sufficiently transparent nor accountable, nor are there any real incentives for U.S. agencies or contractors to provide an accurate evaluation of their efforts to Congress or others. This reflects the general chaos and lack of strategy in U.S. foreign assistance, not dubious intention on the part of individual providers, agencies, or programs.

Strong oversight is needed, ideally from a White House–based coordinator of all foreign assistance efforts. It is critical that the United States find the proper balance between transparent and measurable outcomes of health and development programs and the pressing need for long-term infrastructure investments that may not yield observable outcomes for many years. Only strong leadership can ensure that the quest for accountability does not result in an abundance of short-term, single-issue interventions built atop shaky, stressed infrastructures, executed without regard to local government strategies, and utterly lacking in sustainability.

KEEP PROMISES MADE

Africans often say, "When Washington catches a cold, we get pneumonia." Since mid-2008, the credit crisis and financial meltdown have put Washington metaphorically in an ICU, which means Africa and other very poor regions of the world are heading to the hospice. It is a sad truism of foreign assistance that the very times there are the loudest cries for help for the poor is when the wealthy world is suffering, itself. To put it bluntly, in the face of catastrophic levels of necessary spending on the banking bailout and mortgage crisis it might seem reasonable to hack at the modest $36 billion foreign assistance budget, as was sug-

gested in the presidential campaign, but in so doing Congress risks not only reversing all that has been achieved with U.S. tax dollars since 1990, but also endangering the lives millions of people. Furthermore, any backpedaling in U.S. support risks undermining disease surveillance and response capabilities, thereby directly threatening American security.

The U.S. government should fulfill promises made before the financial crisis, appropriating PEPFAR and dozens of other foreign assistance programs at the FY09 levels with which they were authorized. Moreover, the United States should increase support for agricultural, educational, and infrastructural development, follow the Canadian and European example to untie food aid, and raise the percentage of the federal budget allocated to the 150 Account above the 0.5 percent level. Many members of Congress and both presidential candidates in 2008 vowed to double ODA, bringing the 150 Account up to $44 billion in FY09. This should be done.

The secretary of state should pressure counterparts throughout the G8 to keep promises made over the last decade of summits. In particular, the Gleneagles agreements on Africa and the Heiligendamm and Toyako promises for support of modern health systems development in poor countries must be kept. The Obama administration should send a clear signal to the wealthy world: Promises made to poorer countries for assistance, development and health intervention must be kept, and there must be accountability.

STRATEGIC INCREASES IN DEVELOPMENT ASSISTANCE INVESTMENTS

USAID must have control of its own budget. And Congress should double the USAID budget. Implementation of foreign assistance requires creation of a strong professional base within USAID, PEPFAR, CDC, and other implementing agencies. Congress and the White House should study models for professionalization, including creation of a Global Health Service Corps, recruitment of information technology (IT) specialists, engineers, hydrologists, agricultural specialists, and management expertise.

Morale within crucial ODA agencies—particularly USAID—is poor, and in many cases leads to poor performance. Congress, when revisiting the FA Act, should consider performance incentives, higher skills training, and the overall need to enhance the professional stature of global health and development workers.

A corollary of improved professionalization is empiricism. The White House should insist that evidence-based decision-making guide ODA planning and execution. Scientific standards for demonstrating program efficacy should be developed and used routinely in assessing whether old ways of doing things still hold up in the twenty-first century. Further, mechanisms for rapid implementation of promising new technologies and conceptual approaches to ODA should be introduced, allowing swift field trials and encouraging creative innovation.

MAXIMIZE MULTILATERALISM

As noted in the National Intelligence Council 2025 report, the political forecast calls for an increasingly multi-polar world in which the United States may remain the dominate player in most arenas, but its strength of leadership will derive in large part from the executive branch's ability to leverage partnerships in all aspects of global trade, economics, health, development, diplomacy, climate, and energy negotiations,

anti-terrorism efforts, and strategic geopolitical stability. According to the NIC 2025, the United States will be "one of a number of important actors on the world stage, albeit still the most powerful." America cannot expect success from go-it-alone policies.

Further, global economic contraction means that no donor nation has sufficient resources, alone, to reach major achievement targets in poor countries. The United States needs to grow more comfortable with leveraging multilateral institutions, moving away from bilateral, stand-alone mechanisms. Beyond this, the United States needs to actively promote multi-actor governance arrangements, building on proven public-private partnerships.[64] The United States no longer faces a twentieth-century global development landscape. Today's development terrain includes not only foreign governments and international institutions, but transnational civil society movements and the for-profit private sector. As the United States seeks to get its own economic house in order, it needs to promote similar coherence—without killing creativity—in the emerging architecture of global health governance.

The stress placed by the Bush administration on the ill-defined goals of building democracy and freedom had the unfortunate effect of linking U.S. ODA tightly to foreign policy activities that were widely unpopular worldwide, including the U.S. invasion of Iraq, the Abu Ghraib torture episodes, and publicly expressed administration disdain for the UN system. The Bush administration responded with a go-it-alone execution of most ODA programs.

