HEALTH POLICY NETWORKS –
BRIDGING INTERESTS AND AUGMENTING INFLUENCE IN THE CHANGING
GLOBAL HEALTH POLICY ENVIRONMENT

Nicole K. Bates, MPH

A dissertation submitted to the faculty of the University of North Carolina at Chapel Hill in partial
fulfillment of the requirements for the degree of Doctorate of Public Health (DrPH) in the
Department of Health Policy and Administration.

Chapel Hill
2008

Approved by:
Advisor: Thomas C. Ricketts III
Reader: Suzanne Havala Hobbs
Reader: Rebecca Wells
Reader: Jo Anne Earp
Reader: Donald Holzworth
Reader: Nils Daulaire
Abstract

NICOLE K. BATES: Health Policy Networks – Bridging Interests and Augmenting Influence in the Changing Global Health Policy Environment
(Under the direction of Thomas C. Ricketts, III)

Context: In recent years, global health has grown as a public policy priority in the United States and abroad. U.S. global health policy, once influenced by a small group of stakeholders, is now shaped by an expanded set of actors. The more inclusive policymaking process has, in turn, become more complex.

Objective: This dissertation identifies practical strategies that the Global Health Council (“the Council”), a U.S.-based international membership association, can use to maintain its influence over and benefit from a changed policy environment.

Design: Documenting U.S. global health policy trends over the past decade, transcripts of 40 key informant interviews and a database of 576 organizations affiliated with the Council provide the data for analysis. Policy sciences and organizational sciences approaches frame the study analysis.

Results: Data analysis finds that the Council is now one of many organizations working to shape U.S. global health policy. The Council contributes to the policymaking process and network of policy actors as a direct advocate and broker of policy interactions and information. Increased investments in global health advocacy, however, have rendered these functions less unique. The
Council’s expansive inter-organizational network, rooted in its membership base, might offer additional advantage in the changed policy environment. However, the organization presently engages only a minority of these potentially advantageous relationships.

Conclusion: The Council can maximize its impact by implementing strategies that ensure that its policy processes and products remain effective and preferred by the network of global health stakeholders. These strategies are to: better articulate the organization’s policy identity; monitor more closely core policy functions for preferred outcomes and necessary adaptation; identify stakeholders and prioritize interactions; establish a system for stakeholder policy input; and monitor global health environment trends.

Implications for Practice: This research indicates that the Council’s advocate and broker functions along with its membership network serve as the basis for the organization to continue its positive global health policy authority. By integrating strategies presented in this dissertation with current policy activities, the Council is likely to remain one of the premier global health policy authorities now and in the future.
To those who, when learning of my latest endeavors, always respond, “I know you can do it” and to those who question or doubt why. To those who will look to my experiences as they face opportunities of their own and wonder if they can.
ACKNOWLEDGEMENTS

In my life, I have had a handful of experiences where, even before they took shape, I knew they were “me.” This doctorate is one of those experiences. I thank those who led me to and through this process of academic, professional and self discovery.

I thank my advisor, Thomas C. Ricketts, III, for teaching me how to find peace in ambiguity and to ultimately shape it into something clear and useful. I am also very grateful for having the opportunity to learn from my distinguished doctoral committee. Each member mentored me in a unique skill and way of thinking that has now become a part of my professional approach. Thank you, Sue Havala Hobbs, Jo Anne Earp, Rebecca Wells, Don Holzworth and Nils Daulaire.

I am grateful to the Doctoral Program in Health Leadership in the School of Public Health at the University of North Carolina at Chapel Hill. I’d like to thank Ned Brooks, the program’s first director. I also thank the Holzworth family for their generous investment in the program and me. To my cohort, I am proud to have traveled this road with each of you. We are trailblazers as good leaders should be.

I appreciate the backing of the Global Health Council which has allowed me to continue to make meaningful professional contributions as I have simultaneously undertaken this ultimate academic challenge. I am hopeful that the exploration that I have presented in this dissertation will be of benefit to the Council in its continued good efforts to improve health around the world.

I live an amazing life. In grand fashion and, most times, in more subtle ways, I am reminded of this fact. The world is full of incredibly kind, generous and supportive people. I have
the good fortune of encountering many of them. I would be remiss if I did not acknowledge the positive impact these individuals unwittingly have on me by simply being who they are and being a part of my life.

Most importantly, I credit this achievement to my family. They are my absolute motivation and strength. The good you find in me comes from them.
# TABLE OF CONTENTS

| LIST OF TABLES | xii |
| LIST OF FIGURES | xiii |

## CHAPTER

### 1

- **Introduction** ................................................................. 1
- **Case Study** ................................................................. 1
- **Specific Aim and Research Question** .................................. 2
- **Definitions** ................................................................. 4
- **Significance** ............................................................... 5

### 2

- **Chapter Overview** ......................................................... 7
- **Transformation of the U.S. Policymaking Process** ..................... 7
  - **Associations as Primary Policy Actors** ................................ 8
  - **Rise of Civil Society Advocacy** ....................................... 11
  - **Network-Based Policymaking** .......................................... 13
- **Global Health’s Rise to Policy Prominence** ........................... 13
  - **History of U.S. Global Health Engagement** ........................ 14
  - **Emergence of Global Health Policy Window** ............... 15
- **Chapter Summary** ......................................................... 28
Environment – Capturing the Impact of Past and Predicted Changes .................................. 72
Policy Network – Defining Critical Relationships ................................................................. 79
Chapter Summary .................................................................................................................. 94

Chapter Overview ................................................................................................................ 96
Specifying Parameters of the Council’s Competitive Advantage ....................................... 97

Recommendation 1: Articulate Organizational Policy Identity ............................................. 98
Maximizing Critical Policy Functions to Preserve Institutional Benefits ............................. 100

Recommendation 2: Monitor Policy Functions ................................................................. 100
Managing Relationships within Dynamic Policy Network ...................................................... 108

Recommendation 3: Identify and Prioritize Stakeholders .................................................... 108
Recommendation 4: Establish Mechanism for Stakeholder Policy Input ............................ 114
Guarding Against Structural Inertia by Detecting Environmental Change ....................... 116

Recommendation 5: Monitor the Global Health Environment ............................................ 116
Implementation Considerations .............................................................................................. 119

Is this the Council’s Ideal Policy Identity? ............................................................................ 119
Practical Application .............................................................................................................. 121
Areas for Further Study ........................................................................................................ 122

Network-Based Policymaking ............................................................................................. 122
Membership Associations as Policy Actors ....................................................................... 124
Civil Society Policy Leadership Development .................................................................. 126
Conclusion .............................................................................................................................. 126
APPENDICES ............................................................................................................................ 128
# LIST OF TABLES

<table>
<thead>
<tr>
<th>TABLE</th>
<th></th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Key Informant Interview Participants</td>
<td>46</td>
</tr>
<tr>
<td>2.</td>
<td>Transcript Coding Scheme</td>
<td>48</td>
</tr>
<tr>
<td>3.</td>
<td>Organizational Characteristics Captured in Stakeholder Database</td>
<td>52</td>
</tr>
<tr>
<td>4.</td>
<td>Stakeholder Perspectives on the “Global” Health Council</td>
<td>70</td>
</tr>
<tr>
<td>5.</td>
<td>Recent Global Health Events that Conditioned Respondents’ Statements and Answers</td>
<td>75</td>
</tr>
<tr>
<td>6.</td>
<td>Factors in Global Health’s Future Anticipated by Respondents</td>
<td>76</td>
</tr>
<tr>
<td>7.</td>
<td>Recommended Strategies to Maximize the Global Health Council’s Policy Impact</td>
<td>96</td>
</tr>
<tr>
<td>8.</td>
<td>Measures of Council Stakeholder Saliency</td>
<td>112</td>
</tr>
</tbody>
</table>
### LIST OF FIGURES

