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BUREAU FOR GLOBAL HEALTH: CROSS-BUREAU BUDGET ANALYSIS – FINAL REPORT

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BUREAU FOR GLOBAL HEALTH: CROSS-BUREAU BUDGET ANALYSIS

FINAL REPORT

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ACRONYMS

AA	Assistant Administrators
AOR/COR	Agreement Officer Representative/Contracts Officer Representative
CB	Cross-Bureau
CBB	Cross-Bureau Budget
CII	Center for Innovation and Impact
CT	Country Teams
DAA	Deputy Assistant Administrator
DHI	Digital Health Initiative
DHS	Demographic and Health Survey
FO	Front Office
FY	Fiscal Year
GH	Bureau for Global Health
GHFP	Global Health Fellows Program
GHSI	Global Health Support Initiatives
GHTP	Global Health Technical Professionals
HCTM	Office of Human Capital and Talent Management
HSS	Health Systems Strengthening
ID	Office of Infectious Disease
MCHN	Office of Maternal and Child Health and Nutrition
MECap	Monitoring and Evaluation Capacities
OCS	Office of Country Support
OE	Operating Expense
OHA	Office of HIV/AIDS
OHS	Office of Health Systems
PDMS	Office of Professional Development and Management Support
PEPFAR	President's Emergency Plan for HIV/AIDS Relief
PMI	President's Malaria Initiative
PRH	Office of Population and Reproductive Health
P3	Office of Policy, Programs and Planning
SBC	Social and Behavior Change
SMT	Senior Management Team
STAR	Sustaining Technical and Analytical Resources Project

1. EXECUTIVE SUMMARY

BACKGROUND

The Bureau for Global Health's (GH's) cross-bureau budget (CBB) allocates funds to activities that support the achievement of the goals of the Bureau and Agency as a whole, and whose results cannot be directly attributed to one or more specific Health Program Areas as identified in the Foreign Assistance Standardized Program Structure and Definitions (SPSD), which include: HIV/AIDs, Tuberculosis, Malaria, Global Health Security in Development, Other Public Health Threats, Maternal and Child Health, Family Planning and Reproductive Health, and Nutrition. As currently conceived, the CBB is divided into four major components: Mechanisms, Staff, Office Allocations, and Operations.

In light of recent funding constraints, including a reduction in the contributions to the CBB under the President's Emergency Plan for AIDS Relief (PEPFAR) and the President's Malaria Initiative (PMI), this assessment's primary objectives were: 1) to review how the CBB is currently formulated and executed; 2) to document what is included in the CBB; and 3) to provide recommendations to:

- Rationalize priorities for cross-bureau funding;
- Reduce the demand for cross-bureau funding;
- Increase fairness and transparency in how and why program area offices contribute to cross-bureau mechanisms, staffing, offices, and operations;
- Improve performance/impact of CBB-funded activities relative to Agency and Bureau priorities; and
- Maximize responsiveness of the CBB-funded activities to the field.

The assessment is not a performance evaluation of any office, staff, or mechanism. The findings and recommendations are based on a comprehensive desk review of documents provided by GH leadership and interviews with approximately 70 key staff at the decision-making and operational levels in GH and regional Bureaus. An online survey of senior staff in field missions also provided important insights.

HOW THE CBB IS FORMULATED AND EXECUTED

This assessment reviewed the formulation and execution of GH's CBB in order to recommend improvements in the process aimed at ensuring that the Bureau remains responsive and optimally contributes to current and emerging Administration, Agency, and GH priorities. In doing so, the assessment team dealt with two competing realities: the shrinking pool of funds for the CBB and the dramatically increased demand for programs that support the Agency's "journey to self-reliance," many of which are funded through the CBB.

Since the Congressional appropriations to GH are highly directed to specific health interventions (or program areas), the Bureau created an internal system to "tax" the program area directives to generate funds for administrative support costs and for cross-cutting health activities ("global common goods"). This system is somewhat contentious within GH and not entirely transparent. This assessment team recommends steps both to increase the supply of funds for the CBB and to reduce demand, while also improving transparency and accountability. The assessment team also found issues with how decisions are made on what to include in the CBB. Different components of the CBB are treated differently; there are

no clear priorities for determining CBB investments; and not all aspects of the CBB formulation and review process are transparent.

Major Recommendations for CBB Formulation

- Review the Budget's International Partnership line items to determine if fewer deductions can be made, thus increasing the "adjusted" base that is used for CBB taxation purposes and enabling adjustments to current allocation rates (all "pass throughs" to other organizations would continue to be deducted);
- Increase the surcharges on all mechanisms to cover central costs to the greatest extent feasible;
- Encourage direct (including partial) funding of positions in administrative support offices by program area offices;
- Formulate a Bureau-wide strategy that creates a unifying framework for GH that goes beyond its current three health goals, using it to define specific criteria to evaluate proposals for CBB funding;
- Institute a more rigorous CBB review process, and ensure broader participation on uniform basis; and
- Re-structure the CBB to clearly differentiate between administrative support and program costs.

Major Recommendations for CBB Execution

The team found fewer issues concerning execution of the CBB, although it did identify several steps that would improve Bureau monitoring and accountability of CBB funding flows and results:

- Ensure that the CBB and cross-cutting activities are appropriately covered during annual portfolio reviews and that commitments to the CBB are made by program area offices; and
- If internal "fixes" within GH cannot be developed, work with the Agency to determine if "fixes" can be made to the Phoenix accounting system to better handle the late allocation and bundling of CBB funds with non-CBB program area funds.

The assessment also reviewed three GH-prepared scenarios on how to reduce its pending FY18 $50 million CBB and recommends more targeted cuts as outlined in Section IV of this report.

WHAT IS IN THE CBB

The assessment examined individual components of the CBB, identifying those that are of highest value, as well as redundancies and gaps. Most staffing mechanisms and support mechanisms received high marks in terms of value-added across the Bureau and in the field, as did some program mechanisms such as the Demographic and Health Survey (DHS). Redundancies were identified in health systems strengthening; professional development and capacity-building, including training and e-learning; and evaluation activities. Even though there were redundancies in health systems strengthening work, there were also gaps, including areas such as data management and use. Concerns were also expressed about the flexibility of some staffing mechanisms.

With severely limited time for the assessment, the team did quick reviews of the CBB-funded offices, devoting greatest attention to the Office of Country Support (OCS), the Office of Health Systems (OHS), and the Center for Innovation and Impact (CII). Looking initially at OCS, the office is highly valued by the field and many staff in GH, but there are uncertainties about its scope and role, especially since some GH program areas and regional Bureau offices also have staff with well-defined country support functions.

Major Recommendations for What is Included in the CBB

- Rationalize and more clearly define objectives and expected results from the CBB-funded administrative support mechanisms and consolidate their management in support offices;
- Ensure broader senior management input to the design of support and program mechanisms;
- Review best practices in cross-bureau program management from the *Global Health Fellows Program* (e.g., relating to flexibility and professional development) and apply to other staffing mechanisms;
- Clarify the scope and mandate of OCS and analyze its staffing levels considering the possible transfers of regional bureau health officers into GH as part of the Agency *Transformation*; and
- Tailor OCS's country team (CT) approach and composition to individual country circumstances, while also expanding Front Office support to ensure appropriate role and recognition of CT staff.

MID- TO LONG-TERM STRATEGIC APPROACH AND RECOMMENDATIONS

Much of the assessment was devoted to generating recommendations arising from a review of the current CBB composition, formulation, and execution processes. However, the mid- to long-term need to reconcile the increased demand for health systems strengthening (HSS) and other financial and capacity building efforts with a shrinking CBB was equally urgent. The CBB currently provides $10.5 million a year to OHS and $3.8 million to CII. These levels, even recognizing the other complementary HSS investments by the element offices, are not sufficient to have significant impact.

The team believes that GH needs to adopt a different approach to expand and better integrate its HSS portfolio. Our analysis led us to propose a strategic framework for CBB investments in cross-cutting "global common goods." This approach builds on observed best practices in GH, including how the cross-cutting Social and Behavior Change and Research portfolios have institutionalized strong teamwork across element offices. Both are currently led by Front Office senior advisors.

Major Mid- to Long-Term Recommendations (As Part of GH Transformation Process)

- Consolidate program/technical activities in program mechanisms and manage these in health program area offices, including mechanisms currently managed by OHS and CII; and
- Create a Center of Excellence in Front Office to absorb functions of OHS and CII and of other senior advisors currently located in the FO – providing bureau-wide technical leadership and strategic coordination across the GH Bureau in HSS, innovation, social and behavior change (SBC), research, digital health, partnerships, and other cross-cutting strategic approaches.

The team's intent in providing its recommendations is to build flexibility and efficiency into GH mechanisms, staffing, and operations such that they are "fit for purpose" given potential shifts in funding, priorities, and structures. In putting forth these recommendations, we acknowledge they raise critical questions to be addressed by GH leadership, especially in terms of how and when to implement changes and how best to communicate these decisions to Agency and GH staff worldwide. While recommending this relatively significant change in how GH approaches its CBB – and most importantly its approach to health systems strengthening – the team recognizes that change is difficult and other options exist.

II. BACKGROUND

OBJECTIVES AND METHODOLOGY OF ASSESSMENT

In light of recent reductions in the level of contributions to the Global Health Bureau's CBB, the Bureau contracted with Integra, LLC under the LEAP III contract to conduct an assessment of the CBB process. The assessment was to review the formulation and execution of the CBB in order to improve the process and to ensure that the Bureau will remain responsive to and contribute to current and emerging Administration, Agency, and GH Bureau priorities.

In particular, the assessment will examine and provide recommendations related to the below objectives:

- Rationalize priorities for cross-bureau funding;
- Reduce demand for cross-bureau funding;
- Increase fairness and transparency in how and why element offices contribute to cross-bureau mechanisms, staffing, offices, and operations;
- Improve performance/impact of CBB-funded activities relative to Agency and Bureau priorities; and
- Maximize responsiveness of CBB-funded activities to the field.

The assessment was not a performance evaluation of any office, staff, or mechanism. It was conducted over a four-week period and involved extensive review of documentation, interviews with GH staff and regional bureau health backstop officers, and a survey of health officers in the field. Given the short period of review and the wealth of data to absorb, the team recognizes the limitations in its knowledge of the complex issues and offers its recommendations with humility. See Annex 2 for an in-depth discussion of the assessment methodology.

III. CURRENT CONTEXT

A. GLOBAL HEALTH FUNDING TRENDS AND THE CROSS-BUREAU BUDGET

Building on longstanding global health directives and earmarks for maternal and child health, nutrition, family planning and reproductive health, PEPFAR and subsequent initiatives to fight malaria and other infectious diseases have led to annual USAID global health funding of $2.5 to $3 billion over the past decade. The GH Bureau has had direct management responsibility for a significant percentage of the total – as illustrated in Annex 3A. The funds, however, come with multiple challenges. First, they are directed or earmarked to eight health program areas: HIV/AIDS, Tuberculosis, Malaria, Global Health Security in Development, Other Public Health Threats, Maternal and Child Health, Family Planning and Reproductive Health, and Nutrition. Second, within each of these program areas, the Congress designates "core" (discretionary) funding and "international partnership" funding (tied to very specific activities or institutions). Over time, the proportion of core or discretionary funding has steadily decreased, e.g., from 48% in FY 2012 to 38 percent in FY 2018, leaving GH with almost no flexibility to meet crosscutting needs (Annex 4). Third, the authorizations for PEPFAR and PMI empower their respective Coordinators to set priorities for use of funds. Those priorities are driven by health outcome metrics and therefore limit the availability of these funding streams to cover broader GH Bureau priorities.