Today, in contrast, most other international donors are working through new multilateral channels, seeking to collaborate directly with recipient governments to jointly identify development and health priorities and direct funding accordingly. The United States has preferred to go it alone during the last eight years, and to convince bilateral partners that it is in their interests to accept money that is directed at targets determined back in Washington. This bilateral, made-in-the-USA orientation has had some unfortunate consequences:

- It has undermined harmonization with other major donors whose resources the United States could otherwise leverage to realize common development goals.
- It has hampered alignment of U.S. programs with overall host country priorities.
- Beyond undercutting the principle of "ownership" that the donor community endorsed in the Paris Declaration—and which is a sine qua non for effective development assistance—the current U.S. approach often skews bilateral aid away from the basic needs of the recipient state.[65]

One of the primary challenges for the next president will be to engage a world that has unrealistically high expectations of change after the controversial Bush years. Global health and development are areas where the United States can excel. But building on past positive achievements will require significant changes to the U.S. posture. Today, the United States channels the overwhelming majority of U.S. assistance through bilateral programs that are seldom designed with reference to what other actors are doing. While this might have made sense in the 1960s days of the Alliance for Progress, it makes little sense in an era of scarcity.

The United States signed the Paris Declaration; it should implement its many provisions. The United States should become a lead partner in a global strategy for poverty alleviation, global health, climate change adaptation, and mitigation and general development.

Donor nations have various strengths to offer to the developing world. Through clearer lines of cooperation and global coordination it should be possible to draw on those assets in a manner that synergizes development and health efforts inside poor countries. The challenges facing the international community,

both the developed and developing worlds, are such that donors must stop trying to do a little bit of everything, instead drawing on their respective strengths. In such a calculus, the United States would function in an international development ecology rife with donors and expertise, but with fewer redundancies and greater overall impact.

SPECIFIC RECOMMENDATIONS ON GLOBAL HEALTH COMMITMENTS

There have been attempts over the decades to reform the global health component of the FA Act without confronting the overall 1961 Foreign Assistance Act. In particular, Representative Hugh Carey (D-NY) sponsored the International Health Agency Act of 1971 (H.R. 10042), which sought to create a professional corps of public health, medical, and humanitarian relief experts, working in tandem with—but not managed by—USAID. Though the proposed act underwent multiple hearings in the House and was discussed in the Senate, it never passed to a floor vote in either legislative body.

In general, modernization of global health ODA is best managed through overall reform of foreign assistance. There are, however, some particular health modifications Congress and the White House should consider.

By immediate executive order the Obama administration should revoke the so-called Mexico City policy (also known as the global gag rule), which was instituted by President Reagan in 1984, requiring NGOs to "agree as a condition of their receipt of federal funds" that they will neither "perform nor actively promote abortion as a method of family planning in other nations." Other funding conditional ties should be revisited, including limits on population and reproductive health initiatives, prostitution denunciations required for receipt of certain global health funds, and some agency assertions that correct condom use fails to protect couples from most sexually transmitted diseases, particularly HIV.

As noted above in the discussion of foreign assistance recommendations, empiricism should guide decisions related to global health policy. For too long, aspirations have exceeded, or superceded, evidence. For example, both the G8 and WHO have recently placed great emphasis on the need to build "health systems" in poor countries, but have failed to define what is meant by that phrase. Constructing clinical buildings without training personnel to staff them, or creating IT for patient tracking in places lacking electricity and Internet access cannot possibly meet anybody's definition of "health systems." Metrics for assessing the efficacy of financing schemes for health (such as provision of patient vouchers, government-subsidized universal healthcare, free market mechanisms) are sorely lacking. Systems research has never been well funded in the United States, whether for designing a domestic healthcare system or one overseas. The United States must build up an empirical basis for analyzing, experimenting, managing, and testing health systems innovations, both at home and overseas.

Technology alone cannot solve health challenges—systems for the delivery of new tools must also be in place. But the toolkit for global health is limited, and lacks essential elements for rapid diagnosis of infectious diseases, immunization against HIV, easier child vaccination against a host of diseases, water filtration in rural areas, and chronic disease treatment in conditions of extreme poverty. Research and development, including support of National Institutes of Health (NIH) basic research programs, must be robust, with special attention paid to technological solutions to conditions specific to impoverished regions. Further, ODA programs must be capable of serving as testing grounds for implementation of new tools for health and for peer-reviewed assessment of their performance.

Far greater commitment should be given to aligning U.S. aid priorities in health with the priorities of national governments and local stakeholders, to avoid donor-driven interventions and to ensure sustainability, ownership, and capacity building. In many developing countries this will require the expansion of programs related to maternal health, infant mortality, reproductive health, family planning, and HIV prevention.

The best metric for measuring the performance of medical care systems in developing countries are maternal survival rates; the best measure of the efficacy of basic public health services is child survival. Both metrics are sensitive indicators of the environment of health, such as transport systems to emergency medical care, clean water systems, family food intake, and girls' education. Both measurements are sensitive to short-term incremental achievements, but also provide evidence of long-term development achievements. U.S. foreign assistance leadership should develop effective tools for measuring maternal and child survival and encourage the use of such metrics by program implementers.

In accordance with the recommendation from the Institute of Medicine's December 2008 report, "by the end of the administration's first term, the President and Congress double annual U.S. commitments to global health between 2008 ($7.5 billion) and 2012 ($15 billion). The committee recommends that the U.S. government commit to $13 billion for the health-related Millennium Development Goals (MDGs) and an additional $2 billion to address the challenges of non-communicable diseases and injuries."[66]

The United States knows how to do this business of development and global health. There have been tremendous success stories.[67] In particular, PEPFAR has demonstrated that when the White House identifies a well-defined mission, forges broad bipartisan support, and streamlines bureaucratic organization and operations, tremendous achievements are possible.