**FIGURE**

1. Study Research Questions ............................................................... 3
2. U.S. Government Global Health Spending,  
   International Affairs Budget, FY1997 – FY2007 .................................. 18
4. Congressional Record  
   Global Health Statements, 105th – 110th Congress .......................... 20
5. Global Health Legislation, 105th – 110th Congress ............................ 21
6a. Government Accountability Office Global Health  
    Reports (total), 1997 – 2007 ...................................................... 22
6b. Government Accountability Office Global Health  
    Reports (each year), 1997 – 2007 .............................................. 23
8. Policy Network Conceptual Model –  
    Paths Influencing Global Health Policy ...................................... 40
9. Key Informants – “Mapped” to Conceptual  
    Model ................................................................................. 47
10. Research Questions Organized by Analysis Categories ....................... 57
11. Distribution of Organizations in Council Policy Network .................. 80
12a. Policy Network Organizations by Type ........................................ 81
12b. Policy Network Organizations by Type and Relation to Council .......... 83
13a. Policy Network Organizations by Primary Institutional Function .......... 85
13b. Policy Network Organizations  
    by Primary Institutional Function and Relation to Council ................ 86
14. Policy Network Organizations  
    by Primary Issue Area and Relation to Council ........................... 88
<table>
<thead>
<tr>
<th></th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>15.</td>
<td>Policy Network Advocacy Organizations, Year Founded</td>
<td>89</td>
</tr>
<tr>
<td>16a.</td>
<td>Policy Network Organizations Participating in an Advocacy Coalition</td>
<td>90</td>
</tr>
<tr>
<td>16b.</td>
<td>Policy Network Organizations Participating in Multiple Advocacy Coalitions</td>
<td>91</td>
</tr>
<tr>
<td>17.</td>
<td>Policy Events by Event Topic and Partners’ Relation to the Council</td>
<td>93</td>
</tr>
<tr>
<td>18.</td>
<td>Council Advocacy Function: Preferred Outcome and Adaptation Triggers</td>
<td>102</td>
</tr>
<tr>
<td>19.</td>
<td>Council Convening Broker Function: Preferred Interactions and Adaptation Triggers</td>
<td>105</td>
</tr>
<tr>
<td>20.</td>
<td>Council Exchange Broker Function: Preferred Interactions and Adaptation Triggers</td>
<td>106</td>
</tr>
</tbody>
</table>
CHAPTER 1

Introduction

Global health has, in recent years, encountered a period of public and political favor in the United States and abroad. Growth in domestic and international prominence, public and private support and tangible resources define this period of good will. In the U.S., these positive trends have prompted the emergence of a window of policy opportunity following decades of modest attention by national policymakers. Until recently, a small community of stakeholders with specialized interests shaped the nation’s global health policies. Today, an expanded set of stakeholders are engaging as actors in a policymaking process that has become more inclusive and, therefore, more complex. Organizations that were once one of the select U.S. global health policy actors are now faced with the institutional challenge of maintaining their influence and benefit in a more complex process and densely populated policy field. The Global Health Council (“the Council”) is one such organization. This dissertation explores this organization-environment adaptation challenge from the perspective of the Council as it attempts to cope with this period of change.

Case Study

The Global Health Council is a U.S.-based, not-for-profit international membership association whose mission is to support organizations and individuals working to improve health conditions around the world. The Council’s U.S. advocacy agenda includes the diseases and health-related circumstances that disproportionately affect the world’s poor. Established in 1972, the
Council has been recognized by the U.S. and international community for its engagement in global health issues for more than 30 years.

In recent years, as global health’s prominence has risen on the U.S. policy agenda and in federal and private giving, the Council has increasingly been defined by two main activities. First, the Council has served as an advocate, raising awareness about global health issues among the public and policymakers. Second, the Council has served as a broker of critical relationships and information exchange among the growing network of global health stakeholders. Other advocates, direct service providers, public and private sector financiers and policymakers comprise this stakeholder network. These groups interact in various configurations to establish and advance the global health agenda and increasingly look to the Council to facilitate these relationships. The Council’s direct advocacy and policy broker activities appear to constitute the foundation of the organization’s policy identity in the current global health environment. At the start of this dissertation, however, these roles had not been formally articulated nor had a systematic analysis of changes in the global health policy environment been conducted by the Council. This dissertation attempts to fill those gaps and provide updates to the Council’s policy strategy.

Specific Aim and Research Question

The specific aim of this study is to identify practical strategies that the Global Health Council can use to retain its positive policy identity and influence in the evolving global health environment. This dissertation asks, “How can the Global Health Council maximize the impact of its core policy functions to remain an effective policy actor?” To answer this question, a set of sub-research questions (SRQs) are explored to address the following predicate issues: 1) confirm the Council’s core policy functions, presently characterized as direct policy advocacy and brokering, 2) confirm the nature and scope of recent global health policy changes, defined as the period 1997 –
2007 and 3) establish a baseline knowledge of the characteristics and perceptions of organizations that are work through, with and in competition with the Council to influence U.S. global health policy. Figure 1 displays the relationship among these specific questions.

Figure 1. Study Research Questions

Research Question
How can the Global Health Council maximize the impact of its core policy functions to remain an effective policy actor?

POLICY ENVIRONMENT
SRQ-2.1: How has the global health environment changed?
SRQ-2.2: What is/will be the impact of these changes?

FUNCTION
SRQ-1.1: What are the Council’s core policy functions?
SRQ-1.2: How do these functions impact the policy network?
SRQ-1.3: How do these functions affect the policymaking process?

POLICY NETWORK
SRQ-3.1: What are the characteristics of organizations in the Council’s policy network?
SRQ-3.2: How do stakeholders perceive the Council in relation to other organizations in the global health policy network?
SRQ-3.3: Do views of the Council’s policy role differ among global health stakeholders in its policy network?*

* Discussion of this sub-research question is reflected in responses to other sub-research questions

These baseline questions are meant to capture the dynamics created by the changed policy environment (defined as the more participatory policymaking process and the increased activity by the growing number of policy actors over the last decade). Answers to these questions provide the basis for recommendations that address the study’s main research question regarding the Council’s maximized policy effect. These recommendations are offered to the Council’s leadership for consideration and potential integration into the organization’s future policy strategies.
Definitions

The following definitions are applied to common terms and themes used throughout this dissertation:

1. **Actor**: specific to policy – interest groups, governmental institutions, journalists, and the research community who have different goals, perceptions of the situation, and policy preferences. Acting as stakeholders, these groups and individuals take action within the policymaking process.

2. **Advocate**: also “direct policy actor;” an actor who promotes a specific policy position. In the verb form it is the process of supporting a position.

3. **Broker**: an intermediary that facilitates transactions between other interest groups and policymakers (Heany 2006); in this dissertation, referring to the exchange of information or relationships.

4. **Competitive advantage**: possessing a set of competencies that allow an organization to control its future.

5. **Environment**: conditions external to the Global Health Council; defined as the policymaking process and/or the actors engaged in the process.

6. **Global health**: the specific diseases and populations that are the major contributors to preventable morbidity and mortality outside of the U.S. and which most often disproportionately affect the world’s poor; currently includes HIV/AIDS, other infectious diseases (malaria, tuberculosis and tropical diseases), child health, family planning as well as structural issues including health systems.

7. **Niche**: the role an organization plays described by the limits of its influence and activities.
8. **Policy identity**: specific to the Global Health Council, the sum of independent policy activities or functions (e.g., advocate, broker) that define the organization’s policy role and relevance in the external policy environment.

9. **Policy network**: *Formal*: open and flexible systems of relationships that link a variety of actors representing independent bodies for collective action (Rowley 1997). *Informal*: the virtual space in which stakeholders with common policy interests collaborate, compete and otherwise interact to influence the policymaking process.

10. **Stakeholder**: *Formal*: any group or individual who can affect or is affected by the achievement of the organization’s objectives (Friedman and Miles 2006). *Informal*: one with a vested interest in global health who has influence over or is influenced by: 1) in the policy environment, specific global health policy decisions; and 2) specific to the Global Health Council, organizational decisions and activities.