The GH Bureau recognized this dilemma years ago and created a bureau-wide funding source, now called the CBB, to finance "global common goods". Such common goods relate to activities in central mechanisms (e.g. DHS and MEASURE Evaluation) whose results support the entire Bureau or Agency and cannot meaningfully be attributed to one or more specific health program areas. Funding for the CBB was obtained by "taxing" the program area offices for contributions.

Over time, the CBB grew to cover expanding administrative support needs as well as new health sector priorities such as health systems strengthening and innovation, reaching an annual level of about $50 million – see Annex 3B. The FY 2018 CBB was prepared in June 2018 and approved at a level of $50,190,000. Subsequent to that review, PEPFAR and PMI indicated that they would be unable to contribute to the CBB at the levels being proposed for FY 2018. Those decisions prompted a short-term funding crisis and the request for this review.

An additional factor that has contributed to the current crisis is the low allocation of Operating Expense (OE) funding to GH in comparison to other pillar bureaus. This can be easily seen in multiple tables in Annex 5. If the GH Bureau were allocated its fair share of the Agency's OE account, there would be less demand for the CBB and less pressure to "tax" the program area office budgets.

B. AGENCY PRIORITIES AND THE CROSS-BUREAU BUDGET

New Agency priorities, especially the "journey to self-reliance" and its implicit focus on financial sustainability and host country institutional capacity, are having an important impact on the GH Bureau's work. While individual program area offices have always invested in system strengthening activities, they are increasingly doing so as a result of new Agency priorities. In addition, the "journey" has heightened the need for stronger health systems generally – and thus increased the demand for programs managed by OHS. This increased demand, however, comes at the same time there is less funding to support the

CBB – thereby creating the need to reassess the best approach to fund health systems strengthening activities.

The Agency has also moved forward on "transforming" its programs, processes, structure, and workforce. Programs will be transformed to focus more on strengthening in-country capacity, facilitating locally led development, supporting financial self-reliance, and working with new partners. Processes will be transformed to improve support for field programs and to maximize the impact of every taxpayer dollar. Structures will be adjusted to strengthen support to the field. The workforce will be given greater opportunity to thrive in and adapt to increasingly complex and challenging situations. Most parts of the Agency have already embarked on their "transformations." The GH Bureau is in the initial steps of doing so. The current crisis with the CBB gives the GH Bureau an opportunity to assess potential new ways of organizing itself to meet critical priorities.

IV. HOW THE CROSS-BUREAU BUDGET IS FORMULATED AND EXECUTED: MAJOR FINDINGS AND RECOMMENDATIONS

A. FORMULATION OF THE BUDGET

In looking at how the CBB is currently prepared, we focused on two major aspects of the formulation process: (1) determining the supply of funds for the CBB (the "taxation system"), and (2) reviewing and approving activities or components to be funded by the CBB (decision-making). The analysis in this section is based on interviews with GH staff and reviews of budget tables and other "working" documents used by Office of Policy, Programs and Planning (P3) in its formulation of the CBB.

B. TAXABLE BASE AND TAX RATES FOR THE CBB

I. "TAX" ON PROGRAM AREA BUDGETS

Most GH staff felt that the "taxation system" is not sufficiently transparent, especially since not all program area appropriations are "taxed" according to their share of the total GH budget. As shown in Annex 6, the annual appropriation bill designates funding for the GH Bureau in terms of "Core Budget" and "International Partnerships." The GH Bureau then determines an "adjusted budget" as the basis for determining CBB contributions, including the tax rate (the proportion of the adjusted program area budget to the total adjusted budget).

The adjusted budget is comprised of "core" funding for each program area (as defined in the appropriation); in addition, for some program areas, a portion (albeit small) of the International Partnerships line item is added to the "core." For example, of the $172,550,000 in the International Partnerships line items for Global Health Security and Other Public Health Threats, only $25,334,000 is counted in the "adjusted budget" and "taxed" as a contribution to the CBB. Since the ID Office is managing multiple instruments and programs, we do not believe that the untaxed portion is simply passed on to other organizations; it likely generates a burden on the GH Bureau. Similarly, smaller earmarks – such as for blind children and iodine deficiency – are deducted, thus reducing the total amount of the "adjusted budget." If there were fewer deductions made from the International Partnership line items, the base budget would be larger. This would make it possible to adjust tax rates applied to the individual program area offices and perhaps lead to a fairer taxation formula. Specifically, this would provide important relief to the MCH and Family Planning accounts, both of which have greater discretionary funding and are thus taxed at relatively high rates of 21.5 percent and 26.5 percent respectively (Annex 6).

II. "TAX" ON MECHANISMS

Several of the current mechanisms do an excellent job putting surcharges on buy-ins to ensure that all costs (overhead plus other central or "hoteling" requirements) are covered, thus eliminating the need for CBB funds – e.g., GH PRO and the staffing mechanisms, except for STAR, do cover all costs (GH PRO

through a 25 percent surcharge according to staff interviews). DHS-8 currently levies a 10 percent charge, but it still also requires CBB funding. Could the DHS-8 surcharge be increased to 15-20 percent without jeopardizing field mission demand for its valuable work? Similarly, could STAR and GH-POD be structured to cover more of their central costs through buy-ins from the field or element offices? We were told that predecessors to Breakthrough did not require CBB funds; the current Breakthrough mechanisms do – could those crosscutting costs be covered by a levy on buy-ins?

III. DIRECT FUNDING VS. CBB CONTRIBUTION

PEPFAR has directly funded a number of positions in the P3 and Office of Professional Development and Management Support (PDMS) offices, thus reducing demand on the CBB. Could they and perhaps PMI cover additional positions?

RECOMMENDATIONS: THE CBB TAXABLE BASE AND TAX RATE

- Review the Budget's International Partnership line items to determine if fewer deductions can be made, thus increasing the "adjusted" base that is used for CBB taxation purposes and enabling adjustments to current allocation rates. (All "pass throughs" to other organizations would continue to be deducted).
- Review all mechanisms to determine if levies could be added or increased to cover more central costs and reduce demand for CBB funding.
- Encourage PEPFAR and PMI to look for additional opportunities to direct fund (fully or partially) positions in support offices, e.g., for the Data Hub.

C. CBB STRUCTURE, APPLICATION, AND REVIEW PROCESS

As currently conceived, the CBB is divided into four major components: Mechanisms, Staff, Office Allocations, and Operations. Each is determined and reviewed differently. Mechanisms are reviewed by the Senior Management Team(SMT); Staffing is reviewed through a separate process not explicitly linked to the CBB process; Office Allocations to CII and the OHS are carved out; and Operations are also not reviewed formally.

The four CBB components do not clearly differentiate between administrative support and program costs – e.g., the Mechanisms component includes program instruments such as DHS-8 and Breakthrough along with administrative/support instruments such as GH-POD and Communications Support. In addition, CII and OHS are treated differently: all OHS costs (program and staffing) are included in their $10.5 million carveout in the Office Allocation component, while CII's program costs are in the Office Allocation component and its staffing in the Staff component. In order to provide greater clarity, we differentiated costs, treating CII and OHS similarly, and found that for the overall CBB, approximately $25.9 million is for administrative/support costs and $24.2 for program costs (Annex 7).

RECOMMENDATION

- Re-structure the CBB to delineate administrative support from program costs. See Annex 7 as an example of a template for the CBB, allowing a more transparent review of the entire budget.

Since only the Mechanism portion of the CBB has undergone a Bureau-wide review process, our observations on the process relate solely to it. While staff appreciated the increased transparency of those reviews over the past several years, many issues were identified. The annual guidance provides general criteria, but there is no real statement of priorities for the year. Most importantly, there are no clear, actionable criteria to aid decision-making. This lack of criteria is in part because there is no Bureau-wide strategy to provide a unifying framework for the three major health program area strategic priorities: preventing child and maternal deaths; controlling the HIV/AIDS epidemic; and combating infectious disease.

Because there is no stated prioritization with associated criteria, the process itself is insufficiently rigorous. This is exacerbated by the seeming reluctance of SMT members to say "no" to one another – e.g., in reviewing applications for FY 18, the only rejections we saw were for OHS proposals that were above their $10.5 million carve out. In addition, the review meetings themselves do not always include the right people or information, such as Agreement Officer Representatives/Contracts Officer Representatives (AORs/CORs) who have more detailed information on the proposed activities, including performance of the mechanism to date, pipelines, and the degree to which the field had input on the design of the proposed activity during the earlier Project Approval Document process. Although budget request forms are standardized, information in them is not, e.g., some break out core management costs; others do not. These shortcomings reduce the quality and rigor of discussion. Lastly, there are some communication challenges – e.g., in defining upfront a clear timeline for reviews and decision-making, and in communicating adjustments made to the CBB by the front office after it reviews the SMT's recommendations. This latter communication gap could be from the Front Office to the offices – or, equally likely, from the Office Directors to their staffs.

RECOMMENDATIONS

- Formulate a Bureau-wide strategy that creates a unifying framework for the Bureau as it seeks to achieve its child and maternal death, HIV/AIDS, and infectious disease targets – e.g., by articulating a common approach or vision toward stronger in-country capacity and/or greater integration of services.
- Formulate specific criteria to help evaluate what qualifies for CBB funding, whether programmatic or administrative/support in nature.
- Revise the CBB request forms to reflect new criteria and information on past performance, results, and pipelines; ensure uniform application of the revised forms.
- Enhance rigor of review process by encouraging open debate and transparency, and by ensuring that AORs/CORs are in the room to provide more detailed knowledge.
- Clarify the timeframe of the review and decision-making process and ensure decisions are adequately communicated down the line.

I. EXECUTION OF THE CBB

The CBB portfolio does not appear to be monitored or reviewed in its entirety, although some of the mechanisms are covered in the office portfolio reviews. The team was struck by the lack of uniformity in how information is presented in the overall portfolio reviews, and thus felt the reviews are less than completely helpful in making CBB (or other) decisions.

In monitoring the flow of funds, there appear to be major issues with the Phoenix accounting system, in part because of bundling of CBB and other element funds and in part because of timing issues. Most importantly, the CBB funds are often allocated late to the individual mechanisms– and the AORs/CORs will have used "other" funds for the original purpose of the CBB activity, backfilling when the CBB funds arrive. The team was assured by P3 that this does not present an audit risk, but it was equally clear that the AORs/CORs are nervous operating this way. This situation is further exacerbated because the program area offices are often late in allocating funds; there are even cases when they do not honor the commitment made to the CBB.

RECOMMENDATIONS

- Standardize portfolio reviews to ensure uniform reporting on staffing and finance for the entire GH portfolio, including reporting on usage of the CBB.
- Include the CBB portfolio in its entirety in the annual portfolio review, clustering similar activities as needed and ensuring that performance and pipelines are reviewed and factored into any new proposals.
- Consult with the Agency CFO to determine if changes can be made to the Phoenix accounting system to better accommodate the GH Bureau's needs and to clarify if legal issues exist.
- Ensure all AORs/CORs are given uniform guidance on how to manage funding flows, especially around the frequent delays in allocations.
- Quarterly, monitor funding allocations to the CBB to ensure that commitments are honored.

II. MANAGING THE SHORT-TERM CRISIS

Given likely reduced contributions to the CBB from PEPFAR and PMI, the GH Bureau will not be able to move forward on the approved FY 2018 CBB of $50,190,000. Cuts will need to be made. The team reviewed three scenarios prepared by P3, all of which hold staffing numbers at the proposed level. We believe that more targeted approaches can be taken to reduce the FY 18 CBB.