But PEPFAR has its limitations, as it is—by definition and nomenclature—an emergency initiative, aimed at achieving a finite set of goals in a limited time, backed by billions of dollars. It is a program based on recurrent, commodity-based relief.

PEPFAR is not a development program, or a substitute for a more comprehensive U.S. global health policy and assistance framework. Given that immediate cessation of funding for its HIV treatment programs would surely result in the swift demise of more than one million people, there would seem to be little political possibility of eliminating—for example—$20 billion worth of PEPFAR expenditures over the next five years (bringing the five-year PEPFAR spending down from its authorized $48 billion to $28 billion). If Congress chose to halve the entire 150 Account budget for FY09–FY14, spending more than $11 billion annually over those five years, PEPFAR, Iraq, and Afghanistan could well devour half of the entire foreign assistance commitment.

There is, therefore, a justified fear that HIV/AIDS foreign assistance spending will crowd out other priority global health needs, such as strengthening health systems in developing countries, closing the current 4.3 million-persons gap in skilled healthcare with workforce training; building the physical and organizational health infrastructures in poor countries; achieving the health-related Millennium Development Goals; and tracking infectious diseases worldwide in a pandemics early warning system. PEPFAR has provided "proof of concept" that amazing results can be achieved in difficult environments, but it will leave recipient countries in permanent need of U.S. entitlement support unless it is complemented by a clinical and global health prevention strategy and other assistance streams.

This remarkable state of affairs is the result of a laudable shift from acute public health foci in global health to chronic, long-term care. HIV treatment is akin to diabetes management: interventions are required every day for what will be, if successful, decades of added life. Until the HIV treatment challenge was

embraced, the international donor community had never previously taken on a chronic disease challenge. Now that it has adopted that commitment for some 1.7 million people living in very poor countries, PEPFAR leaders face the challenge of finding ways to both expand access to HIV treatment and diminish the long-term entitlement burden to U.S. taxpayers. The only way to achieve these seemingly contradictory goals is to embrace HIV prevention while simultaneously building systems within target countries that can eventually be expected to carry the treatment burden on their own.

Congress should be very clear about this PEPFAR dilemma: new infections mean more people to treat, but few (if any) of the targeted countries can be expected to achieve self-reliance for AIDS programs within the next decade. Therefore, Congress should give PEPFAR leadership a maximum of flexibility in pursuing HIV prevention strategies, dropping current barriers to reproductive health interventions, and aggressive condom distribution. Congress should also encourage the NIH to continue vigorous pursuit of an AIDS vaccine. And the new NSC leadership of ODA should bridge gaps between PEPFAR, USAID, CDC, and other agencies in an effort to formulate strategies for building country self-reliance in HIV treatment.

MAKE HEALTH A MAJOR FEATURE OF U.S. FOREIGN POLICY AND DIPLOMATIC ACTIVITIES

The president and the 111th Congress should elevate the importance of development as a core aspect of U.S. global engagement, on par with and reinforcing (but distinct from) defense and diplomacy. The "three Ds" should be the tripod sustaining U.S. foreign policy: if any leg is short or weak, the entire structure will collapse. This elevation should include major rhetorical attention from President Obama himself and an articulated strategic framework from the executive branch.

In accordance with the recommendation of the Institute of Medicine on December 15, 2008, "The U.S. government can take this opportunity to demonstrate, through policies and actions, that this nation fundamentally believes in the value of better health for all. The committee is calling on the next president to highlight health as a pillar of U.S. foreign policy."[68]

The secretary of health and human services (HHS) should give very careful consideration to appointments to the Office of Global Health Affairs (OGHA). The OGHA is the face of the United States in international health, intended to provide coherent diplomatic and global policy advice to the secretary of HHS. In addition, the OGHA is pivotal to coordinating health-relating activities with the departments of State, Commerce, and Defense, and the White House. OGHA advises U.S. trade negotiators regarding intellectual property issues relevant to drugs, vaccines, and medical products. OGHA has historically played a vital role in negotiations related to the Biological Weapons Convention. Finally, no office in the U.S. government has as much influence as OGHA with the leadership of WHO, the Global Fund to Fight AIDS, Tuberculosis and Malaria, GAVI, UNICEF, and other multilateral global health players. For all of these reasons, it is imperative that the Obama administration choose the leadership of OGHA with great care, seeking individuals with international experience, knowledge of health issues, and diplomatic skills. Congress should continue to support the OGHA with ample resources to execute its roles; at a minimum, its FY09 budget should remain at FY08 levels.

MAKE HEALTH A CENTER OF GRAVITY FOR U.S. STRATEGIES ON DEVELOPMENT ASSISTANCE

For far too long the United States has engaged in crisis response, rather than addressed underlying needs in desperate regions of the world. This stems both from the fragmentation of U.S. foreign assistance efforts (both public and private), and the proclivity to focus on single crises. The later orientation in turn spawns further fragmentation of foreign assistance, creating a vicious cycle.

The fragmentation makes no practical sense. There are no sharp boundaries on the ground that demarcate where the needs for health end and those for development begin. Even within the health piece of foreign assistance the delineations created by donor funding streams rarely reflect the needs profile for disease response. There is a strong consensus view among stakeholders that better integration of health and development programs, reflecting shared strategic goals, will lead to greater efficiency and long-term sustainability. For example, the dire shortage of trained healthcare workers—the key stumbling block to significant improvements in medical care—cannot be overcome without investment in basic education at the K-12 levels. Infectious diseases deaths in school-aged children cannot be conquered without investment in safe water systems. Malnutrition cannot be alleviated without sustainable agricultural development. And no program, no matter how narrow its target may be, can realize a donor exit strategy unless it is linked tightly to an overarching plan for raising the average GDP per capita in recipient nations.