**Significance**

The newly-acquired status of global health as a national policy priority has had considerable consequence on policy actors, their activities and decisions (Kickbusch 2002; Ollila 2005). Established and emerging actors alike are not accustomed to this level of attention, political support and pressure from public and private stakeholders for a return on financial, policy and program investments. All interested parties must learn to navigate a complex new environment. Participants in this newly crowded field must sufficiently comprehend the dynamic, network-based nature of the current policymaking process and determine the appropriate application of their respective policy strategies. Actors must identify patterns, processes and positioning that will allow them to remain effective policy forces over time. This need applies directly to the Global Health Council as it now finds itself as but one of many actors working to identify a sustainable role in the
policymaking process and among the network of policy actors.
In the United States, two distinct trends have converged to define a new policy environment for global health. The first of these is a new policymaking process that began to emerge in the 1970s. Over the past three decades, the historically private process has “opened” for some policy issues including health to include an increasingly diverse set of policy actors and strategies. The second trend is the sudden and significant rise in global health’s profile over the past decade. This chapter reviews these trends to provide context for the environment in which the Council now operates and seeks to find its most effective role.

Transformation of the U.S. Policymaking Process

The past 30 years represent an evolution in how the practice of policymaking has been carried out in the U.S. (Dunn and Kelly 1992). A traditional view of the policymaking process follows a linear progression through a series of stages that include agenda setting, policy formulation and legitimation, implementation and evaluation (Carlsson 2000). This framework was particularly useful in the 1970s and early 1980s as it reduced a complex process to discrete stages that could be studied and, thus, explained (Sabatier 1999). Although useful in early stages of policy research, this approach has also been the basis for criticism over the past 20 years, largely because of its inflexibility and, therefore, inherent inability to capture the nuances of the actual policymaking process. It is increasingly evident that in practice, the process is far from linear. The actual process is far more iterative, less
rational and more sensitive to unpredictable pressures from the environment and policy actors. Government reforms of the 1970s and 1980s allowed for increased participation by more policy actors more frequently throughout the policymaking process. This shift from the traditionally closed, linear view of the policymaking process to a more interactive and network-based model has rendered earlier accounts of the process increasingly irrelevant and has led to more detailed studies of policy actors and their influence (Heclo 1978).

**Associations as Primary Policy Actors**

The policymaking process relies on a diverse set of actors who promote the wishes and demands of specific constituencies. Among others, these actors include interest groups, governmental institutions, journalists and the research community. Each group has different policy goals, perceptions and priorities. Thus creates the series of strategic interactions through the political system to negotiate for priority and favors and to deliver policy benefits to specific communities. This delicate process falls under the general rubric of advocacy.

The degree of inclusiveness of the policymaking process has been characterized in many ways. One long-standing conceptualization was based on the notion of an “iron triangle.” In this view, policies were influenced by three primary stakeholder groups: private lobbyists and their constituents, legislative power centers, and a captive executive agency. The “iron triangle” operated in a highly insular environment. There was little space for external influence on the policymaking process despite the fact that many outside of the “iron triangle” were directly affected by the decisions made from within.

As a consequence of this limited access, constituencies historically relied upon intermediary bodies to give them a “voice” in the exclusive deliberations that affected the broader community. Large national associations and unions were among the few non-
governmental actors privy to segments of the negotiations that occurred within the “iron triangle.” These umbrella groups typically mediated relations between policymakers and the communities affected by the policies (Knoke 1990). Researchers believed that this “gatekeeping” role could control access, information and resources. Constituents and policymakers accepted this centralized control, trusting the umbrella organizations to possess and use such power responsibly.

Associations matured as public interest groups in the 1960s and became relevant policy actors. This change was largely precipitated by shifts in the opportunities that individuals had to engage in politics, new techniques and models for building organizations and a transformation of sociodemographic factors including race, gender and class (Knoke 1986; Skocpol 1999). During that period, associations were transformed from umbrella organizations that primarily focused on locally-based civic participation to those that catered to specialized professions and special interest groups. According to the Encyclopedia of Associations, there were 6,500 associations at the national level in 1958. In 2006, that number had grown three-fold to 20,285, many based in Washington, D.C. near the original "iron triangle" (American Society of Association Executives 2006).

Along with the growth in their number was a corresponding growth in associations’ participation in policy debates and the political process (Skocpol 1999). Over time, associations became increasingly relevant policy actors, influencing relationships and decisions at every stage of the policymaking process. The growth in the number and activity level of national associations forced the expansion of the “iron triangle,” suggesting that the
policymaking paradigm in its original form was no longer applicable\textsuperscript{1}. The influence of associations soon eclipsed the role of political parties as major players at the federal level for some policy sectors. This fact was perhaps most recently demonstrated in health by the role of the Pharmaceutical Research and Manufacturers of America Association (PhRMA) and the AARP in legislative debates surrounding the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

The role of large national associations is changing yet again. Ironically, though the number of national associations has grown, associations’ political agendas appear to have become less driven by members. The reason behind this shift is two-fold. First, more associations exist, each representing distinct segments of the broader community on a given policy issue – essentially a balkanization of the policy agenda. In conjunction with this growth, association staff have become more professionalized. This elevated institutional sophistication has given associations increased internal capacity to develop and promote an agenda among specific audiences rather than relying on members to create the agenda (Skocpol 1999). Arguably, these associations are increasingly disconnected from the constituencies they claim to represent (Skocpol 1999). This change has important institutional implications for politically active umbrella organizations.

Second, individuals who would have been members of associations have become more empowered and active, relying less on associations to speak on their behalf. Many individuals and groups now approach policymakers directly. At the other extreme of engagement, individuals and groups that do not perceive benefit in association affiliation express their political views through more indirect and time-limited activities such as

---

\textsuperscript{1} Some argue that the “iron triangle” is still in effect in certain sectors such as energy or other policies that remain driven by private interests. Therefore, the reduced relevance of this concept in this dissertation refers to social issues and primarily health.
political donations rather than long-term affiliations (Bosso 2003). As individuals and organizations find their own voices, associations have been forced to re-evaluate their roles as representatives of the community. The American Medical Association (AMA) is a large national association that has invested significant time and resources to explore the changing relationship with its membership base and the association’s impact on the policymaking process. The AMA’s experience is summarized in Appendix A. A solid membership base is critical to associations like the Global Health Council that rely on a constituency for revenue, indirect policy action and policy reputation legitimacy.

Rise of Civil Society Advocacy

Today, forces external to the “iron triangle” can influence policies as they are developed, negotiated and implemented. This is evident, particularly in social policy domains, in the recent exponential growth of nongovernmental organizations that promote “civil society” and the increasing role these stakeholders play at all stages of the U.S. policymaking process. As a result of this increased participation, these organizations have become co-producers, rather than simply consumers, of policy (Nyland 1995).

The increasing numbers of non-governmental policy actors wanting to have influence on policy outcomes often coalesce as informal or transient interest groups. The growth of interest groups, described by Schlozman and Tierney (1983), over recent decades has been accompanied by the emergence of new advocacy strategies and techniques as well as an infusion of private resources supporting these activities (Knoke 1986; Schlozman and Tierney

Civil society is often viewed as a "third sector," distinct from government and business. Civil society refers essentially to the so-called "intermediary institutions" such as professional associations, religious groups, labor unions and citizen advocacy organizations that give voice to various sectors of society and enrich public participation in democracies. In the U.S., the term is often used interchangeably with or exchanged for nonprofit organizations (NGOs).
1983; Skocpol 1999). Private industry stakeholders have joined civil society as global health policy actors (Ollila 2005).

The birth of the Bill & Melinda Gates Foundation in 2000 marked a sea change in the global health field from a previously sparsely populated and disjointed community to a more crowded arena with a growing number of policy actors and advocates (Cohen 2002, 2006; Okie 2006). Through its Global Health Program, the Gates Foundation had, as of 2007, provided $7.8 billion in global health grants, with $766.6 million \(^1\) dedicated to advocacy (Bill & Melinda Gates Foundation 2007). A primary result of grant maker investments in advocacy has been an increase in the number of organizations engaging in global health policy, both directly influencing policymakers and interacting with each other through informal networks and formal partnerships. These direct advocacy and collective action approaches have dramatically reconfigured previously existing policy networks and created new ones.