RECOMMENDATIONS

- Review the significant variation in vacancy rates among the CBB-funded offices to achieve targeted cost savings by not filling many of the vacant positions. Highest priority should be given to filling PDMS positions, as they have the highest vacancy rate in the Bureau - 43% vs. a range of 15-19% for the other CBB-funded offices such as P3, OCS, OHS, as per Staff Tracking Sheets (Annex 8). Expected savings: $2-2.5 million.
- Decrease the CBB contributions for the DHS-8 and Breakthrough mechanisms by adjusting budgets for buy-ins to include a larger surcharge. For example, either increase the surcharge for DHS-8 to 15- 20% and/or forge an agreement with the program area offices to pay directly for activities now in the CBB. The predecessor mechanisms for Breakthrough did not require CBB funding, clearly indicating that CBB funding should not be essential. Expected savings: $3-4 million.
- Since the GH-POD mechanism received mixed reviews from staff, cuts could most likely be made. Funds could then be focused on what GH-POD does best. Expected savings: $1 million.
- Encourage PMI and PEPFAR to directly fund more positions in the support offices.
- Review and evaluate Scenarios 1 and 3 (as prepared by P3) in the event further cuts in the CBB are needed. Both these scenarios recommend two levels of across-the-board percentage cuts. Any such cuts should be based in part on pipelines. Scenario 2 does not cut expenditures, but instead recommends increased "tax" rates for some offices. We believe that the proposal to increase the MCH "tax" to either 24.7% or 28.4% and the FP/RH "tax" to 30.5% or 35.2% is excessive.

V. WHAT IS INCLUDED IN THE CROSS-BUREAU BUDGET: MAJOR FINDINGS AND RECOMMENDATIONS

Building on the proposed reorganization of the CBB line items, this section summarizes major findings with respect to three FY2018 CBB components: support mechanisms, program implementation mechanisms, and OCS. For each component, short-term recommendations are presented. The principal data sources for this section's analyses are the FY18 CBB Mechanism Justifications, staff interviews, the field staff survey, the Bureau for GH Mission Survey 2017 Summary Report, the portfolio reviews, and the GH-POD II 2018 Needs Assessment Report.

A. INTERNAL OPERATIONAL/ADMINISTRATIVE SUPPORT MECHANISMS (ANNEX 7)

Staffing Mechanisms (Global Health Technical Professionals (GHTP), Sustaining Technical and Analytical Resources Project (STAR), Firehouse, Global Health Support Initiative (GHSI), Procurement Support)

Value: In general, these mechanisms provide high value and critical HR recruitment and deployment support, including for field offices. Interviewed staff employed under these mechanisms appreciate the professional development opportunities provided. Some respondents noted that the multiplicity of staffing mechanisms allowed for a degree of flexibility in terms of matching the mechanisms' mandate and scope to hiring managers' needs.

Redundancy: Staff are not clear about the scope of the various mechanisms in relation to one another. This is of particular relevance when one mechanism ends (e.g. Global Health Fellows Program (GHFP)) and new mechanisms are designed as follow-on.

Gaps and General Observations: There is concern that the current staffing mechanisms do not work well for recruitment of highly specialized expertise, such as statisticians and data analysts. This is partly due to the high competition for such expertise external to USAID. Internally, the mechanisms are not as flexible as is needed to recruit and retain senior experts, given limitations on promotions, onerous logistics and paperwork, limits on timeframe for employment (e.g. GHTP – one year and then must transition), and restrictions on who can be interviewed (e.g. one respondent stated that for GHSI, there is a restriction on recruiting candidates who have been out of the States for 3 years or more in the last 5 years.) Staffing mechanisms that are cooperative agreements (e.g. STAR) have greater flexibility than do the contract mechanisms. In some cases, such as STAR, the CBB also funds some programmatic activities. For GHSI, there is no CBB request for core "hoteling" costs, suggesting that staffing mechanisms could be structured in such a way as not to need cross-bureau funds for such overhead costs. Management of the staffing mechanisms is spread across offices (PDMS, Assistant Administrators (AA), Office of Population and Reproductive Health (PRH), OCS), and the line of coordination with PDMS is unclear.

Training and Professional Development Mechanisms (GH-POD II)

Value: There were mixed reviews about the quality and value of the cross-bureau funded activities. We were not able to do a systematic assessment of the relative value of the various activities in part because many staff were not aware of what they are, and because we had insufficient information about the rationale of and demand for the various activities in the CBB request. Respondents stated the activities are especially important for program-funded staff, as they have less access to Agency-wide Office of Human Capital and Talent Management (HCTM) programs. Additionally, senior staff noted that two GH-POD activities have particularly high value: i) support for GH's "Culture of Leadership" efforts, and ii) coaching of health sector staff. For additional recommendations on priorities for GH-POD, refer to the 2018 Internal Assessment of GH-POD Report.

Redundancies: Within the CBB, there are multiple requests to support training, eLearning, curriculum development and guidance, as well as general capacity building of USAID staff. It is not clear what should rightfully fall under GH-POD's CB-funded activities versus those of other mechanisms (e.g. GHTP, DHI, MECAP, Data Hub-GH Data) as well as under the various offices' program implementation mechanisms.

Evaluation and Knowledge Management Mechanisms (KMS II, MECap)

Value: It is difficult to define the specific mechanisms that belong under this "support" function since what is included in USAID program monitoring, evaluation, learning, and knowledge management is not well defined. In theory, all support mechanisms could justify cross-bureau funding for evaluation and learning, and many of them do. Some program implementation mechanisms also request cross-bureau funding for these purposes (e.g. K4Health). It is worth noting that GH PRO was consistently cited as providing high value for USAID program (central and field) activity assessments and evaluations. Thanks to its costing structure, GH PRO requests no cross-bureau funding.

Redundancies: As stated above, it is not clear what should be prioritized for the CBB across mechanisms, and staff are uncertain when to access MECap versus GH PRO versus other evaluation mechanisms in the Agency (e.g. PPL).

Data Management and Use Mechanisms (Data Hub – GH Data)

Value: The only support mechanism receiving cross-bureau funding in this category is the Data Hub. The Hub provides high value for data analytics for business intelligence, data literacy (data visualization and use), data management, and warehousing in response to some GH operating units and field mission requests. The Data Hub is also building data use capacity, principally through a cohort-based coaching and mentoring program of GH office staff resulting in data analytics certification. Additionally, the Data Hub has introduced cost efficiencies in centralizing software and licensing requests and in managing Agency databases.

Gaps and General Observations: The scope and priority mandate for the Data Hub is not well understood across GH and in the field. Office of HIV/AIDS (OHA) expressed concerns that they have not received the level of support requested, especially considering past CBB investments. It is not clear what the criteria are for cross-bureau investments in the Hub (e.g. staffing versus software and license procurement). There is also concern that offices and missions may be requesting support beyond the scope of the Hub, and that operating units are not covering the costs of services provided above and beyond the Hub's core mission.

SHORT-TERM RECOMMENDATIONS

- For all support mechanisms: rationalize and clearly define scope, objectives, and results expected.
- Educate GH staff concerning the above, including what services are provided with CB funding.
- Involve senior management staff from all offices (or their designees) in the design of support mechanisms so there is consensus reached on what justifies CB funding and how mechanisms complement or add value to other mechanisms in the GH Bureau or Agency.
- Review best practices in *GHFP* management structure and processes and apply to other support mechanisms, as feasible given constraints for contracts vs. cooperative agreements.
- Consolidate the management of support mechanisms in support offices.

B. PROGRAM IMPLEMENTATION MECHANISMS (SEE ANNEX 7)

Value: It was widely recognized both in Washington and the field that the DHS is among the most highly valued mechanisms offered by GH. It is well understood what activities under the DHS are true public goods, and there is broad support to protect USAID's past investments in the DHS, although PEPFAR has determined that it will not invest in the DHS moving forward. As the GH flagship activity for the HIS component of health systems, MEASURE Evaluation was cited as having high value. Across the board, health financing and social behavior change (including human-centered design) mechanisms and expertise are in high demand.

Redundancies: There are three main areas of confusion and/or redundancy. The first is in HSS, writ large. Mechanisms for the individual HSS components (financing, human resources, governance, pharmaceutical management, and information) reside in program area offices, CII, as well as in OHS. Second, in terms of *evaluation* mechanisms (external to USAID programs), there is a lack of clarity and some redundancy between the scope and mandate of MEASURE Evaluation and those mechanisms funding research, impact evaluations, or implementation science within specific offices – such as Breakthrough-Research and Data for Impact. It is assumed that some of the CBB program mechanisms in OHS also implement evaluation activities. A third area of redundancy is in *digital health* (DHI – digital Square) and other *data/information* mechanisms. Staff, especially in the program area offices, are unclear what the CBB supports and what returns on program area investments accrue to them.

Gaps and General Observations: The highest demand for programmatic technical assistance and mechanisms is in the area of HSS, most notably expressed by the field and regional health office respondents. Yet there is no bureau-wide strategic approach or agreement on how to proceed with HSS. Further, since HSS-related programs implemented by OHS and CII are not channeled through the CBB mechanism review process, the program area offices are not sufficiently familiar with these OHS and CII programs. This negatively affects strategic coordination and management of program implementation mechanisms. Several interviewees noted that collaboration was stronger in HSS before creation of the OHS, in part due to the inevitable bureaucratic issues that arise whenever new offices are created. At the same time, strategic coordination and management of the SBC portfolio and mechanisms were held up as examples of best

practices for teamwork across GH for mechanisms that have no earmarked funding, but are managed in health program area offices, rather than in a standalone office or center.

C. Office of Country Support

SHORT-TERM RECOMMENDATIONS

- Clearly define how program implementation mechanisms differ from support mechanisms.
- Involve senior management staff from all offices (or their designees) in the design of program implementation mechanisms so there is consensus reached on what justifies cross-bureau funding and how mechanisms complement other mechanisms in the GH Bureau or Agency.

Cross-bureau funding is allocated to both support offices (PDMS, P3, OCS) and some program implementation offices (OHS, CII) for staffing and operations in addition to mechanisms. The process for determining CB funding allocations to offices follows different procedures than for mechanisms. While the team looked at the three support offices, the report focuses on OCS because its functions are more discretionary and because some of its roles are also performed by other offices. This section outlines major findings and recommendations with respect to OCS, which receives considerable CB-funding for staffing, but which currently does not manage mechanisms, except for its support role with Firehouse.

Value: The scope and role of OCS and the CTs it coordinates are unclear, especially given the fact that some of OCS' services are provided through other offices' staffs and mechanisms. The field health officers uniformly find high value in OCS for the support it provides ensuring communication between the GH Bureau and missions and for coordinating technical assistance in response to requests. OCS is also valued by missions for their efforts to provide an integration perspective across the oftentimes siloed program area offices. The field values OCS staff who travel to the mission for extended periods of time to provide interim backstopping for staff on leave, to help with activity or strategy design, to assist with procurement, budgeting, and other related direct hire functions.

Redundancies: Performance of CTs received mixed reviews. Examples were given of CT leads or members providing support that is redundant with what regional health staff or other GH staff provide. In the case of OHA, there is an entire division whose mandate is to provide country support. As a result, missions often directly request support from these staffs, rather than go through OCS coordination. This is also the case for other program area offices; they sometimes directly provide support without coordinating with CTs.

Gaps and observations: Staff participation on CTs is voluntary and not necessarily written in their scopes of work. There is great variability in staffs' desire to work on CTs, depending on the country portfolio and challenges. This results in highly variable team performance. Questions have arisen concerning implications of the Agency's proposed *Transformation* process for placement of regional bureau health officers in GH. What role would they have and where would they fit into the CT support system? Additionally, it is observed, but not entirely clear how or why, OCS is now "managing" staffing mechanisms. OCS is the GH liaison for Firehouse, managed by the M Bureau, which is used to help fill mission staffing gaps. While missions pay costs of TDYers, Cross-bureau funding is used in Firehouse to cover on-boarding costs in Washington and some "hoteling costs." It is also unclear how and why it was determined that the staffing

component of the GH-PRO follow-on would be managed in OCS. Finally, geographic distance between GH Bureau offices and other Bureau offices (e.g. regional) is a significant constraint on collaboration.