EXPAND U.S. LEADERSHIP IN GLOBAL HEALTH BY INCREASING COMMITMENTS TO GLOBAL HEALTH CHALLENGES

At this time, postconflict transition assistance and targeted single-issue campaigns receive more funding than general health and development efforts. The balance does not seem appropriate, as long-term development and infrastructure support garner a comparatively paltry amount of support. The president should instruct his designated leader(s) of ODA implementation to develop guidance regarding the appropriate proportionality of funding and work with Congress to create support for long-term, game-changing assistance programs.

American influence in global health challenges will improve with more financial expenditures, of course, but money is not the sole basis of friendship, or enmity, toward the U.S. global health leadership role. Untying food aid and building programs for sustainable regional agricultural development will demonstrate that America is both committed to long-term food security and is harmonizing its policies with those of most other donor nations. Similarly, the ODA leadership inside the NSC, the Office of the Secretary of State, and the HHS secretary should work closely with U.S. trade negotiators to find ways to protect pharmaceutical patents without imposing unjust burdens on developing countries. They should work with the Commerce Department and Food and Drug Administration (FDA) to develop better incentive mechanisms for pharmaceutical and medical devices investments in research and development of new tools for health in poor countries. Such efforts will go a long way toward winning over skeptics in emerging market countries that have insisted America only cares about the health and profits of Americans.

From a national security standpoint it is imperative that the United States vigorously reenter debates over modification of the Biological Weapons Convention, with special attention to issues of verification and international intervention.

In an effort to improve international transparency over diseases and outbreaks, the United States should encourage research and development of high thru-put rapid assays (primarily high-speed genetic tests that can handle thousands of samples daily) for a broad range of microbes, and encourage private industry to mass produce such screening devices in forms that are affordable and can be used by minimally trained individuals in resource-scarce settings. As a corollary of this improvement in local disease surveillance, the United States should lead G8 nations in supporting profound improvements in WHO capacity to detect and respond to outbreaks. Encouraging cooperation between private sector actors in this arena and UN agencies will not only speed state-of-the-art technological improvements; it will also create a synergy in creative and technological capabilities.

As the world leader in basic science research, the United States has always been the global hope for biomedical innovation. The United States should maintain that leadership role while encouraging work on drugs, vaccines, medical devices, and laboratory tools relevant to resource-scare countries with desperate shortages in skilled personnel. By strategically integrating health efforts with overall development schemes, U.S. innovators may be able to lead the world in finding tools that affordably target environmental causes of disease, such as unsafe water and contaminated foods.

The United States can also play a pivotal leadership role in encouraging the rest of the donor world to better reconcile donor and recipient needs and interests. While advocates within donor states may feel certain disease-specific programs should be paramount, a recipient state may first prefer to target national productivity through provision of corrective eyeglasses to myopic children and reading glasses to adult workers with prysbiopia.

Finally, a remarkable amount of change in the U.S. global health leadership role will result from fairly minor alterations in the tone and flavor of American discourse with international agencies, UN actors, private sector stakeholders, and recipient countries. America's voice in the global health world—whether coming from HHS, State, the White House, or DOD—should reflect an earnest desire to improve the life expectancies and well-being of people the world over, working in partnership for lasting change.

Conclusion

The American people are generous, and their efforts have built bridges, even in troubled times, between the United States and the impoverished, neediest populations of the world. The United States can, indeed must, maintain its firm commitment to this mission. And the nation must resolve to meet the challenges of health, poverty, underdevelopment, and instability with a stronger, more coherent foreign assistance strategic perspective, backed by a reorganized assistance infrastructure that is evidence-based and led by the White House.

The United States can succeed on all counts.

The United States faces seemingly overwhelming economic, national security, and domestic problems that will persist for the duration of the 111th Congress, and possibly the entirety of President Barack Obama's term in the White House. Against this backdrop, the foreign assistance budget, fragmentation, and strategic confusion could easily be overlooked.

That would be a tragedy.

America needs a new face in the world, and in return the world needs calm, stability, and hope for long, healthy, productive lives. Strategically inspired, well-coordinated foreign assistance efforts can bring America a new seat at the international table. Muddling along with foreign assistance business as usual is a recipe for failure and fiscal waste. Moving forward with generous support and strong leadership, guiding a bold strategic vision of why and how America engages in the world, is the right thing to do. Whether it is about prolonging lives with anti-HIV medicines, protecting infants with vital vaccines, building economic capacity with roads and bridges for transport of goods, or preparing the children of today to be the leaders of their communities tomorrow—these are America's challenges.

The United States can, should, and will meet them.