The infusion of advocacy resources has established a new cadre of global health policy actors who, by their sheer presence and overlapping interests in global health policy outcomes, have modified the policymaking process and policy outcomes. New resources have also changed the dynamic among these groups. Now, in order to succeed in the policymaking process, each actor must understand his specific role and contribution in the process and how he interacts with others. This understanding is particularly relevant to membership-based associations like the Global Health Council that, at one time, may have exercised a representative or otherwise dominant role among the various policy actors but now interact as a peer.

---

\(^1\) Since its inception through March 2007, the Gates Foundation has provided $766,612,229 through a portfolio of "Research, Advocacy and Policy" grants.
Today, advocacy is increasingly executed by a densely populated network of policy actors. Associations, which are usually nonprofit, have been joined by a number of public and private groups also acting as policy actors. These groups often work via coalitions to advance specific policy agendas, and are engaging in the policymaking process with status and influence increasingly equal to associations. Over time, group forces create the dynamic pressure system that shapes policy interactions and outcomes. Groups come together for lobbying – more commonly referred to by public interest groups as advocacy. They complement these direct attempts to influence policy with other activities such as testifying at hearings before the U.S. Congress, mobilizing the public through grassroots campaigns and influencing popular opinion through the media (Knoke 2001). These common advocacy strategies are the most common motivation for otherwise independent organizations become partners in coalitions and other collective manifestations of the policy network (Andrews and Edwards 2004; Heaney 2003). This network perspective on policymaking emerged in the 1980s in response to the traditional, linear model and other limiting depictions of policymaking including the "iron triangle" that were judged to be, if no longer accurate, at least inadequate by contemporary scholars (Sabatier 1999). Although the network perspective is not without its criticism for its lack of a central framework, it defines an significant segment of contemporary policy actor activity (Carlsson 2000; Sabatier 1999).

Global Health’s Rise to Policy Prominence

The current period of political favor toward global health is evidenced by increased resources, elevated policy conversation and a general approval among the American people of U.S. global engagement. These trends are generally mirrored abroad (Kickbusch 2002; Ollila 2005;
Yach and Bettcher 1998). While the current period of support may have been long-desired by global health stakeholders, it was not predicted nor were its subsequent effects, including the larger pool of policy actors.

History of U.S. Global Health Engagement

For more than a half-century, U.S. government (USG) global health engagement has been steady, yet modest. Relatively little attention has been paid to the portfolio within the larger national policy agenda. Nevertheless, USG investments have contributed to notable global progress, including: the eradication of smallpox in 1977; a 40 percent reduction in the under-five child mortality rate over the past 30 years; a 60 percent reduction in measles deaths since 1999; and 175 countries worldwide that are now polio-free (Global Polio Eradication Initiative 2007; Ahmad, Lopez, and Inoue 2000; Elliman and Bedford 2007; Levine and Kinder 2004; The World Bank 2006).

The past decade (1997–2007) has represented a period of elevated USG attention to and investment in global health. This commitment has been paired with tremendous activity by public and private non-government stakeholders also committed to the global health agenda. Much of global health’s attention has been generated by the issue of HIV/AIDS. The pandemic was affirmed as a threat to national and global security by the Clinton Administration and the United Nations Security Council in 2000 as well as by then-Secretary of State Colin Powell in 2002. Because health is increasingly viewed as a central component of U.S. foreign policy, global health (with emphasis on AIDS, sporadic infectious disease outbreaks and the threat of bioterrorism) has emerged as an established item on the national policy agenda (Fidler 2006; Kickbusch 2002). Primary indicators of policy activity – legislation, funding, political debates and advocacy – have surged for global health during this period.
Emergence of Global Health Policy Window

Political systems are unable to simultaneously consider all potential policy issues (Jones 1984). There are simply too many issues and actors with disparate interests. As a result, specific issues and their actors are organized into “subsystems” where more detailed attention can be paid and specific negotiations conducted. At times, however, issues emerge from their subsystem and receive attention by the full political system. This rise to policy prominence most often occurs when a set of otherwise independent factors come together under unique circumstances. Kingdon offers a “multiple streams” framework that helps to understand the specific factors and dynamics that elevate issues’ status within the policy agenda. According to Kingdon, three streams – Problems, Policies and Politics – converge at some point and dramatically increase the chances that an issue captures the attention of policymakers (Kingdon 1995). This convergence is known as a "policy window," an ephemeral period in which heightened attention to and action on a specified agenda are most likely to occur.

Problems

Kingdon’s first stream, Problems, is created when empirical indicators are communicated or when dramatic events call attention to problems. Over the past decade, experts have begun to explore and express health’s effects in politically relevant ways. For example, in 2001, the Commission on Macroeconomics and Health, which views improved health as a central input to poverty reduction and socioeconomic development, outlined global disease burdens and associated costs along with recommendations for strategic investments across health-specific and health-related areas (Commission on Macroeconomics and Health 2001). The Disease Control Priorities Project has now twice successfully documented the epidemiology of disease burden and calculations of “best buys” in health. The knowledge produced from this project is intended to inform health
policy making in developing countries. Similarly, journals such as *The Lancet* have published series dedicated to specific global health topics, including child health. Increased media exposure to images, stories and bold trend forecasts about existing and emerging infectious diseases such as AIDS and avian influenza has also highlighted global health issues in dramatic fashion (Garrett 1995; Osterholm 2005). This approach frames global health as a threat rather than an opportunity. This negative characterization resonates with U.S. policy and opinion leaders who have increasingly viewed health in terms of national or other self-interests (Kickbusch 2002). Finally, well-established organizations including the Council on Foreign Relations, the Center for Strategic and International Studies, the Woodrow Wilson Center for International Scholars and the Henry J. Kaiser Family Foundation have, since 2000, established programs to explore global health topics and their links to a domestic agenda or broader foreign policy platforms. This dedicated attention to health from non-global and non-health specific institutions demonstrates the belief that the U.S. stands to gain domestic and international advantage by including health as a central component of its national discourse and foreign policy agenda (Kassalow 2001).

**Policies**

The Policy stream represents the space where a select few issues receive serious consideration (Sabatier 1999). The elevated status of these issues is evidenced by increased federal spending as well as the increased volume of discussion about global health topics in the form of papers, hearings and other tangible policy products.

**U.S. Government Investments**

In 1997 U.S. government (USG) global health spending totaled just under $1 billion. Ten years later, in 2007, USG global investments surpassed $5 billion, an exponential increase not
replicated in any other non-military international assistance or domestic portfolio. The bulk of the increase in global health spending has been due to investments in global AIDS, which totaled a modest $119 million in fiscal year (FY) 1997 but grew nearly 30-fold to $3.2 billion in FY 2007. The U.S. President’s Emergency Plan for AIDS Relief (PEPFAR), a five-year, $15 billion bilateral initiative to support AIDS programming in 15 targeted countries, was responsible for most of the funding growth. The program also provides contributions to the Global Fund to Fight AIDS, TB and Malaria (“the Global Fund”), a multilateral financing mechanism to support interventions for these three high-profile infectious diseases. The U.S. played a central role in the establishment of PEPFAR and the Global Fund, both launched in 2003.

In 2005, malaria joined global AIDS as a U.S. global health priority. In FY 1998, the first year for which malaria spending was specifically tracked, USG spending was $21.9 million. In FY 2007, two years after the announcement of the President’s Malaria Initiative (PMI), a five year bilateral initiative to support malaria interventions in 15 African countries, USG spending was $248 million, on track to reach the President’s $1.2 billion pledge by FY 2010. Global AIDS and malaria investments combined with emergency funding for avian influenza preparedness and other public health emergencies to represent the bulk of U.S. resource growth in global health since 1997. In contrast, spending for non-AIDS and non-malaria global health programs has experienced almost zero-growth over the past decade until just recently.