RECOMMENDATIONS

- Clarify scope and mandate of OCS consistent with sources of demand for its services. This includes focusing on inherently USAID functions in support of the field (e.g. interim staffing, design, procurement, budgeting, orientation of staff to GH resources, etc.)
- Analyze OCS staffing in light of Agency Transformation.
- Revise CT scope and clarify roles of team members. Since one size does not fit all countries or regions in terms of CT support, ensure that revisions are adapted to mission needs (e.g. one team covering all of francophone West Africa, different team structure for countries limited to only one or two element funding streams such as HIV/AIDS and TB).
- Increase Front Office support to OCS and the CTs, including ensuring performance reviews and recognition of GH staff serving as CT members.

VI. MID- TO LONG-TERM STRATEGIC APPROACH AND RECOMMENDATIONS

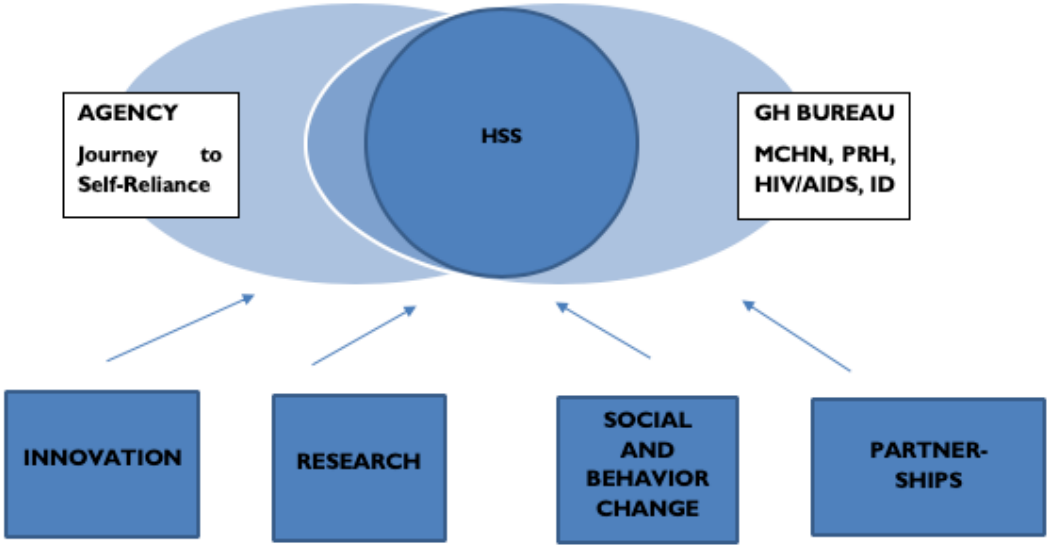
Based on the above findings and discussion, it is clear the CBB plays a critical role in the provision of services valued across the GH Bureau. While the earlier recommendations address many of the short (and longer) term issues surrounding the CBB, there are broader contextual considerations that suggest bolder changes may be needed. They include:

- The Agency's "journey to self-reliance" will increase the demand for expertise in HSS, including innovative new approaches;
- Funding constraints due to inflexibility of appropriations and pressures on program area offices to focus their programming on direct health outcomes; and
- Inconsistent and sometimes problematic integration of health program areas and cross-cutting interventions in the GH Bureau and the field.

Neither GH nor USAID as a whole will achieve their goals unless health systems globally improve. Given the importance of USAID's technical leadership to the global effort, GH's senior team must take action to identify and invest in creative solutions pertaining to the highest value global health-related "public goods and services" that cannot be justified for program area funding.

As previously noted, the GH Bureau should formulate an overarching strategic framework for its three major health priorities. We have suggested a possible framework (below) that builds on our analysis of the CBB process. It is not meant to be comprehensive or scaled in terms of GH programming, but it does visualize key components of the prioritization and restructuring to be considered for the longer term.

FIGURE 1: STRATEGIC FRAMEWORK



In this framework, HSS is positioned as the priority global health public good necessary to achieve the Agency's "Journey to Self-Reliance," which prioritizes building local capacity and commitment for sustained, accountable, and transparent development. These health system interventions are equally critical to improving health service use and achieving GH strategic objectives. USAID clearly recognizes this on the global scale, and, as noted in Section V, significant HSS investments are being made through the directed program area appropriations. However, there is insufficient funding for system-wide or crosscutting health systems investments, and insufficient coordination of program area-specific systems strengthening activities to achieve global health priorities.

In contrast, interviews indicated that several crosscutting approaches critical to Agency and GH goals – innovation (includes digital health, human centered design), research, social and behavior change, and partnerships – are already informally institutionalized in the GH Bureau. They create a model for how crosscutting work can be done, such as staffing the front office with high level experts, creating program mechanisms (many of which are managed in the program area offices), providing global leadership to drive policy formulation and capacity building, and undertaking research for innovation and scaling.

The above model suggests structural changes in how GH is currently organized, even while recognizing that the Bureau is just beginning to discuss changes it will be making as part of the Agency's transformation. We propose these changes for the GH Bureau's *consideration* as it continues with its internal reviews. The team's intent is to build flexibility and efficiency into GH mechanisms, staffing, and operations such that they are "fit for purpose" given potential shifts in funding, priorities, and structures. In putting forth these recommendations, we acknowledge they raise critical questions to be addressed by GH leadership, especially in terms of how and when to implement changes as part of the GH Bureau's transformation and how best to communicate these decisions to Agency and GH staff worldwide.

If the Bureau were not facing such serious funding constraints and if it could devote significant resources to OHS to lead a bureau-wide effort, our recommendations might be different. But, given the budget constraints, we believe GH should move towards a CBB of approximately $25 million per year for *administrative support* purposes. If other recommendations related to direct payments by program area offices and surcharges to cover all overhead and central costs are implemented, then the demand for CBB *program* funding could be limited to the actual experts serving in the Center of Excellence – perhaps $5 million per year. This would result in a CBB of approximately $30 million per year, a number which would be easier to generate through a more transparent and fairer CBB formulation process. While recommending this relatively significant change in how the GH Bureau approaches its CBB– and most importantly its approach to health systems strengthening – the team recognizes that change is difficult and other options exist.

RECOMMENDATIONS

- Prioritize internal administrative/support mechanisms and support office staffing when allocating cross-bureau funding. Since the bulk of these costs are for staffing, the GH Bureau should review its human resource plans and focus on filling the most critical vacancies – currently those are in PDMS.
- Consolidate program/technical activities in program implementation mechanisms, including those mechanisms currently managed in OHS and CII, and manage these mechanisms only in health program area offices.
- Create a "Center of Excellence" in the Front Office composed of senior staff with expertise and credibility in health systems, innovation, SBC, research, digital health, partnerships, and other cross-cutting strategic approaches. The Center would absorb functions of OHS and CII, as well as Senior Advisors in the Front Office, and its experts would provide technical leadership and, equally importantly, lead coordination across program area offices in the model of how SBC and research coordination are currently led.
  - Undertake assessment of skills, expertise, and experience needed in these senior positions; prioritize recruitment of staff and fill vacancies where gaps are identified.
  - Give highest priority for program staffing with cross-bureau funds to those senior positions in the front office, not otherwise funded with OE or program area funding.
- Designate DAAs as line managers of senior advisors in Center of Excellence. By extension, DAAs would provide front office leadership for strategic coordination of resource allocation for "public goods" staffing and mechanisms in HSS, research, innovation, SBC, and partnerships.

ANNEX 1: LIST OF RECOMMENDATIONS

RECOMMENDATIONS
THE CBB TAXABLE BASE AND TAX RATE
Recommendation 1: Review the Budget's International Partnership line items to determine if fewer deductions can be made, thus increasing the "adjusted" base that is used for CBB taxation purposes and enabling adjustments to current allocation rates. (All "pass throughs" to other organizations would continue to be deducted).
Recommendation 2: Review all mechanisms to determine if levies could be added or increased to cover more central costs and reduce demand for CBB funding.
Recommendation 3: Encourage PEPFAR and PMI to look for additional opportunities to direct fund (fully or partially) positions in support offices, e.g., for the Data Hub.
CBB APPLICATION & REVIEW PROCESS
Recommendation 4: Re-structure the CBB to delineate administrative support from program costs. See Annex 7 as an example of a template for the CBB, allowing a more transparent review of the entire budget.
Recommendation 5: Formulate a Bureau-wide strategy that creates a unifying framework for the Bureau as it seeks to achieve its child and maternal death, HIV/AIDS, and infectious disease targets – e.g., by articulating a common approach or vision toward stronger in-country capacity and/or greater integration of services.
Recommendation 6: Formulate specific criteria to help evaluate what qualifies for CBB funding, whether programmatic or administrative/support in nature.
Recommendation 7: Revise the CBB request forms to reflect new criteria and information on past performance, results, and pipelines; ensure uniform application of the revised forms.
Recommendation 8: Enhance rigor of review process by encouraging open debate and transparency, and by ensuring that AORs/CORs are in the room to provide more detailed knowledge.
Recommendation 9: Clarify the timeframe of the review and decision-making process and ensure decisions are adequately communicated down the line.

RECOMMENDATIONS
CBB EXECUTION
Recommendation 10: Standardize portfolio reviews to ensure uniform reporting on staffing and finance, especially with regard to usage of the CBB.
Recommendation 11: Include the CBB portfolio in its entirety in the annual portfolio review, clustering similar activities as needed and ensuring that performance and pipelines are reviewed and factored into any new proposals.
Recommendation 12: Consult with the Agency CFO to determine if changes can be made to the Phoenix accounting system to better accommodate the GH Bureau's needs and to clarify if legal issues exist.
Recommendation 13: Ensure all AORs/CORs are given uniform guidance on how to manage funding flows, especially around the frequent delays in allocations.
Recommendation 14: Quarterly, monitor funding allocations to the CBB to ensure that commitments are honored.
Recommendation 15: Review the significant variation in vacancy rates among the CBB-funded offices to achieve targeted cost savings by not filling many of the vacant positions. Highest priority should be given to filling PDMS positions, as they have the highest vacancy rate in the Bureau - 43 percent vs. a range of 15-19 percent for the other CBB-funded offices such as P3, OCS, OHS, as per Staff Tracking Sheets (Annex 8). Expected savings: $2-2.5 million.
Recommendation 16: Decrease the CBB contributions for the DHS-8 and Breakthrough mechanisms by adjusting budgets for buy-ins to include a larger surcharge. For example, either increase the surcharge for DHS-8 to 15- 20 percent and/or forge an agreement with the program area offices to pay directly for activities now in the CBB. The predecessor mechanisms for Breakthrough did not require CBB funding, clearly indicating that CBB funding should not be essential. Expected savings: $3-4 million.
Recommendation 17: Since the GH-POD mechanism received mixed reviews from staff, cuts could most likely be made. Funds could then be focused on what GH-POD does best. Expected savings: $1 million.
Recommendation 18: Encourage PMI and PEPFAR to directly fund more positions in the support offices.
Recommendation 19: Review and evaluate Scenarios 1 and 3 (as prepared by P3) in the event further cuts in the CBB are needed. Both these scenarios recommend two levels of across-the-board percentage cuts. Any such cuts should be based in part on pipelines. Scenario 2 does not cut expenditures, but instead recommends increased "tax" rates for some offices. We believe that the proposal to increase the MCH "tax" to either 24.7 percent or 28.4 percent and the FP/RH "tax" to 30.5 percent or 35.2 percent is excessive.
SUPPORT MECHANISMS