Endnotes

1. *Beyond Assistance: Report on Foreign Assistance Reform (*Washington, DC: HELP Commission, 2007); *Commission on Smart Power* (Washington, DC: Center for Strategic and International Studies, 2007); Richard G. Lugar, *Embassies Grapple to Guide Foreign Aid Embassies Grapple to Guide Foreign Aid: A Report to Members of the Committee on Foreign Relations, United States Senate* (Washington, DC, November 16, 2007); Robert Andrews and Mark Kirk, co-chairs; J. Stephen Morrison and Kathleen Hicks, project directors, *Integrating 21st Century Development and Security Assistance: Final Report of the Task Force on Nontraditional Security Assistance* (Washington, DC,*:* Center for Strategic and International Studies, 2008); Jeremy M. Weinstein, John Edward Porter, and Stuart E. Eizenstat*, On the Brink: Commission on Weak States and US National Security* (Washington, DC*:* Center for Global Development, 2004); Lael Brainard, ed., *Security by Other Means,* (Washington, DC: The Brookings Institution*,* 2006); Modernizing Foreign Assistance Network *, New Day, New Way: U.S. Foreign Assistance for the 21st Century* (Washington, DC*:* Center for Global Development, 2008; Carol Lancaster, *George Bush's Foreign Aid: Transformation or Chaos?* (Washington, DC*:* Center For Global Development, 2008); U.S. Coalition for Child Survival, *Presidential Transition 2009: U.S. Foreign Assistance and Support for Child Survival Health* (Washington, DC*,* December 2008); *Foreign Assistance Briefing Book* (Washington, DC: InterAction*,* 2008).

2. The original 1961 language of the Foreign Assistance Act further states, "United States development cooperation policy should emphasize five principal goals: (1) the alleviation of the worst physical manifestations of poverty among the world's poor majority; (2) the promotion of conditions enabling developing countries to achieve self-sustaining economic growth with equitable distribution of benefits; (3) the encouragement of development processes in which individual civil and economic rights are respected and enhanced; (4) the integration of the developing countries into an open and equitable international economic system; and (5) the promotion of good governance through combating corruption and improving transparency and accountability. The Congress declares that pursuit of these goals requires that development concerns be fully reflected in United States foreign policy and that United States development resources be effectively and efficiently utilized."

3. In the 1961 Foreign Assistance Act, the following language directly stipulates global health efforts:

"Sec. 104. Population and Health:

(a) FINDINGS—The Congress recognizes that poor health conditions and uncontrolled population growth can vitiate otherwise successful development efforts. Large families in developing countries are the result of complex social and economic factors which change relatively slowly among the poor majority least affected by economic progress, as well as the result of a lack of effective birth control. Therefore, effective family planning depends upon economic and social change as well as the delivery of services and is often a matter of political and religious sensitivity. While every country has the right to determine its own policies with respect to population growth, voluntary population planning programs can make a substantial contribution to economic development, higher living standards, and improved health and nutrition. Good health conditions are a principal element in improved quality of life and contribute to the individual's capacity to participate in the development process, while poor health and debilitating disease can limit productivity.

(b) ASSISTANCE FOR POPULATION PLANNING—In order to increase the opportunities and motivation for family planning and to reduce the rate of population growth, the President is authorized to furnish assistance, on such terms and conditions as he may determine, for voluntary population planning. In addition to the provision of family planning information and services, including also information and services which relate to and support natural family planning methods, and the conduct of directly relevant demographic research, population planning programs shall emphasize motivation for small families.

(c) ASSISTANCE FOR HEALTH AND DISEASE PREVENTION—(1) In order to contribute to improvements in the health of the greatest number of poor people in developing countries, the President is authorized to furnish assistance, on such terms and conditions as he may determine, for health programs. Assistance under this sub-section shall be used primarily for basic integrated health services, safe water and sanitation, disease prevention and control, and related health planning and research. The assistance shall emphasize self-sustaining community-based health programs by means such as training of health auxiliary and other appropriate personnel, support for the establishment and evaluation of projects that can be replicated on a broader scale, measures to improve management of health programs, and other services and suppliers to support health and disease prevention programs.

(2) (A) In carrying out the purposes of this subsection, the President shall promote, encourage, and undertake activities de-signed to deal directly with the special health needs of children and mothers. Such activities should utilize simple, available technologies which can

significantly reduce childhood mortality, such as improved and expanded immunization programs, oral rehydration to combat diarrheal diseases, and education programs aimed at improving nutrition and sanitation and at promoting child spacing."

4. *Building Public-Private Partnerships to Invest in Infrastructure* (Washington, DC: World Bank, 2008), http://web.worldbank.org/WBSITE/EXTERNAL/NEWS/0,,contentMDK:21935582~pagePK:34370~piPK:34424~theSitePK:4607,00.html.

5. "Global Financial Crisis Could Hamper Uganda's Fight Against HIV/AIDS, Officials Say," IRIN, October 27, 2008.

6. Lorne Craner, Bill Frist, Kenneth Hackett and Alan Patricof, "U.S. Aid Should Be Earned," *New York Times*, December 20, 2008.

7. It has been suggested that one way to calculate the risks for humanitarian and public health players is with an algorithm dubbed DWI, for Dirty War Index.

$$\text{DWI} = \frac{\text{Number of "dirty," i.e., undesirable or prohibited, cases*}}{\text{Total number of cases}} \times 100$$

*Cases are defined as death, injuries, and actions that violate the Geneva Accords.

Madelyn Hsiao-Rei Hicks and Michael Spagat, "The Dirty War Index: A Public Health and Human Rights Tool for Examining and Monitoring Armed Conflict Outcomes," *PLOS Medicine*, Vol 5: 12:e243, December 2008.