Figure 2 captures USG spending from the International Affairs budget, the primary source of USG global health funding. This account supports programs administered by the U.S. Agency for International Development (USAID), the State Department (primarily through the Office of the

---

1 Bilateral initiative are programs established by a single host country – in the case of PEPFAR, the U.S. – with a single or group of recipient countries. Multilateral initiatives are programs such as the Global Fund that receive financial inputs from multiple donors and most often have multiple recipient countries.
Global AIDS Coordinator (OGAC)) and contributions to international programs including those carried out by United Nations agencies.

Figure 2. U.S. Government Global Health Spending, International Affairs Budget, FY1997 –FY2007

The U.S. also administers global health programming through its domestic Health and Human Services account funding the Centers for Disease Control and Prevention (estimated at no directly appropriated funds in FY 1997 and $334 million in FY 2007) and for basic sciences research at the National Institutes of Health (CDC Global Health Spending, FY1997-2007 2007). Modest resources are also provided to other departments and agencies including the Department of Defense, for example, supporting malaria vaccine research. Research and development allocations, however, are determined at the agency level and cannot be confidently reported.
Congressional Discussion & Debate

A June 2007 review of hearings recorded in the LexisNexis® Congressional Database and statements appearing in the Congressional Record, the official record of the proceedings and debates of the United States Congress, illustrated a steady increase in the number of references to global health topics\(^5\). Congressional hearings and legislation are two primary ways in which policymakers express interest in policy issues. Increases in global health events and products loosely mirror the funding trends described above. The number of global health hearings grew seven-fold during the past decade, with tuberculosis, malaria and global AIDS as the most commonly featured topics. Figures 3-5 display the frequency of mentions of issues in global health in congressional hearings, official proceedings and legislation\(^6\). Original data tables appear in Appendix B.

The mentions of specific global health terms in the Congressional Record demonstrate the level of policy attention to these issues. In-depth research on the contents of these references and the political contexts of the 105\(^{th}\) – 110\(^{th}\) sessions of Congress would be necessary to explain the observed increase or decline in congressional mentions of global health issues over time. Research of that nature is, however, beyond the scope of this dissertation. The current results illustrate that the most commonly referenced terms have been those which either existed in the U.S. as well as abroad (e.g., tuberculosis), were politically charged (e.g., family planning), received increased

\(^{5}\) The review focused on the period 1997-2007. This timeframe captures activities of the 105\(^{th}\) – 109\(^{th}\) full congressional sessions and the first half of the first session of the 110\(^{th}\) Congress (January to July 2007).

\(^{6}\) The review only confirmed that the search terms were mentioned; it does not capture the context. Therefore, it is not possible to elicit from these data whether the reference was specific to global or domestic health issues, if the reference was positive or negative or whether the bulk of the statement was dedicated to the topic. In some cases, multiple similar terms were used so search returns may overlap among terms (e.g., “global AIDS,” “global HIV/AIDS”). Terms that can be specifically considered to address global health – global health, global AIDS and tropical diseases – returned the least legislation.
Figure 3. Global Health Hearings, 105th – 110th Congress

Source: LexisNexis Congressional Database, 2007

Figure 4. Congressional Record Global Health Statements, 105th – 110th Congress

federal funding (i.e., AIDS and malaria) or were viewed as pending public health emergencies, such as infectious disease outbreaks and bioterrorism preparedness. In Figures 3 – 5, and for the remaining figures in this chapter, trends appear to drop for the 110th Congress or the calendar year 2007. When this review was conducted in July 2007, the 110th Congress was only six months in to its first session. Even initial activity in the first months of 2007 and the 110th Congress demonstrated the important fact that policy attention toward global health continued and appeared to be on the rise.

Policy Research & Official Inquiries

As attention to global health has increased so too have the number of investigations and policy writings on the issue. There are three major sources of global health policy inquiry and positioning that illustrate this trend. The Government Accountability Office (GAO) and the Congressional Research Service (CRS) are two established extensions of Congress recognized for their in-depth analysis of policy issues. These offices respond to inquiries by members of Congress.
and, through their reports, provide the evidence base and justifications for a number of congressional policy decisions. The Institute of Medicine (IOM), a component organization of the National Academies of Sciences, was chartered by Congress in 1970 to be an advisor on scientific and technological matters, and serves as another valued issue authority. The IOM has, for many years, been called upon generally and through legislation to conduct studies and convene stakeholders to establish an objective opinion on key topics. Although chartered by Congress and affiliated with the National Academy of Sciences, the IOM operates independently from the government.

Figure 6a. Government Accountability Office Global Health Reports (total), 1997 – 2007

Source: Government Accountability Office, 2007
During the period 1997 – 2007, the GAO issued anywhere between 26 to 78 reports each year indexed using key global health search terms (Figures 6a and 6b). The IOM released a total of 38 reports under its global health program (Figure 7). Because the CRS only officially releases its reports to Congress, the total number of global health reports was not publicly available. However, a lead global health expert at CRS reports that the number of requests for global health related studies has increased significantly in recent years (Congressional Research Service 2007).

Figure 6b. Government Accountability Office Global Health Reports (each year), 1997 – 2007

Source: Government Accountability Office, 2007

---

7 As with trends of the 105th-110th Congress, reports on the period 1997-2007 capture only half of the year 2007 reflecting when trends were reviewed and reported here.

8 A number of the reports returned under individual search terms were duplicates of reports returned for other terms. Double counting has occurred. In addition, returns include domestic and international topics and may not have been explicitly about the search term.

9 A comprehensive listing of CRS reports is not publicly available. Over 200 GAO reports are available – too many to list individually. Reports, however, can be found at www.gao.gov, searched by key term. Data tables for these figures appear in Appendix B.
The nature of congressional inquiries also has begun to change as an increasing number of policymakers ask for recommendations regarding appropriate intervention strategies in addition to basic information on the issue. This shift demonstrates a more sophisticated interest in key global health topics and potential policy solutions (Congressional Research Service 2007). The GAO and CRS shared a similar trend where global health reports requests, during this period, began to overlap with non-health topics such as economics, defense and the environment. The increased number and frequency of specific global health and global health-related reports by the GAO, CRS and IOM is consistent with the premise that the policy environment has changed.

Figure 7. Institute of Medicine Global Health Reports, 1997 – 2007

Source: Institute of Medicine, 2007

Political Commitments

Important demonstrations of political will by the U.S. government over the past decade, such as the President’s Emergency Plan for AIDS Relief (PEPFAR), the Global Fund to Fight AIDS,
Tuberculosis and Malaria ("the Global Fund") and the President’s Malaria Initiative (PMI), have been complemented by public commitments at the international level. These include high-level leadership forums such as the United Nations Special Sessions on HIV/AIDS (2001, 2006), the World Economic Forum and G8 summits (with consistent reference to global health priorities over the past decade, most notably, Okinawa in 2000 and Gleneagles in 2005). The inclusion of global health on the agendas of these high-level forums has been actively supported by the U.S.

Global health’s priority over the past decade has not been limited to traditional policy mechanisms such as Congress and the presiding Administration. In addition to sitting U.S. leaders’ interests in global health, former national leaders also began to adopt global health as a diplomatic priority. This shift was demonstrated first by the work of The Carter Center and, most recently, the William J. Clinton Foundation and its Global Initiative. In addition, the annual World Health Organization member state assembly continued to document progress and identify emerging global health priorities. Political declarations such as the 2000 United Nations Millennium Declaration,\(^{10}\) the 2001 Abuja Declaration by African Heads of State, the 2005 Paris Declaration on Aid Effectiveness and others have reaffirmed leadership commitment and established regional and global targets for health. International agencies such as the Joint United Nations Programme on HIV/AIDS (1995) and multilateral programs such as the World Bank Booster Program for Malaria Control in Africa (2005) secured resources from donors and began to provide leadership in recipient countries. The momentum for global health has continued as it has firmly established itself as a part of national and international health, development and economic conversations.