RECOMMENDATIONS
Recommendation 20: For all support mechanisms, rationalize and clearly define the scope, objectives, and results expected.
Recommendation 21: Educate GH staff concerning the above, including what services are provided with CB funding.
Recommendation 22: Involve senior management staff from all offices (or their designees) in the design of 'support' mechanisms so there is consensus reached on what justifies CB funding and how mechanisms complement or add value to other mechanisms in the GH Bureau or Agency.
Recommendation 23: Review best practices in *GHFP* management structure and processes and apply to other support mechanisms, as feasible given constraints for contracts vs. cooperative agreements.
Recommendation 24: Consolidate the management of support mechanisms in support offices.
PROGRAM IMPLEMENTATION MECHANISMS
Recommendation 25: Clearly define how program implementation mechanisms differ from support mechanisms.
Recommendation 26: Involve senior management staff from all offices (or their designees) in the design of 'program' implementation mechanisms so there is consensus reached on what justifies CB funding and how mechanisms complement other mechanisms in the GH Bureau or Agency.
OFFICE OF COUNTRY SUPPORT
Recommendation 27: Clarify scope and mandate of OCS consistent with sources of demand for its services. This includes focusing on inherently USAID functions in support of the field (e.g. interim staffing, design, procurement, budgeting, orientation of staff to GH resources, etc.)
Recommendation 28: Analyze OCS staffing in light of Agency Transformation (e.g. role of regional bureau health staff).
Recommendation 29: Revise country team scope and clarify roles of team members. Since one size does not fit all countries or regions in terms of country team support, ensure that revisions are adapted to mission needs (e.g. one team covering all of francophone West Africa, different team structure for countries limited to only one or two program area funding streams such as HIV/AIDS and TB).
Recommendation 30: Increase Front Office support to OCS and the CTs, including ensuring performance reviews and recognition of GH staff serving as CT members.
MID- TO LONG-TERM STRATEGIC APPROACH

RECOMMENDATIONS
Recommendation 31: Prioritize internal administrative/support mechanisms and support office staffing when allocating cross-bureau funding. Since the bulk of these costs are for staffing, the GH Bureau should review its human resource plans and focus on filling the most critical vacancies – currently those are in PDMS.
Recommendation 32: Consolidate program/technical activities in program mechanisms and manage these mechanisms in health element offices, including those mechanisms currently managed in OHS and CII.
Recommendation 33: Create a "Center of Excellence" in the Front Office composed of senior staff with expertise and credibility in health systems, innovation, SBC, research, digital health, partnerships, and other cross-cutting strategic approaches. The Center would absorb functions of OHS and CII, as well as Senior Advisors in the Front Office, and its experts would provide technical leadership and, equally importantly, lead coordination across program area offices in the model of how SBC and research coordination are currently led. • Undertake assessment of skills, expertise, and experience needed in these senior positions; prioritize recruitment of staff and fill vacancies where gaps are identified. • Give highest priority for program staffing with cross-bureau funds to those senior positions in the front office, not otherwise funded with OE or program area funding.
Recommendation 34: Designate DAAs as line managers of senior advisors in Center of Excellence. By extension, DAAs would provide Front Office leadership for strategic coordination of resource allocation for "public goods" staffing and mechanisms in HSS, research, innovation, SBC, and partnerships.

ANNEX 2: METHODOLOGY FOR DATA COLLECTION AND ANALYSIS

Introduction. The Global Health (GH) Bureau's CBB allocates funds to activities that support the achievement of the goals of the Bureau and Agency as a whole, and whose results cannot be directly attributed to one or more specific Health Program Areas. The CBB is funded by proportional contributions from the Health Program Areas identified in the Foreign Assistance Standardized Program Structure and Definitions (SPSD) that include HIV/AIDs, Tuberculosis, Malaria, Global Health Security in Development, Other Public Health Threats, Maternal and Child Health, Family Planning and Reproductive Health, and Nutrition. The formula for determining program area funding allocations to the CBB is discussed in the main body of the Report.

As currently conceived, the CBB is divided into four major components: Mechanisms, Staff, Office Allocations, and Operations.

Purpose of the Assessment.

In light of recent reductions in the level of contribution to the CBB under the PEPFAR and PMI accounts, the assessment reviewed the formulation and the execution of the CBB (including the funding flow) and how best to rationalize its continued support and contribution to the GH's, Administration's, and the Agency's priorities and operations.

In particular, in analyzing the data generated and reviewed, the assessment sought to provide recommendations to:

- Rationalize priorities for cross-bureau funding
- Reduce demand for cross-bureau funding
- Increase fairness and transparency in how and why program areas contribute to cross-bureau mechanisms, staffing, offices, and operations.
- Improve performance/impact relative to Agency and Bureau priorities
- Maximize responsiveness to the field

As noted, in the main body of the Report, the assessment was not a performance evaluation of any office, staff, or mechanism.

Assessment Questions (AQs). The AQs for this assessment were organized around five broad areas, as can be seen below:

- The CB funding flow.
- Formulation and execution of the CBB process.
- Value-added of the CBB portfolio in meeting and/or responding to shifts in the GH, Administration, and Agency priorities and operations.

- Redundancies/duplications under CBB-funded activities and mechanisms with respect to what is directly being funded by the four element offices.
- Gaps/unmet needs that should be funded in the CBB.

Methodology. The following methodology was used for the assessment:

1. **Desk Review of Documents, Data, and Secondary Sources**: Documents provided by the GH Bureau were reviewed. Some of the budget tables, the "tax" allocation tables, the Global Health Bureau FY 2018 CBB Request sheets, the PDMS staff tracking tables, and the FY18 Portfolio Reviews, were particularly useful in assessing the CB funding flows and the CB-funded staffing components. A complete Bibliography is provided in Annex 9.
2. **Key Informant Interviews (KIIs):** A broad range of interviews were held with the GH staff at multiple levels and funding sources, including interviews with a small number of key stakeholders outside the GH Bureau, such as from the regional bureaus.
3. **Group Discussions:** Group discussions, especially with budget staff at the operational and strategic levels, helped to create synergy and bring to light issues and clarifications that otherwise may not have surfaced.
4. **Field Health Officer Survey:** An online questionnaire created and managed through *Survey Monkey* was sent to the email distribution list "Mission Health Leads," which included Health Office Directors in the field and other Health Foreign Service Officers (FSOs), some of whom are currently located in GH.

During the Entry Brief, the assessment team was encouraged to get an understanding of the staff's perception of the CBB process and portfolio, especially on its transparency, accountability, and its alignment to GH priorities and operations. In response, staff from the below-listed stakeholder groups were interviewed. An effort was made to ensure that both decision-makers (Front Office, Office Directors, Deputy Directors, and Senior Advisers) as well as operational staff (from headquarters and the field, including AORs/CORs), were interviewed. It was deemed particularly important to capture the field perspective, given the new Agency priorities, especially the "journey to self-reliance" and its focus on host country (local) institutional capacity strengthening:

1. GH Front Office
2. PMI
3. Four Program Area Offices (OHA, MCHN, ID, PRH)
4. Three CB-funded Support Offices (P3, PDMS, OCS)
5. Two CB-funded Program Offices (OHS, CII).
6. Former GH Bureau Staff
7. Regional Bureau Health Staff
8. Health Sector Field Advisory Committee (FAC)
9. Health FSOs in missions and in GH

A common set of questions was used to interview GH staff in groups 1 to 8 above. The assessment team was flexible and adapted the questions based on the respondents' role, familiarity with CBB, longevity with USAID, etc. Some terminology was changed on the questionnaires (such as the reference to 'buckets'), as the team's understanding improved over the assessment period.

A Survey Monkey questionnaire was sent to field mission health leads with a limited number of questions, primarily to gauge the usefulness/value of CB-funded mechanisms, redundancies and gaps, as viewed from the perspective of the field.

The Questionnaire used for the GH Bureau staff interviews in Washington and the field survey are provided in Attachment 1 and Attachment 2, respectively, at the end of this Annex; the findings of the Survey Monkey are presented in Annex 9.

Approximately 70 staff were interviewed in Washington, including staff from GH and the Regional Bureaus. Some senior staff in the Africa Bureau and OHA were not available for interview as they were attending PEPFAR meetings in S. Africa. A list of staff interviewed is provided in the Table below:

LIST OF STAFF INTERVIEWED

NAME	**POSITION**
2/21/2019: ENTRY MEETING WITH BUREAU OF GLOBAL HEALTH (BGH) TEAM	
FRONT OFFICE	
1. ALMA GOLDEN	- ASSISTANT ADMINISTRATOR (ACTING) & SENIOR DAA
2. KERRY PELZMAN	- DAA
3. MONIQUE WUBBENHORST	- SENIOR ADVISOR
4. DAVID STANTON	- SENIOR ADVISOR
5. GRAHAM HIGGINS	- SPECIAL ASSISTANT
OFFICE OF POLICY, PROGRAMS & PLANNING (P3)	
6. JAY PATEL	- EXECUTIVE DIRECTOR
7. ROBBIN BOYER	- SENIOR ADVISOR, P3
8. JENNIFER MOCK	- BUDGET AND PROGRAM ADVISOR
9. MAITHY TRANPHUNG	- BUDGET ANALYST
10. BETH CORNETT	- PRESIDENTIAL MANAGEMENT FELLOW - P3 (BY PHONE)
E3:	
11. YOON LEE	- COR, LEAP III (BY PHONE)
Total No. of BGH staff at Group Discussion: 11	

KEY INFORMANT INTERVIEWS (KIIs): FRONT OFFICE	
1. ALMA GOLDEN	- ASSISTANT ADMINISTRATOR (ACTING) & SR. DAA FOR MCHN; OHA; OHS
2. IRENE KOEK	- DAA: OID; P3
3. KERRY PELZMAN	- DAA: PRH; OCS; PDMS
4. MONIQUE WUBBENHORST	- SENIOR ADVISOR
5. DAVID STANTON	- SENIOR ADVISOR (ALSO DISCUSSED DIGITAL HEALTH)
6. ELIZABETH FOX	- SENIOR ADVISOR
7. MATT BARNHART	- SCIENCE ADVISOR
8. GRAHAM HIGGINS	- SPECIAL ASSISTANT
Total Number of KIIs: 8	
KIIs: THE PRESIDENTIAL MALARIA INITIATIVE (PMI)	
PMI:	
1. KEN STALEY	- COORDINATOR
2. RICHARD STEKETTEE	- DEPUTY PMI COORDINATOR
Total Number of KIIs: 2	

KIIs: FOUR PROGRAM AREA OFFICES: HIV/AIDS (OHA), MATERNAL & CHILD HEALTH AND NUTRITION (MCHN); POPULATION & REPRODUCTIVE HEALTH (PRH); AND INFECTIOUS DISEASES (ID)	
OHA	
1. POLLY DUNFORD	- DIRECTOR
2. RACHEL LUCAS	- DIVISION CHIEF, STRATEGIC INFORMATION, EVALUATION & INFORMATICS
3. ROBERT FERRIS	- DIVISION CHIEF, PREVENTION, CARE, AND TREATMENT
MCHN:	
1. BARBARA HUGHES	- DIRECTOR (OUTGOING)
2. ANNE PENNISTON	- DIVISION CHIEF, NUTRITION
3. KATE CRAWFORD	- COUNTRY OFFICE DIRECTOR (INCOMING DIRECTOR, MCHN)
PRH:	
1. ELLEN STARBIRD	- DIRECTOR
2. KENDRA PHILLIPS	- DEPUTY DIRECTOR
3. SHAYMI DE SILVA	- DEPUTY DIRECTOR
4. TARA LEWING	- BUDGET ADVISOR
ID:	
1. PAUL MAHANNA	- DIRECTOR
2. CHRISTINE CHAPPELLE	- DEPUTY DIRECTOR
3. MEGAN FOTHERINGHAM	- DEPUTY DIRECTOR
4. RASHMI DIGHE	- BUDGET ADVISOR
Total Number of KIIs: 14	