8. For detailed recommendations on how U.S. food policy could better build resiliency in poor countries and decrease dependency, see "IFPRI's Action Plan for the Food Price Crisis," http://www.ifpri.org/themes/foodprices/foodprices.asp, and Laurie Garrett, "Food Failures and Futures," Council on Foreign Relations Press, May 2008, http://www.cfr.org/publication/16289/food_failures_and_futures.html.

9. Joachim von Braun, "Rising Food Prices: What Should Be Done?" IFPRI Policy Brief, April 2008, http://www.ifpri.org/pubs/bp/bp001.asp.

10. "US Action Plan on Harmonization," http://www.oecd.org/dataoecd/23/26/30094584.pdf.

11. "DACref_Reference Total Net ODA," OECD, http://stats.oecd.org/wbos/Index.aspx?DatasetCode=REF_TOTALODA.

12. The World Bank Group, Africa Region, *Findings: Health Expenditures, Services and Outcomes in Africa*, Findings No. 157, (Washington, DC: World Bank, 2000).

13. Marty Makinen, "Health Financing in Sub-Saharan Africa 2007," Abt Associates. Inc., February 28, 2007, http://www.wilsoncenter.org/events/docs/Makinen.pdf.

14. For example, the Global Business Coalition to Fight AIDS, Tuberculosis and Malaria (GBC) has 220 members, most of which rank among the top 500 corporations in the world. In the GBC mission statement are these words: "Public-sector agencies cannot win the fight alone. They want and need businesses' partnership. The fight can only be won with active and focused application of business infrastructure, skills, and brand power. So our role must—and does—go well beyond providing financial support."

15. "Global Fund Disbursements by Region, Country and Grant Agreement (in USD equivalents)," The Global Fund, http://www.theglobalfund.org/en/files/disbursementdetails.pdf.

16. "Latest Results: March 2008," The United States President's Emergency Plan for AIDS Relief, http://www.pepfar.gov/about/c19785.htm.

17. "World Malaria Report 2008," World Health Organization, http://malaria.who.int/wmr2008.

18. "Trends in aid to health 1973-2006," OECD, October 2008, www.oecd.org/dac/stats/health.

19. "The Data Report 2008," http://www.one.org/report/en/execSummary.html.

20. "Launching report by mdg gap task force, Secretary-General underscores need for quantitative, qualitative shift in efforts to halve extreme poverty," UN News Centre, Department of Public Information, News, and Media Division, September 4, 2008, http://www.un.org/News/Press/docs/2008/sgsm11777.doc.htm.

21. "2007 ODA," OECD, April 2008, http://www.oecd.org/document/37/0,3343,en_2649_33721_40385189_1_1_1_1,00.html.

22. World Bank. "World Bank Group Boosts Support for Developing Countries," November 11, 2008, http://web.worldbank.org/WBSITE/EXTERNAL/NEWS/0,,contentMDK:21973077~pagePK:34370~piPK:34424~theSitePK:4607,00.html.

23. "UK Keeps Aid Promises to the World's Poor," UK in the USA: Foreign and Commonwealth Office, October 2008, http://ukinusa.fco.gov.
uk/en/newsroom/?view=News&id=6831836.

24. German officials auction CO_2 credits and will direct 225 million euros from those sales in 2009 to overseas development programs.

25. Elena Polidori, "Bono accusa: con la manovra meno aiuti ai paesi poveri," *La Republica*, July 2008, http://www.repubblica.it/2008/07/sezioni/economia/conti-pubblici-76/bono-accusa/bono-accusa.html.

26. "OECD calls for Aid Pledge from donor countries," OECD, October 30, 2008, http://www.oecd.org/home/0,3305,en_2649_201185_1_1_1_1_1,00.html.

27. Ibid.

28. David Roodman, "2008 Commitment to Development Index" (Washington, DC: Center for Global Development, 2008), http://www.cgdev.org/content/article/detail/1387273.

29. Ambassador John J. Danilovich, "Why Fight Global Poverty," *Huffington Post*, October 23, 2008, http://www.huffingtonpost.com/amb-john-j-danilovich/why-fight-global-poverty_b_137357.html.