---

\(^{10}\) The Millennium Declaration established the Millennium Development Goals (MDGs) – eight targets to meet the needs of the world’s poor by 2015. Three of the MDGs are specific to health: #4 – reducing child mortality; #5 – improving maternal health; and #6 – combating AIDS, tuberculosis and malaria (United Nations 2000).
Politics

Kingdon’s final Politics stream consists of three elements: national mood, pressure group campaigns and legislative turnover. In 2000, the Global Health Council commissioned the public opinion polling firm Lake, Snell, Perry & Associates (LSPA) to conduct a national poll to explore Americans’ opinions about global infectious diseases. This national survey of 1,110 Americans found that respondents ranked the spread of global infectious diseases on par with other global threats such as “war and terrorism” and “poverty and hunger.” According to the poll, six in 10 Americans saw the spread of infectious diseases as more of a problem in 2000 than three to four years earlier. Eighty percent of respondents believed that a global epidemic like SARS would emerge in the next five years. More than 60 percent believed that the U.S. should play a major role in fighting global infectious diseases. The LSPA survey also found that Americans had a growing concern about how the nation was perceived abroad. While Americans were supportive of assistance, they expressed a strong desire for the demonstration of aid effectiveness.

According to a 2006 Research!America poll, 39 percent of Americans believed that improving health around the world should be a top priority of the U.S. government\(^\text{11}\). Although 82 percent of Americans reported that they were not currently doing anything to improve global health, 80 percent believed that it was important for the U.S. work to improve health globally (Research!America 2006). While the 2003 LSPA and 2006 Research!America polls are not directly comparable, they do suggest a fairly consistent awareness of global health by the American public as well as a sense that the U.S. should be engaged in improving health outside of the country.

During this same period that political resources and public awareness have grown, the field of global health policy actors has been populated at a comparable rate. Private foundation grant

\(^{11}\) Improving health was ranked third, following fighting terrorism and protecting the environment. Health was ranked just above improving living conditions, peacekeeping efforts and fighting the illegal drug trade.
making, discussed earlier in this chapter, has dramatically increased the number of global health advocates. These advocates collaborate through many forums. At the global level, a host of partnerships with explicit advocacy components have been launched, including the Roll Back Malaria Partnership (1998), Stop TB Partnership (2000) and the Partnership for Maternal, Newborn & Child Health (2005). Similar coalitions exist at national levels, including in the U.S. where at least four of the major disease issue advocacy coalitions are convened or otherwise supported by the Global Health Council. Some coalitions have been time-limited. A number, however, are long-standing institutions within the community. Membership within these coalitions is on the rise and diversity among members is increasing. Coalition partners are becoming more active throughout the policymaking process.

Finally, while a subset of global health topics have been associated with ideological or partisan orientations, interest in global health has been largely bipartisan over the past decade with the major increases in investment occurring under an eight-year Republican administration. As a result, political engagement in global health has been less associated with the party in control of the government and more influenced by the emergence of global health threats, the longevity of political "champions" and the introduction of new and potential supporters of the global health agenda.

The current period of global health support began during the second term of the Clinton Administration with a Republican-controlled Congress. The Bush Administration, in 2001, began a phase of both Republican-controlled legislative and administrative branches of U.S. government, as well as significant growth in global health (primarily AIDS) spending. Also in 2001, a SARS outbreak and domestic anthrax attacks brought the issues of health systems preparedness, bioterrorism and the link between health and national security to rapid attention. The year 2003 marked the launch of PEPFAR and the Global Fund. In 2006, Democrats gained control of both
the House of Representatives and the Senate for the first time since the 103rd Congress. This shift in power, along with a late 2006 recognition by the media and policymakers of extensively-drug resistant tuberculosis (XDR-TB) and preliminary discussions of the reauthorization of the PEPFAR program, has contributed to Congress’ continued attention to global health topics. As of July 2007, political attention to global health appeared steady.

Chapter Summary

While specific changes in global health over the past decade have been increasingly referenced in scientific, public and policy circles, there is limited comprehensive documentation of these changes. Furthermore, these trends have not been paired with a discussion of the policymaking process that underwent an equally significant metamorphosis. This chapter overviewed relevant policy events and products that, together, confirm a period of intensified activity and change for global health since 1997. The global health topics and related policy dynamics represent the factors to which policy actors, including the Global Health Council, are working to adjust.
CHAPTER 3

Chapter Overview

The Global Health Council is confronted with two challenges. The first is a challenge presented by the policymaking process that has undergone change; the second is an organizational challenge as the Council attempts to adjust institutional strategies to changes in the external environment. Therefore, a comprehensive understanding of the Council’s best policy behavior requires a broad view of the policy environment as well as a focus on the organization’s specific strategies. An ecological approach, which allows for analysis at multiple levels, satisfies this need and is used here.

As this research documents a real-time case study, it is intrinsically not theoretical in nature and, therefore, does not test a particular theory. The policy sciences and organizational sciences literatures offer a set of core concepts, terminology and useful structures that help to explore and respond to this study’s research questions. This chapter reviews the ideas that guided analysis and informed recommendations as to how the Council could maximize the effect of its policy functions to remain effective over time.
“Environment”

The term “environment” is used in two ways throughout this dissertation. In its first use, environment speaks to the policymaking process and its products, i.e., legislation, funding and programs, like those outlined in Chapter 2. In this context, it is most often labeled as the “policy environment.” In its second use, environment refers to the growing network of global health stakeholders and, specifically, the organizations and individuals that engage as actors in the policymaking process. The Global Health Council is concerned with the combined environmental effect of the policymaking process and its policy actors. However, a first-order question about the changes in the broader policy environment that affects all actors, including the Council, must be addressed. The specific definition of environment can be generally determined using textual context.

“Stakeholder”

The term “stakeholder” is also used in two ways throughout the dissertation. By traditional definition, a stakeholder is “any group or individual who can affect or is affected by the achievement of an organization’s objectives” (Freeman 1984). For the purposes of this project, global health program implementers, financiers, policymakers and advocates – including the Global Health Council – are all stakeholders with a shared global health interest. Many of these individual organizations are also, through their formal and informal relations with the Council, stakeholders of the organization. Therefore, the stakeholder term can refer to global health in general and,
specifically, to the Global Health Council. As with the term “environment,” the specific use of “stakeholder” can generally be determined using textual context.

The Global Health Council’s Policy Identity

The Global Health Council is an established organization in the Washington, D.C.-based global health community. The Council is one of the few global health organizations in the U.S. that promotes a comprehensive global health agenda, defined as the aggregate of specific diseases and populations that define the greatest global burden of disease. This orientation is different from most of its member organizations and partners which promote single diseases, special populations or some other, but incomplete, combination of the global health agenda. As a result, the Council is uniquely situated between the issue-specific organizations and specialized communities. It, therefore, has the ability to link, for example, child survival and infectious disease stakeholders or AIDS and family planning groups that might not otherwise work together. Within its membership base, the Council also has the ability to bring together otherwise disconnected types of organizations such as pharmaceutical companies and universities or activist-oriented non-governmental organizations (NGOs) and foundations or think tanks. In this way the Council connects smaller, interest-specific networks to form a more complete global health network.

Brokering Network-Based Policy Interactions

The Council’s current policy reputation is based on the organization’s consistent execution of its core policy functions. These functions appear to be as an advocate and policy broker. The Council’s advocacy role is traditional, defined by direct engagement with policymakers to influence their policy decisions. The broker role, however, is a newer concept defined as such for the first time in this dissertation.
Actors can serve a number of roles in their efforts to influence policy. Roles may change based on the stage of the policymaking process as well as the presence and activities of other stakeholders. The literature suggests that organizations that serve as brokers are strategically situated to influence policies and the direction of community action (Heany 2006; Carpenter, Esterling, and Lazer 2004). In the current policymaking environment, stakeholders increasingly operate in complex and multiple networks. The broker position is viewed as one of network leadership and power and is, therefore, highly valued (Rowley 1997).

A broker is an intermediary who facilitates transactions by standing between interest groups that are not connected directly to one another (Heany 2006). Through their membership base, associations interact with organizations that likely share a common belief or policy goal but do not necessarily work together. Associations are, therefore, generally well-positioned to fill the broker role. However, no single type of organization has emerged as more successful or effective in this role (Carpenter, Esterling, and Lazer 2004). Therefore, the Council’s association status is not a reliable predictor of fit for the important network role of policy broker.