NAME	POSITION
KIIs: CROSS-BUREAU FUNDED SUPPORT OFFICES – POLICY, PROGRAMS & PLANNING (P3); PERSONNEL DEVELOPMENT & MANAGEMENT SYSTEMS (PDMS); AND COUNTRY SUPPORT (OCS)	
PDMS:	
1. SHARON CARNEY	- DIRECTOR
OCS:	
1. MARGARET SANCHO	- DIRECTOR
2. WILLA PRESSMAN	- DEPUTY DIRECTOR
P3:	
1. JAY PATEL	- EXECUTIVE DIRECTOR
2. DANA OTT	- DIRECTOR (A)
3. ROBBIN BOYER	- SENIOR ADVISOR - BUDGET & POLICY DIV.
4. JONATHAN WHITEHEAD	- BUDGET ANALYST/BUREAU TRANSITION COORDINATOR, SAEO DIV.
5. JENNIFER MOCK	- ADVISOR - BUDGET & POLICY DIV.
Total Number of KIIs: 8	

NAME	POSITION
GROUP DISCUSSION (P3 STAFF MEETING) – P3, DIVISION OF STRATEGY, ANALYSIS, EVALUATION & OUTREACH (SAEO)	
1. MARITA EIBL 2. JONATHAN WHITEHEAD 3. MOYRA McNAMARA 4. KATY HADLEY 5. DENNIS DURBIN 6. LEEZA KONDOS 7. JASON WUCINSKI 8. IVANA FERRER 9. MARC CUNNINGHAM 10. KATRINA MORRIS 11.KATHERINE HALL 12. JEFF EVENS *Total No. of BGH staff at Group Discussion: 12*	DIVISION CHIEF BUDGET ANALYST/BUREAU TRANSITION COORDINATOR, SAEO DIV. (BY VIDEO-CONFERENCE) (BY PHONE)
KIIs: CROSS-BUREAU FUNDED PROGRAM OFFICES – ***OFFICE OF HEALTH SYSTEMS (OHS); AND CENTER FOR INNOVATION AND IMPACT (CII)***	
OHS: 1. KELLY SALDANA CII: 1. DAVID MILESTONE 2. AMY LIN *Total Number of KIIs: 3*	 - DIRECTOR - DIRECTOR - ACTING DEPUTY DIRECTOR

NAME	POSITION
KIIs: CROSS-BUREAU FUNDED ACTIVITY AND PROGRAMS MECHANISM MANAGERS – AORS/CORS	
1. MATT BARNHART	- STAR
2. JEFF EVANS	- KMS II, GH-PRO
3. ALTIN ILIRJANI	- DATAHUB
4. MICHAEL WILBURN	- GH-POD II, GHTP
5. HOPE HEMSTONE	- BREAKTHROUGH RESEARCH & ACTION
6. MADELINE SHORT	- DHS-8
Total Number of KIIs: 6	
KIIs: REGIONAL BUREAUS – ASIA; EUROPE & EURASIA (E&E); LATIN AMERICA & CARIBBEAN (LAC)	
LAC:	
1. REBECCA MINNEMAN	- MALARIA ADVISOR
2. JULIE GERDES	- ZIKA TECHNICAL ADVISOR
ASIA:	
1. LUCY MIZE	- TEAM LEADER
E&E:	
1. BHAVNA PATEL	- ADVISOR
Total Number of KIIs: 4	
KIIs: FIELD ADVISORY COMMITTEE (FAC)	
1. ELISA ADELMAN	- GH/OHS
2. JULIE BOCCANERA	- GH/PRH
Total Number of KIIs: 2	
KIIs: FORMER USAID STAFF	
1. WADE WARREN	- FORMER DAA, GLOBAL HEALTH BUREAU
Total Number of KIIs: 1	
FIELD SURVEY:	
MISSION HEALTH LEADS	
TOTAL NUMBER OF RESPONDENTS:	*11*
Total Number of Key Informant Interviews (KIIs):	*48*
Total Number of BGH staff at Group Discussion:	*23**
Total Number of Respondents for the Field Survey:	*11***

NOTE: *Actual number 11 (23 reflects 11 individual double counted since they appeared in more than one meeting plus the Special Assistant in the Front Office). **As of 3/19/2019.

Limitations. The following limitations are noted:

- As currently conceived, the CBB is divided into four major components: Mechanisms, Staff, Office Allocations, and Operations. Since only the Mechanism portion of the CBB has undergone a Bureau-wide review process, our observations on the process relate solely to it.
- The short timeline within which the assessment was conducted, limited the assessment team's ability for in-depth review of additional documentation and data sources.
- There was a low response to the field survey questionnaire, especially from the African field Missions, possibly because the timing of the survey conflicted with the PEPFAR meetings in S Africa. However, despite the limited number of responses received, the field responses did not differ greatly from opinions expressed in Washington. Some respondents wrote that they did not feel they understood the CBB well enough to respond. We are certain that we would have received more responses, in general, and more detailed responses had we been able to provide more detailed information in the survey questionnaire on the contents of the CB-funded portfolio.
- The late receipt and comprehensiveness of documentation and data sources from the GH Bureau made it difficult to compare and cross check numbers and facts to ensure greater accuracy.
- These recommendations are proposed with incomplete information about the outcomes of the Agency Transformation. However, the intent is to build flexibility and efficiency into GH mechanisms, staffing, and operations such that they are "fit for purpose" given potential shifts in funding, priorities, and structures

ANNEX 3A: GH BUREAU BUDGET BY YEAR AND PROGRAM AREA

GH BUREAU BUDGET – CORE AND INTERNATIONAL PARTNERSHIPS, FY 2014 - 2018

	FY 2014 Enacted	FY 2015 Enacted	FY 2016 Enacted	FY 2017 Enacted	FY 2018 Enacted
GHP-USAID Total	**2,769,450**	**2,783,950**	**2,833,450**	**3,054,950**	**3,020,000**
GH Bureau Total (excluding GAVI)	**686,249**	**688,049**	**677,399**	**713/99**	**615,408**
% of GHP-USAID	**25%**	**25%**	**24%**	**23%**	**20%**
Cross-Bureau Budget Total	**53,613**	**50,480**	**49,549**	**53,365**	**50,190**
% of GHP-USAID	**2%**	**2%**	**2%**	**2%**	**2%**
HL.1 HIV/AIDS	**189,249**	**190,249**	**189,249**	**143,156**	**130,689**
Global Health - Core	**95,204**	**96,204**	**95,204**	**49,111**	**36,644**
GH - International Partnerships Total	**94,045**	**94,045**	**94,045**	**94,045**	**94,045**
GH/IP - Commodity Fund	20,335	20,335	20,335	**20,335**	20,335
GH/IP - International AIDS Vaccine Initiative (IAVI)	28,710	28,710	28,710	2,871.0	28,710
GH/IP - Microbicides	45,000	45,000	45,000	45,000	45,000
HL.2 Tuberculosis	**68,300**	**68,300**	**68,900**	**76,993**	**69,27**
Global Health - Core	**48,300**	**48,300**	**48,700**	**56,793**	**47,274**
GH - International Partnerships Total	**20,000**	**20,000**	**20,200**	**20,200**	**22,000**
GH/IP - MDR Financing	5,000	5,000	5,200	5,200	7,000
GH/IP - TB Drug Facility	15,000	15,000	15,000	15,000	15,000
HL.3 Malaria	**53,000**	**53,000**	**53,500**	**53,500**	**56,000**
Global Health • Core	**53,000**	**53,000**	**53,50**	**53,500**	**56,000**
HL.4 Global Health Security in Development (GHSD)	**72,100**	**72,500**	**72,500**	**142,500**	**72,550**
GH - International Partnerships Total	**72,100**	**72,500**	**72,500**	**142,500**	**72,550**
GH/IP - Global Health Security in Development	72,100	72,500	72,500	142,500	72,550
HL.5 Other Public Health Threats	**99,750**	**100,000**	**100,000**	**100,000**	**100,000**
GH - International Partnerships Total	**99,750**	**100,000**	**100,000**	**100,000**	**100,000**
GH/IP- Neglected Tropical Diseases (NTD)	99,750	100,000	100,000	100,000	100,000

HL.6 Maternal and Child Health	**81,950**	**80,200**	**74,450**	**78,850**	**75,168**
Global Health - Core	**81,950**	**80,200**	**74,450**	**78,850**	**75,168**
HL.7 Family Planning and Reproductive Health	**101,900**	**104,300**	**98,800**	**97,800**	**93,067**
Global Health - Core	**99,100**	**99,100**	**93,600**	**95,000**	**90,267**
GH - International Partnerships Total	2,800	5,200	5,200	2,800	2,800
GH/IP - New Partners Fund	2,800	5,200	5,200	2,800	2,800
HL.9 Nutrition	**17,500**	**17,000**	**17,500**	**17,500**	**15,160**
Global Health • Core	**15,000**	**14,500**	**15,000**	**15,000**	**12,660**
GH - International Partnerships Total	2,500	2,500	2,500	2,500	2,500
GH/IP - Iodine Deficiency Disorder (IDD)	2,500	2,500	2,500	2,500	2,500
ES.4 Social Services	**2,500**	**2,500**	**2,500**	**3,500**	**3,500**
GH - International Partnerships Total	**2,500**	**2,500**	**2,500**	**3,500**	**3,500**
GH/IP - Blind Children	2,500	2,500	2,500	2,500	3,500

ANNEX 3B: FY 2018 CROSS-BUREAU BUDGET

MECHANISM	HOST OFFICE	FY 2017 Actual ($000)	FY2018 Approved ($000)
MEASURE Evaluation IV	OHA	2,378	1,120
D4I	OHA		880
K4H	PRH	710	535
DHS-8	PRH	5,122	5,690
Breakthrough Research	PRH	700	900
Breakthrough Action	PRH	600	500
GH-POD II	PDMS	3,950	4,125
GHTP Outreach	PDMS		32
STAR	AA		1,445
Comms Support (One World)	AA	100	100
Env. Compliance Support (ECOS)	P3	600	680
KMS II	P3	1,103	953
DHI (PATH) - Digital Square	P3	550	600
Procurement Support	P3	1,000	1,267
MECAP	P3	200	140
Data Hub - FSA IAA	AA	408	300
Data Hub - GH DATA	P3	550	581
Firehouse	OCS		263
Youth Power Learning	OHA		150
GHFP	PDMS	789	
WHO	P3	150	
HERD		158	
SUB-TOTAL		**19,068**	**20,261**
STAFF (AA,CII, P3, PDMS, OCS)			
GHFP II	PDMS	1,403	314
GHTP	PDMS	2,249	1,577
GHSI III	PRH	12,300	10,000
STAR	AA	1,693	
PSC		804	1,750
FSL		335	450
AAAS FELLOWS		427	418
SUB-TOTAL		**19,211**	**14,509**
OFFICE ALLOCATIONS			
OHS (including CBB staff)		10,500	10,500
Front Office (not including CBB staff)		1,500	1,500
CAII (not including CBB staff)		1,646	1,646
SUB-TOTAL		**13,646**	**13,646**
OPERATIONS			
IT TAX (CBB funded staff)		650	825
Space Tax (CBB funded staff)		540	657
Smart Phones (CBB funded staff)		150	168
GTRAM (bureau-wide)		50	75
Shared Supplies (bureau-wide)		50	50
SUB-TOTAL		**1,440**	**1,775**
TOTAL CROSS-BUREAU BUDGET		**53,635**	**50,190**

(Extracted from P3 Table Showing CCB Annual Budget: FY 2014 – 2018)

ANNEX 4: GH BUDGET DECLINING FLEXIBILITY

BUDGET YEAR (ACTUALS)	USAID GH CORE BUDGET ($000)	USAID GH INTERNATIONAL PARTNERS BUDGET ($000)	TOTAL GH ACTUAL BUDGET ($000)	CORE AS A PERCENTAGE OF TOTAL GH BUDGET
FY 2012	371,630	398,545	770,175	48.25%
FY 2013	370,331	392,017	762,348	48.58%
FY 2014	411,502	468,695	880,197	46.75%
FY 2015	391,822	496,745	888,567	44.10%
FY 2016	531,191	531,945	1,063,136	49.96%
FY 2017	372,661	640,545	1,013,206	36.78%
FY 2018	355,612	587,395	943,007	37.71%

(Budget Actuals from Congressional Budget Justifications – FY 2014 – FY 2020)

ANNEX 5: ALLOCATION OF OE

In reviewing the GH Bureau's use of multiple staffing mechanisms housed within the CBB and the staffing of the cross-bureau offices (AA/GH, P3, PDMS, OCS, and OHS), the assessment team saw the high degree to which the Bureau relies upon program-funded staff to manage its large portfolio. This provoked the team to look at OE allocations to GH, especially in comparison to the other pillar bureaus (DCHA, E3, Food Security) and the Development Lab.