30. The ONE Campaign is a nonpartisan effort that seeks to raise public awareness about the issues of global poverty, hunger, disease, and efforts to fight such problems in developing countries, http://www.one.org.
31. Paul Collier, *The Bottom Billion: Why the Poorest Countries are Failing and What Can be Done about It* (London: Oxford University Press, 2007).
32. World Vision, the largest faith-based organization dedicated to foreign assistance, makes this clear in its mission statement: "World Vision is an international partnership of Christians whose mission is to follow our Lord and Saviour Jesus Christ in working with the poor and oppressed to promote human transformation, seek justice and bear witness to the good news of the Kingdom of God."
33. The General Accounting Office recently identified pandemic preparedness, disease surveillance and food safety as issues among the top thirteen items requiring immediate attention from the Obama Administration. See: http//www.gao.gov/transition_2009.
34. "Global Trends 2025: A Transformed World," National Intelligence Council (Washington, DC: Government Printing Office, 2008), p. 23.
35. Ibid, p. 75.
36. "Shared Destinies: Security in a globalized world," IPPR Commission on National Security in the 21st Century (London: Institute of Public Policy Research, 2008).
37. Karen Monaghan, "Strategic Implications of Global Health" (Washington, DC: National Intelligence Council, 2008).
38. Kofi Annan, "The Way Forward," *International Herald Tribune*, November 16, 2008.
39. Kevin Cahill, *Preventive Diplomacy: Stopping Wars Before They Start* (New York: Routledge, 2000).
40. J. Brian Atwood, M. Peter McPherson, and Andrew Natsios, "Arrested Development: Making Foreign Aid a More Effective Tool," *Foreign Affairs*, November/December 2008.
41. Ibid.
42. President's Emergency Plan for AIDS Relief (PEPFAR), President's Malaria Initiative (PMI), Millennium Challenge Corporation (MCC), integration of planning and budgeting by the U.S. Agency for Development (USAID) and the Department of State, and increasing prominence of the Department of Defense (DOD) in providing economic assistance.
43. "U.S. Overseas Loans and Grants (Greenbook)," USAID, http://qesdb.usaid.gov/gbk/index.html.
44. "Debt relief is down: Other ODA raises slightly," OECD, April 2007, http://www.oecd.org/dataoecd/27/55/40381862.pdf.
45. "The United States: Development Assistance Committee Peer Review," OECD, 2006, http://dec.usaid.gov/index.cfm?p=search.getCitation&CFID=4408&CFTOKEN=68197454&id=s_7AFA08A2-D566-FC5C-D2432C406FF99F6F&rec_no=145003.
46. Carol Lancaster, *George Bush's Foreign Aid: Transformation or Chaos*? (Washington, DC: Center for Global Development, 2008).
47. The State Department argued that this shift from DAA to ESF was just a bookkeeping exercise. Stewart Patrick, Sheila Herrling, and Sami Bazzi, "Billions for War, Pennies for the Poor" (Washington DC: Center for Global Development, 2007).
48. Tiaji Salaam-Blyther, "Trends in U.S. Global AIDS Spending: FY2000-FY2007" (Washington, DC: CRS Reports for Congress, 2006).
49. "U.S. Overseas Loans and Grants (Greenbook)," USAID, http://qesdb.usaid.gov/gbk/index.html.
50. The five strategic objectives are: peace and security, governing justly and democratically, investing in people, economic growth, and humanitarian assistance. http://www.state.gov/documents/organization/88433.pdf.
51. Mead Over, "Prevention Failure: The Ballooning Entitlement Burden of U.S. Global AIDS Treatment Spending and What to Do About It," Working Paper 144 (Washington, DC: Center for Global Development, 2008), http://www.cgdev.org/content/publications/detail/15973.
52. Nandini Oomman, Michael Bernstein, Steven Rosenzweig, "Following the Funding for HIV/AIDS," Center for Global Development, October 10, 2007, www.cgdev.org/files/14569_file_FollowingFunding.pdf.
53. "Congressional Budget Justification: Foreign Operations, Fiscal Year 2009," U.S. State Department, 2008, http://www.usaid.gov/policy/budget/cbj2009/101368.pdf.
54. Gareth Evans, *The Responsibility to Protect: Ending Mass Atrocity Crimes Once and for All* (Washington DC: The Brookings Institution Press, 2008).
55. Paul Collier, *The Bottom Billion: Why the Poorest Countries Are Failing and What We Can Be Done About It* (London: Oxford University Press, 2008).
56. William Easterly, "Foreign Aid Goes Military!" *New York Review of Books*, December 4, 2008, pp. 51–54.
57. Anthony C. Zinni and Leighton W. Smith Jr., "A Smarter Weapon," *USA Today*, March 27, 2008, http://blogs.usatoday.com/oped/2008/03/a-smarter-weapo.html.
58. Miriam Pemberton and Lawrence Korb, "U.S. Should Boost Nonmilitary Security: Foreign Aid, Diplomacy, Key to Strategic Success," *Defense News*, September 29, 2008, http://www.defensenews.com/story.php?i=3746181.
59. Representative Robert Andrews and Representative Mark Kirk, "Integrating 21st Century Development and Security Assistance" (Washington, DC: Center for Strategic and International Studies, 2008).
60. Committee on International Relations' Committee on Foreign Relations, *Legislation on Foreign Relations Through 2002: Foreign Assistance Act of 1961* (P.L. 87–195) , Volume I–A, Current Legislation and Related Executive Orders, U.S. House of Representatives, http://www.usaid.gov/policy/ads/faa.pdf.

61. "The Development Effectiveness of Food Aid: Does Tying Matter?" OECD, 2005.
62. Alan Bjerga, "Dead Children Linked to Aid Policy in Africa Favoring Americans," *Bloomberg News*, December 8, 2008.
63. Alex Renton. "How America is betraying the hungry children of Africa," *The Guardian,* May 27, 2007, http://www.guardian.co.uk/lifeandstyle/2007/may/27/foodanddrink.features.
64. Such as the GAVI Alliance or multi-stakeholder governance structures like the Global Fund to Fight AIDS, Tuberculosis and Malaria or the International Health Partnership, among others.
65. According to the OECD, "The Paris Declaration, endorsed on 2 March 2005, is an international agreement to which over one hundred Ministers, Heads of Agencies and other Senior Officials adhered and committed their countries and organisations to continue to increase efforts in harmonisation, alignment and managing aid for results with a set of monitorable actions and indicators," http://www.oecd.org/document/18/0,2340,en_2649_3236398_35401554_1_1_1_1,00.html.
66. "The U.S. Commitment to Global Health: Recommendations for the New Administration," Institute of Medicine, December 15, 2008, http://www.iom.edu/CMS/3783/51303/60714.aspx.
67. Ruth Levine and the What Works Working Group, with Molly Kinder, *Millions Saved: Proven Successes in Global Health* (Washington, DC: Center for Global Development, November 2004), http://www.cgdev.org/content/publications/detail/2840.
68. "The U.S. Commitment to Global Health: Recommendations for the New Administration" Institute of Medicine, December 15, 2008, http://www.iom.edu/CMS/3783/51303/60714.aspx.