The specific tasks an organization executes appear to be a better indicator than organizational type of effective policy brokerage. Organizations that navigate informal communication networks by providing accurate, reliable and timely information, convene formal coalitions (or facilitate other forms of collective policy action) or serve as a bridge between otherwise disconnected constituencies are the most likely brokers. The Council conducts each of these activities. Therefore, by type and its menu of policy activities, the Council appears to be a legitimate policy broker. Combined with direct advocacy activities, the Council’s broker actions may define an institutional advantage and contribute to its
sustained policy influence. Study data allow for an exploration of this potential advantage characteristic.

Defining Organizational Advantage

According to organizational ecology, the environment favors organizations and populations of organizations that are able to reproduce their core structure. Organizations establish institutional reliability and accountability by faithfully implementing a set of advantageous traits and activities over time (Carroll 1984). These traits commonly establish individual organizations as a known quantity in the broader population. In a stable environment, the literature suggests that these institutionalized traits and practices serve an organizational benefit. The benefit of these features can be lost when the environment changes, as it has for global health over the past decade. Organizational activities that were effective before changes occurred may threaten the organization’s long-term relevance if those strategies become ineffective in the new environment and the organization it is not willing or able to change its approach. Hannan and Freeman (1984) call this resistance “structural inertia” (Hannan and Freeman 1984). To ward off structural inertia and maximize adaptation ability, the Global Health Council must understand the nature of its core policy functions and whether the functions provide a current organizational benefit and potential future advantage in the changing environment.

Organizationally advantageous policy functions are the set of competencies that not only contribute to an organization’s institutional reputation during stable times, but also enable the organization to remain effective amidst changes in the environment. The concepts of niche and competitive advantage help to frame the examination of which of the Council’s policy functions provide an organizational advantage or enhance longevity of the organization’s policy influence (Barney 1991; Hannan, Carroll, and Polos 2003).
General ecology defines a niche as “the set of resources or limiting conditions that enable a population to survive” (Hannan and Freeman 1989). An alternative, more conventional, view of niche in the policy field is the position that an organization holds in relation to others. While these definitions differ, they both depict a distinct space where something – in this case, an organization like the Global Health Council – can exist. Both definitions also imply that changes in conditions internal or external to the Council may affect its status as a first-tier global health policy actor and broker among the field of newly defined stakeholders. Based on my focus on a single organization, the utility of the formal population-level niche concept is limited in this study. Niche instead will serve here as a more general symbol or way to think about the uniqueness of the Council’s role and where it “fits” within the network of global health stakeholders. Competitive advantage provides the appropriate conceptual focus at the level of individual organization.

Sustaining Competitive Advantage

The functions and institutional characteristics that protect the Global Health Council’s niche while contributing to its survival and success constitute its competitive advantage (Barney 1991). Basic competitive advantage exists when an organization is implementing a value-creating strategy that is not simultaneously being implemented by a current or potential competitor. Sustained competitive advantage has the added criteria of institutional features, tasks or products that are unique to the organization’s strategy. Advantage is only sustained if an organization’s strategy continues to exist after efforts to duplicate the strategy have ceased. By this definition, the Council will achieve a sustained competitive advantage once it confirms viable core policy practices such as its advocate and broker activities and implements them in a way that outperforms competition over time. The research question (page 2) assumes that the Council wants to achieve a sustained competitive policy advantage.
The influence of global health policy environment changes

The increase in support for global health advocacy activities along with more direct access to policymakers and their decisions, as described in Chapter 2, have led global health organizations to modify their structures and strategies. An increasing number of historically program-focused organizations have added advocacy or policy functions and new advocacy-only organizations have been established. As a result, the Global Health Council is now just one of many organizations in a growing community of stakeholders attempting to influence global health policy outcomes. Like the Council, these organizations define and execute strategies to influence policy outcomes and shape the policy environment. Also like the Council, the organizations are shaped by trends and shifts in the policy environment that are beyond their influence and control. This experience follows thinking within the organizational ecology perspective whereby organizations are shaped by the context in which they are created (Aldrich and Pfeffer 1976; Carroll 1984).

The Global Health Council is sensitive to the policy environment’s direct influence on its activities as well as its effect on the broader population of organizations also working to influence global health policies. As the socio-ecological framework implies, experiences at one level have consequences at other levels. Population-level effects can, therefore, be measured in individual organizations, as illustrated using the Global Health Council as a case study. This premise suggests that the study of the policy environment’s direct impact on the Council is enhanced by exploration of the environment’s pressure on the general population of global health stakeholders in which the Council finds itself. While the primary research question focuses on the level of the individual organization, its sub-questions capture potential changes in other organizations in the population that may reinforce the policy environment in affecting the Council’s strategic policy decisions.
Adapting to the Changing Policy Environment

Stable environments in politics and policy – even organizational life cycles – are rare. Instead, the environment is fundamentally dynamic. The global health “policy window” that has emerged over the past 10 years represents the combined result of shifts in public awareness and opinion, epidemiological and demographic changes, economic variables and policy trends. These factors are constantly changing with mutual, yet unequal, influence on each other. Their balance cannot be predicted with precision or artificially constructed. As a result, policy change can take decades (Sabatier 1999).

Benefit-Preserving Institutional Features

A subset of the organizational sciences literature suggests that organizations that respond favorably to the environment and persist through change have certain institutional features or employ a set of strategies that either protect the organization against external pressures or lead it to adapt to new environmental features (Aldrich 2008). According to the organizational sciences literature, older organizations and organizations with higher technology capacity have an institutional advantage over younger organizations and organizations with less sophisticated capacity to communicate and interact (Alexander 2000). The Council’s relative policy maturity as a 35-year old organization working in global health should operate in its favor. Its actual and perceived technology strategies will be useful to understand, although detailed exploration of the organization’s technological structures and strategies will be limited as this aspect is not central to this policy-focused study. While useful in understanding the Council’s potential current advantage, the literature provides little insight about how these characteristics impact organizations during periods of environmental change. Despite this limitation, these characteristics and strategies remain generally useful and are considered during analysis and in the development of this study.
Stakeholder Relations

The Global Health Council’s policy identity is dependent on ongoing relationships and interactions with diverse constituencies. The organizational sciences literature suggests that organizations that are perceived by stakeholders to be a “value added” in relationships or service are more likely to persist through change. Organizations with strong inter-organizational relationships and that are intentional in having some degree of heterogeneity in their connections also appear better prepared to withstand environmental pressures (Andrews and Edwards 2004; Klijn 1996).

Part of the Council’s successful adaptation to the changing policy environment will be the proper identification, prioritization and management of the growing network of global health stakeholders. According to stakeholder theory, stakeholders can shape an organization’s decisions, performance and outcomes. It is, therefore, in an organization’s interest to understand with whom they are working, under what terms and conditions and to what end. This holds particularly true for membership-based and advocacy organizations like the Council whose core activities are based on dynamic relationships that result in sometimes intangible, non-attributable policy outcomes.

Stakeholder knowledge is typically achieved by defining potential stakeholders, their interests, activities and possible effect on a focal organization’s operations – an exercise known as stakeholder mapping (Freeman 1984). Genuine stakeholders can then be separated from non-stakeholders allowing the focal organization to tailor operational strategies and deploy limited resources in a manner most favorable to its goals (Mitchell, Agle, and Wood 1997). This dissertation makes use of data that roughly “maps,” or at least identifies, organizations in the Council’s current policy network.

The subset of stakeholder relations literature provides numerous frameworks by which an organization can sort stakeholders and tailor interactions to preserve a desired relationship over time. A number of typologies have been created to help organizations determine stakeholders’
relative importance and most appropriate management strategies (Friedman and Miles 2006; Mitchell, Agle, and Wood 1997; Page 2002; Savage et al. 1991; Freeman 1984). One typology of interest and potential use in the analysis of Global Health Council stakeholders was presented by Mitchell, et al. (1997). In this model, stakeholders who emerge as particularly salient to organizations demonstrate some combination of power, legitimacy and urgency over the focal organization’s agenda. The balance of these attributes informs specific organizational approaches which must be managed over time through tailored interactions, close monitoring and, when necessary, strategy adaptation (Friedman and Miles 2006; Mitchell, Agle, and Wood 1997). These stakeholder concepts suggest that the Council’s policy functions may be best executed to different degrees among its large and diverse constituency based on features such as the type of organization interacted with and/or the organization’s relation to the Council. The data used in this study support the exploration of this proposition.