We used only publicly available data for our analyses: (1) the FY 2017 USAID Staffing Report to the Congress that lays out all categories of DH, DH-equivalent, and institutional contractor positions, by funding source, as of September 30, 2017; and (2) the 2019 Congressional Budget Justification for all budget numbers (FY 2017 actuals). For the GH Bureau program budget numbers, we combined the GH Core and GH International Partnership line items since most of the latter fund programs that are in fact managed by the GH Bureau. The GAVI transfer is a clear exception, but we did not know whether the other pillar bureau budgets included similar transfers, so we opted not to exclude GAVI from the GH budget number.

Several tables are attached showing staffing numbers for GH and the other bureaus, organized by funding (OE or program) and by whether the positions are Direct Hire (DH), DH-equivalent, or institutional contractors. The DH and DH-equivalent positions can manage programs and perform inherently governmental functions; the institutional contractor positions can be only advisory or in support roles. We then compared these staffing levels to program levels managed by the pillar bureaus. The tables include the DCHA Bureau, but we believe its operating model is unique and less comparable to the other pillar bureaus. We therefore believe that it is most appropriate to compare the GH Bureau to the E3 and Food Security bureaus and to a lesser extent, the Development Lab.

The following tables are included in this annex:

1. FY 2017 Operating Expense Allocations to USAID Pillar Bureaus – this table shows overall OE allocations to the bureaus, including the relatively generous allocations to the E3 and Food Security bureaus and the Lab.

2. GH Bureau Staff Funding Compared to Other USAID Pillar Bureaus – this table shows that only 18% of GH's positions were OE-funded vs. 47% for the Lab, 38 % for the Food Security Bureau, 36% for the E3 Bureau and 22% for DCHA.

3. Pillar Bureau Staffing Compared to Budgets Directly Managed -- Recognizing that PEPFAR and PMI authorizations allow GH to use program funds for some OE positions and to have greater flexibility in creating program-funded Direct Hire-equivalent positions, this table looks at program dollars in relation to DH and DH-equivalent positions. Even including these program-funded DH-equivalent positions, the GH Bureau is significantly less well covered than the E3 and Food Security bureaus and the Lab.

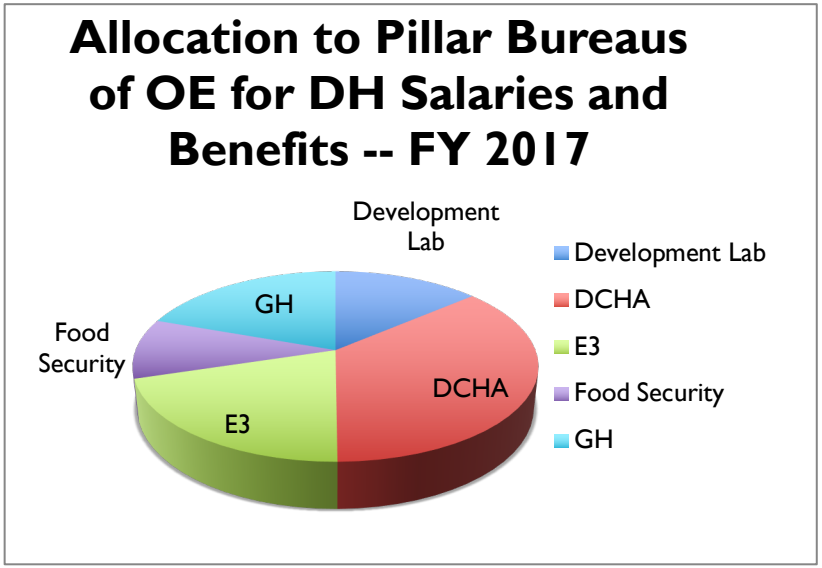
Because we were using public data sources and did not have in-depth knowledge about the program budgets, the tables should be looked at as only indicative. More detailed analysis will be required. But, given the increasing difficulty the GH Bureau has generating funds for the CBB, it should discuss OE allocations with the Agency.

TABLE A. 2017 OE ALLOCATIONS

FY 2017 OPERATING EXPENSE ALLOCATIONS TO PILLAR BUREAUS

BUREAU	FY 2017 ACTUAL OE FOR USDH SALARIES AND BENEFITS ($000s)	FY 2017 ACTUAL OE FOR NON-PERSONNEL COSTS ($000s)	TOTAL FY 2017 OE ALLOCATION ($000s)	FY 2017 ACTUAL PROGRAMMING BUDGET ($000S)	PROGRAM $ MANAGED PER DOLLAR OF OE FOR STAFFING ($000s)
Development Lab	12,080	5,283	17,363	62,000	5
DCHA	31,758	3,002	34,760	4,673,416	147
E3	17,914	4,492	22,406	309,124	17
Food Security	8,957	848	9,805	183,000	20
GH	17,198	1,446	18,644	1,013,206	59

(From FY 2019 Congressional Budget Justification – Supplemental Tables)



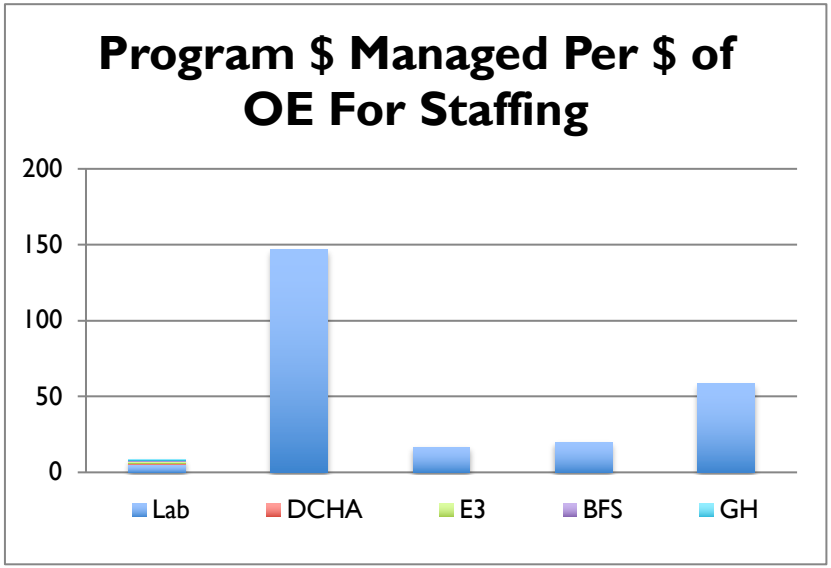


TABLE B. PILLAR BUREAU STAFFING – OE COMPARISON

GH BUREAU STAFF FUNDING COMPARED TO OTHER USAID PILLAR BUREAUS

BUREAU OR OFFICE	Number of OE Funded Positions	Number of Program Funded Positions	Total Positions	OE Positions as Percent of Total Number of Positions	2017 Actual Obligations as Reported in 2019 Congressional Budget Justification	Program $ Per Total Number of Staff ($000)	Program $ Per OE Funded Position ($000)
Global Health Bureau	96	433	529	18.10%	1,013,206	1,915	10,554
DCHA	197	715	912	21.60%	4,673,416	5,124	23,723
E3	100	176	276	36.20%	309,124	1,120	3,091
Food Security	57	93	150	38.00%	183,000	1,220	3,211
Development Lab	87	96	183	47.50%	62,000	339	713

(From 9/30/2017 USAID Staffing Report to the Congress)

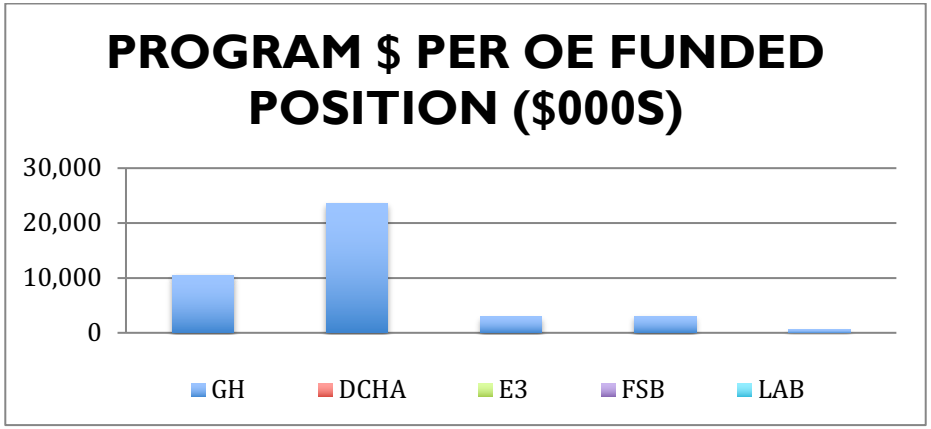
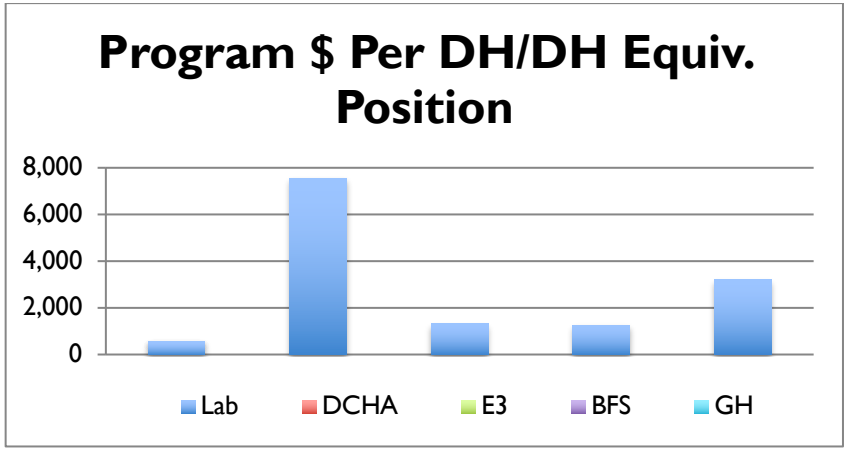


TABLE C. PILLAR BUREAU STAFFING – DH OR DH-EQUIVALENT POSITIONS

PILLAR BUREAU STAFFING COMPARED TO BUDGETS
BUDGET DIRECTLY MANAGED

BUREAU	TOTAL DH OR DH EQUIVALENT POSITIONS	TOTAL INST. CONTRACTOR POSITIONS	TOTAL POSITIONS	FY 2017 BUREAU BUDGET ($000S)	PROGRAM $ PER DH OR DH EQUIVALENT POSITION ($000S)	PROGRAM $ PER TOTAL NO. OF POSITIONS ($000S)
Development Lab	106	74	180	62,000	585	344
DCHA Bureau	617	295	912	4,673,416	7,574	5,124
E3 Bureau	229	47	276	309,124	1,350	1,120
Food Security Bureau	141	9	150	183,000	1,298	1,220
GH Bureau	314	215	529	1,013,206	3,227	1,915