About the Author

Laurie A. Garrett is senior fellow for global health at the Council on Foreign Relations. Ms. Garrett was the president of the National Association of Science Writers during the mid-1990s. She is the only writer ever to have been awarded all three of the Big "Ps" of journalism: the Peabody, the Polk, and the Pulitzer, and she has been honored with two doctorates in humane letters honoris causa, from Weslayan Illinois University and the University of Massachusetts, Lowell. Her expertise includes global health systems, chronic and infectious diseases, and bioterrorism. Ms. Garrett is the best-selling author of *The Coming Plague: Newly Emerging Diseases in a World Out of Balance* and *Betrayal of Trust: The Collapse of Global Public Health*. She is also author of the recent CFR Working Paper *Food Failures and Futures.* She lives in Brooklyn, New York.

Advisers

Daniella Ballou-Aares
Dalberg Global Development Advisors

Seth Berkley
International AIDS Vaccine Initiative

Donna J. Barry
Partners In Health

Kevin M. Cahill
Center for International Health and Cooperation

Nils Daulaire
Global Health Council

David Fidler
Center on American and Global Security,
Indiana University School of Law

Robert Hecht
Results for Development Institute

Brett House
United Nations Development Program

Thomas E. Novotny
Joint San Diego State University|UC San Diego
Program in Global Health

George E. Rupp
International Rescue Committee

Stewart Patrick
Council on Foreign Relations

Jeffrey L. Sturchio
Corporate Council on Africa

Note: This report reflects the judgments and recommendations of the author. It does not necessarily represent the views of its advisers or participants, whose involvement in no way should be interpreted as an endorsement of the report by either themselves or the organizations with which they are affiliated.

Initiative Participants

Obijiofor Aginam
United Nations University

Daniella Ballou-Aares,
Dalberg Global Development Advisors

Seth Berkley
International AIDS Vaccine Initiative

Andrew Barrer
US Coalition for Child Survival

Donna J. Barry
Partners In Health

Shellie Bressler
Senate Foreign Relations Committee

Reuben E. Brigety II

Colonel John S. Clark Jr., USAF
Council on Foreign Relations

Paul F. Clayman
APCO Worldwide

Isobel Coleman
Council on Foreign Relations

Nils Daulaire
Global Health Council

Laura Efros
Merck & Co., Inc.

Mark Feinberg
Merck & Co., Inc.

Andras Forgacs
Richmond Management LLC

Adrienne Germain
International Women's Health Coalition

Jeffrey D. Gilbert
International Affairs, Pfizer Inc.

Lawrence O. Gostin
Georgetown University Law Center

Paul Grove
Senate Appropriations Committee

Melanie Havelin
John M. Lloyd Foundation

Margaret A. Hamburg
Nuclear Threat Initiative

Judith Helzner
John D. and Catherine T. MacArthur Foundation

Kent Hill
U.S. Agency for International Development

J. Anthony Holmes
Council on Foreign Relations

Omer Imtiazuddin
Acumen Fund

Colonel Jay Kennedy, USMC
Council on Foreign Relations

Rihanna Kola
Merck & Co., Inc.

Carol Lancaster
School of Foreign Service, Georgetown University

Heidi Larson
aids2031 and Clark University

Craig Lasher
Population Action International

Ruth Levine
Center for Global Development

Jacob Lew
Citi Alternative Investments

Cynthia Lewis
Bill & Melinda Gates Foundation

Charles MacCormack
Save the Children

Nancy Mahon
MAC AIDS Fund

Sebastian Mallaby
Council on Foreign Relations

Susan McCue
Message Inc.

Lisa Meadowcroft
AMREF USA

Paul Meyer
Voxiva

Fitzhugh Mullan
George Washington University

Thomas E. Novotny
Joint San Diego State University/UC San Diego Program in Global Health

Raymond C. Offenheiser
Oxfam America

Victoria Obst
Dalberg-Global Development Advisors

Stewart M. Patrick
Council on Foreign Relations

Carol Peasley
Centre for Development and Population Activities

Steven C. Phillips
Exxon Mobil Corporation

Elizabeth Pisani
Scientist and Author

Jennie Quick
PSI

Jonathan D. Quick
Management Sciences for Health

Miriam Rabkin
Mailman School of Public Health, Columbia University

Gordon Raley
Family Health International

Anne C. Richard
International Rescue Committee

Scott Rosenstein
Eurasia Group

Jonathan Scanlon
Oxfam

Kammerle Schneider
Council on Foreign Relations

Mike Shannon
ViaNovo

Gayle Smith
Center for American Progress

Ann M. Starrs
Family Care International

Jeffrey L. Sturchio
Corporate Council on Africa

John E. Tedstrom
Global Business Coalition on HIV/AIDS, Tuberculosis and Malaria

Noam Unger
The Brookings Institution

Ronald Waldman
Mailman School of Public Health, Columbia University

Tom Walsh
The President's Emergency Plan for AIDS Relief

Elizabeth Williams
John Snow International, Liberia

Sam Worthington
InterAction

Michele Wymer
Senate Appropriations Committee