(Data from 2019 Congressional Budget Justification Supplemental Tables and FY 2017 USAID Staffing Report to the Congress)



ANNEX 6: GH CROSS BUREAU ALLOCATION

GH Cross-Bureau Allocation Percentages

Cross-Bureau Allocation Percentages by Year	2015	2016	2017	Proposed 2018
3.1.1 HIV/AIDS	23.9%	24.1%	13.3%	11.1%
3.1.2 Tuberculosis	12.0%	12.3%	13.2%	14.3%
3.1.3 Malaria	13.2%	13.5%	14.5%	15.9%
3.1.4 Global Health Security in Development (GHSD)	3.1%	3.1%	3.3%	3.5%
3.1.5 Other Public Health Threats	3.2%	3.3%	3.5%	3.7%
3.1.6 Maternal and Child Health	16.4%	16.3%	21.5%	21.4%
3.1.7 Family Planning and Reproductive Health	24.6%	23.6%	26.5%	26.5%
3.1.9 Nutrition	3.6%	3.8%	4.1%	3.6%

GH Cross-Bureau Calculation of Allocation Base

Allocation Calculation- Detail	FY 2015	FY 2016	FY 2017	FY 2018 653(a)	FY 2018 Cross-Bureau Adjusted	FY 2018 Cross-Bureau Allocation
TOTAL	888,567	912,399	912,945	917,270	351,509	100%
3.1.1 HIV/AIDS	186,607	189,249	143,045	133,051	39,006	11.10%
GH/IP - Commodity Fund	20,335	20,335	20,335	20,335	-	
FH/IP - International AIDS Vaccine Initiative (IAVI)	28,710	28,710	28,710	28,710	-	
GH/IP - Microbicides	45,000	45,000	45,000	45,000	-	
Global Health - Core	92,562	95,204	49,000	39,006	39,006	
3.1.2 Tuberculosis	68,300	68,900	68,900	78,774	50,274	14.30%
GH/IP - TB Drug Facility	15,000	15,000	15,000	15,000	-	
GH/IP - MDR Financing	5,000	5,200	5,200	13,500	-	
Global Health - Core	48,300	48,700	48,700	50,274	50,274	
3.1.3 Malaria						

Allocation Calculation- Detail	FY 2015	FY 2016	FY 2017	FY 2018 653(a)	FY 2018 Cross-Bureau Adjusted	FY 2018 Cross-Bureau Allocation
	53,000	53,500	53,500	56,000	56,000	15.90%
Global Health - Core	53,000	53,500	53,500	56,000	56,000	
3.1.4 Global Health Security in Development (GHSD)*	72,500	72,500	72,500	72,550	12,334	3.50%
GH/IP - Global Health Security in Development	72,500	72,500	72,500	72,550	12,334	
3.1.5 Other Public Health Threats**	100,000	100,000	100,000	100,000	13,000	3.70%
GH/IP - Neglected Tropical Diseases (NTD)	100,000	100,000	100,000	100,000	13,000	
3.1.6 Maternal and Child Health***	280,200	309,450	356,200	365,168	75,168	21.40%
GH/IP - Gavi, the Vaccine Alliance	200,000	235,000	275,000	290,000	-	
Global Health - Core	80,200	74,450	81,200	75,168	75,168	
3.1.7 Family Planning and Reproductive Health	108,460	98,800	97,800	93,067	93,067	26.50%
GH/IP - New Partners Fund	5,200	5,200	2,800	2,800	2,800	
Global Health - Core	103,260	93,600	95,000	90,267	90,267	
3.1.9 Nutrition	17,000	17,500	17,500	15,160	12,660	3.60%
GH/IP - Iodine Deficiency Disorder (DD)	2,500	2,500	2,500	2,500	-	
Global Health - Core	14,500	15,000	15,000	12,660	12,660	
3.3.2 Social Services	2,500	2,500	3,500	3,500	-	0.00%
GH/IP - Blind Children	2,500	2,500	3,500	3,500	-	

* As in past years, GHSD's adjusted allocation is equal to 17% of its GH - Core Budget
** As in past years, NTD's adjusted allocation is equal to 13% of its GH - Core Budget
*** Fiscal Years 2014 - 2017 include a $2m polio adjustment agreed to in 2014; 2017 was the last year for the polio adjustment

ANNEX 7: GH CROSS-BUREAU BUDGET RESTRUCTURED

FUNDING PURPOSE/LINE ITEM	$ (thousands)
GH Internal Operational and Support Costs	**25,970**
Funding Mechanisms	
K4H	535
GH-POD	4,125
GHTP (Outreach)	32
STAR (core/hotel costs)	1,445
Comms Support (One World)	100
KMS II	953
Environmental Compliance	680
Procurement Support Mechanism	1,267
MECAP	140
Data Hub -- GSA IAA	300
Data Hub -- GH DATA	581
Sub-Total	**10,158**
Staffing (AA, P3, PDMS, OCS + core/hotel costs; excludes CII staffing)	
Sub-Total	**12,537**
Operations	
Sub-Total	**3,275**

FUNDING PURPOSE/LINE ITEM	$ (thousands)
GH Cross-Bureau Program Costs	**24,221**
Funding Mechanisms	
MEASURE Evaluation IV	1,120
D4I	880
DHS-8	5,690
Breakthrough (Research)	900
Breakthrough (Action)	500
Youth Power Learning	150
DHI (PATH) Digital Square	600
Sub-Total	**9,840**
Cross-Bureau Programmatic Offices	
OHS Staffing	1,915
OHS Programming	8,585
CII Staffing	2,235
CII	1,646
Sub-Total	**14,381**
TOTAL CROSS-BUREAU BUDGET	**50,190**

ANNEX 8: GH POSITIONS BY CATEGORY - VACANCIES

GH BUREAU POSITION VACANCIES – BY HIRING CATEGORY

OFFICE	DIRECT HIRE CIVIL SERVICE VACANCIES	FSO VACANCIES	FSL VACANCIES	DIRECT HIRE EQUIVALENT VACANCIES	INST CONTRACTOR VACANCIES	TOTAL VACANCIES	TOTAL POSITIONS	VACANCIES AS PERCENT OF TOTAL POSITIONS
AA	5	0	0	0	3	8	24	33.30%
CII	0	0	1	0	2	3	16	18.70%
P3	3	0	0	0	3	6	40	15.00%
PRH	5	0	4	0	12	21	95	22.10%
ID	6	2	1	4	15	28	126	22.20%
MCHN	6	0	1	0	13	20	76	26.30%
OHA	33	5	4	1	18	61	221	27.60%
OCS	0	1	0	1	2	4	22	18.20%
PDMS	7	0	0	2	9	18	43	41.80%
OHS	4	0	0	0	2	6	31	19.30%
TOTALS	**69**	**8**	**11**	**8**	**79**	**175**	**694**	**25.20%**

(From PDMS Staff Tracking Sheet – March 2019)

ANNEX 9: FIELD SURVEY RESULTS

An online questionnaire created and managed through *Survey Monkey* was sent to the email distribution list "Mission Health Leads", which included Senior Health Officers some of whom are currently located in GH. Obtaining field perspective was meant to provide a broader and more robust consideration of CBB funded programs and offices regarding value added, potential redundancies, and alignment with agency priorities. A total of 11 responses were received. The low response rate is likely due to respondents feeling they were not familiar enough with the content and formulation of the CBB (e.g. requests for clarification and a list of CBB funded programs). Despite the limited responses, the field responses did not differ greatly from opinions expressed in Washington.

- Mechanisms related to health systems strengthening, advancing health product regulation, and innovative finance were cited as high value.
- The DHS was regularly cited as very high value.
- Regarding CB funded offices, OCS's role in managing country team support and coordinating communication within the bureau, were highly valued by the field.
- The OHS was commonly noted as having the potential for redundancy in the field with one respondent commenting that the office "should not be managing projects but would be more useful if it took on a cross-bureau coordinating/technical assistance role".
- Field responses indicated the high demand for health systems strengthening and cautioned against implementing multiple instruments without strong coordination.
- In response to agency priorities and bureau transformation, a Health Officer remarked that "it will be important for GH to become involved in how all these [CBB] structures that are envisioned to provide support to the field ultimately coordinate so we understand who we go through first for any kind of assistance."

ANNEX 10: BIBLIOGRAPHY

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ANNEX 11: MEMORABLE QUOTES

ON CBB FORMULATION

"The CB budget formulation process was a good one - not perfect - but grew out of the demand for non-earmarked money for public goods. It was an exercise in allocating scarce resources. Over the years, the number and types of global goods has exploded, driven by political imperatives."

"Currently, CBB is seen more from the lens of 'securing' funding than making a 'public goods investment. There is no vision or value to what should be accomplished. Much of this is based on relationships formed."

"CBB is seen as a tax with no return on investment."

"Determining the cross-bureau budget was always a huge challenge when I was in GH - because it was difficult to show impact on earmarked funds. However, it is clear that sustained results cannot take place without strong health systems. I think a standard and agreed upon percentage may be the only way to help protect these programs and then they should be linked to strong indicators that can measure progress and results. I don't think there is a good answer to this question but continuing to fund the basic building blocks for development is critical."

"MCHN cannot be a universal donor."

"Need to be tougher in assessing staffing needs."

"[Review process for CBB]: there are sacred cows; if you go after funding for one of the sacred cows, need allies with you."

"Squeaky wheels get funding."

ON TRANSPARENCY OF PROCESS

"….in the absence of a clear set of criteria that defines what constitutes a CCB mechanism, any activity/mechanism can be justified; 'you can drive a truck through it'."

"There needs to be a debate about the criteria for CBB funding. Right now, the criteria are "bottom up" from the GH Bureau. We should be setting criteria starting with Agency priorities, then missions' priorities, then Bureau priorities. We need to be more nimble in the global space. Element sectors are too stove-piped to be innovative."

"I don't think even leadership knows what qualifies as a CBB-funded activity; I don't even know all the Bureau-wide activities. For some, 'Bureau-wide' just means that it can take all sorts of funds."

"… no carve outs for anyone; need to put pros and cons of all decisions on the table; all decisions have ripple effects."

"…difficult to get visibility on timeline. The FO decision-making is not transparent – and even if the information is shared, it rarely reaches below the Division Chiefs level."

"Zero visibility"

ON CBB EXECUTION

"Fiefdoms and people [are] locked into areas of technical expertise. Some people have been CORs/AORs for 20 years – [the] offices need more flexibility."

"Work streams do not match funding streams. Use of Phoenix to record funding exacerbates problem – it operates "first in; first out" –therefore [it is] difficult to track element funding."

"Having an annual All Hands or other meeting where all the cross-bureau projects are discussed would be helpful and understanding which offices are funding most of the cross-bureau activities. It would be important to have parity in funding from all offices, including HIV."

VALUE-ADDITION OF CBB

"Public goods are valued – and not seen as residual item in budget."

"USAID is failing in terms of databases and information systems. We lost the opportunity to do this through the CBB, so now information systems are being funded vertically."

"We should do more stocktaking. Everyone agrees DHS is a global good."

"Highest priority should be to health systems as a whole - managed, organized and overseen in an accountable manner. This is priority for the journey to self-reliance."

SOME FIELD PERSPECTIVES

"The Bureau needs to work with the Administrator to ensure that there are clear lanes for AID and CDC in the field. If we're giving considerations to budgets - we should also consider this dynamic."

"Duplication doesn't seem to be common. Serving in a GDO position, I have utilized the OCS Country Team support and broadened it to include E3, FFP colleagues and Regional bureau colleagues to have one coordination mechanism with DC that cuts across the social sectors supported in the Mission."

For more information, please contact:

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