Conceptual Framework

The Global Health Council’s current understanding of its actual role and effect in the policymaking process and among the network of global health policy actors is limited. Core concepts rooted in the policy sciences and organizational sciences provide a basis for the analysis of the Council’s organization-environment relations. As a membership-based organization that relies on the largely intangible policy processes products, an essential element of the Council’s success is its ongoing successful relationship with stakeholders throughout the entirety of the policymaking process. Specific to the policy environment, there have been many attempts to describe the relationships among various policy actors and the role they play in the policymaking process (Andrews and Edwards 2004; Dawes et al. 1986; Dowding 1995; Heaney 2003; Knoke 1986; Schlozman and Tierney 1983). Research in this area has resulted in a body of literature that
characterizes these actors and relationships using terminology such as networks, communities and other terms that are often overlapping in definition and study.

**Conceptual Model**

Ecological frameworks best capture the multilayered influence and dynamics described in this study. These frameworks illustrate the environmental factors that exert pressure on the broader community of stakeholders and provide a spatial representation of the relationship among stakeholders. Organizational ecology suggests that there are different types of organizations (i.e., populations) shaping and shaped by the environment. The Global Health Council operates in an environment where organizations may classify themselves as: 1) program implementers; 2) policy advocates; 3) policymakers; 4) financiers; or any combination of these types. Stakeholder theory suggests that organizational strategies vary based on the type of relationship between the focal organization and its stakeholders. As a membership organization, the Council’s primary relationship distinction is “members” versus “non-members.” Non-members can be further classified into those with whom the Council has some level of affiliation and those with whom the Council does not interact. These ecological principles are combined to construct the study’s basic conceptual model, represented in Figure 8, which demonstrates the Global Health Council’s policy network and the various paths to influencing global health policy.

In Figure 8, global health stakeholders in the Council’s network are classified in two ways. Organizations appear, by type, in four quadrants. Each quadrant represents a population niche within global health that a set of organizations fills based on available resources and a defined set of skills and activities. These organizations are assumed to be stakeholders of the global health agenda and, in this study, of the Global Health Council. These organizations are further assumed to be affected by the changes in the global health policy environment, detailed in Chapter 2. Each of
these populations has a vested interest in global health policies and seeks to influence them in some way. In practice, organizations may fit into more than just one single quadrant. The quadrants outlined are, therefore, not mutually exclusive and are presented in this simplified manner for analysis purposes only.

In addition, organizations appear in Figure 8 based on their relation to the Council. Council relations are depicted as a set of concentric circles moving from the innermost level representing organizational members of the Council, to organizations with whom the Council interacts on a voluntary basis largely through advocacy coalition or as event partners and, at the outermost realm,
organizations with whom the Council currently has no relations but which still operate as legitimate
global health stakeholders. Organizations fit into only one category of relation to the Council as a
member, non-member affiliate partners or non-affiliated organization. Four potential pathways of
policy influence exist.

First, the Council has in-house advocacy capacity with the mandate to influence policy
outcomes. These Council-specific efforts are assumed to have direct access to and influence in the
policymaking process (Path 1).

Second, organizational members often rely on the Council to influence policy on their
behalf, as is common in a traditional member-association relationship (Path 2). These organizations
are often program implementers without in-house advocacy functions or, as recipients of U.S.
government funding, limited in their legal ability to engage in the policymaking process.

Third, the Council’s non-member affiliates sometimes work through issue advocacy
c coalitions convened or attended by the Council (Path 3a). These organizations are more likely to
have in-house capacity to work on policy issues or other resources. As a result, these organizations
may have additional, more direct paths to other organizations and policymakers (Path 3b). These
organizations are considered to be partners with whom the Council often collaborates and, at
times, competes for attention, influence and attribution for policy outcomes.

Finally, non-affiliated organizations tend to engage in global health policy independently
(Path 4). The path of these organizations to policymakers is unknown to the Council as the Council
does not interact with them or track their activities. Exploration of Path 1 provides insight into the
Council’s claim as a direct policy advocate. Paths 2 and 3a allows for study of the Council’s claim
as a policy broker. Paths 3b and 4 shed light into the alternate network relations and competing
direct advocacy and policy broker mechanisms also influencing the global health policymaking
process.
This model assumes that all organizations are susceptible to environmental pressures. These pressures may take the form of social factors such as public opinion, demographic changes, epidemiological shifts, organizational structures, financial mechanisms or changing politics and policy. The current analysis is limited to global health policy (i.e., the policymaking process, its products and engaged policy actors) and situates organizations as they relate to the Council. For current purposes, the Council is assumed to be centrally located at least among its members and non-member affiliates. The Council’s position relative to non-affiliated organizations is unknown and its exploration is beyond the scope of this study.

Chapter Summary

Organizations in the Council’s policy network interact independently and with each other to transform the global health agenda. While Figure 8 is just one of many ways that the Council’s policy network could be visually characterized, the conceptual model captures the relevant elements of types of organizations, their relation to the Council and the environment’s influence on these organizations, including the Council. In an effort to answer how the Council can maximize its core policy functions in the changing environment, multiple data sources are used to establish whether the Council, in fact, serves as a direct policy advocate and/or a primary policy broker among its members and affiliates. Data provided from a strategic planning exercise undertaken by the Council during the course of the research allowed an initial exploration of some of the key organization-environment concepts outlined in this chapter.
CHAPTER 4

Chapter Overview

This study’s specific and applied research aim is to help Global Health Council executives understand the nature of the changing policy environment in order to revise (if necessary) the organization’s policy approach. Through analysis of these data, appropriate adjustments in the organization’s policy approach will increase hopefully the Council’s likelihood of an ongoing role in the policy arena and enhance its reputation as the leading advocate and broker of global health policy. This chapter outlines the specific data and analysis methods used to generate this knowledge.

Study Design

This dissertation presents a case study of the Global Health Council as it attempts to identify and implement its core policy functions in a global health policy environment that has, over the past decade, undergone significant change. The case study approach allows for an in depth exploration of the external circumstances and internal institutional features that influence the Council’s current policy activities. This detailed analysis seeks to inform the Council’s options for future policy activity and effectiveness (Patton 2002). The extent to which findings and recommendations can be generalized to settings, populations and circumstances beyond those that currently apply to the Global Health Council are, however, likely to be limited.
Methods

Data for this study were collected as a part of an 18-month strategic planning exercise carried out by the Global Health Council during the period May 2006-October 2007. These data included: 1) responses from 40 semi-structured key informant interviews of organizations with some affiliation to the Council; and 2) a database compiled by Council staff to catalogue core institutional characteristics of 576 organizations with an established affiliation to the Council. Organizations in the database include organizational members of the Global Health Council, members of ongoing advocacy coalitions either convened or attended by Council staff and organizations with whom the Council has co-hosted a policy event during the period 2005-2007. Details of the database are described in the Stakeholder Analysis section that follows on page 51.

The data reported in Chapter 2 documenting the changing global health policy environment was gathered expressly for background evidence for this dissertation independent from the Council’s strategic planning exercise. Details on the methodology of data collection for specific global health policy trends (presented in Chapter 2) are provided along with original data tables in Appendix B.

Key Informant Interviews

As a part of its strategic planning exercise, the Global Health Council commissioned an external consultant to conduct interviews with representatives from organizations identified by Council leadership as relevant global health entities and important stakeholders to the organization. These interviews were conducted in February through April 2007. Interviews captured stakeholder perceptions about the changing environment as well as respondents’ views of existence and impact of the Council’s policy activities. Interview responses were transcribed, with participants’ consent,

---

12 Forty key informant interviews were conducted during the strategic planning exercise. A total of 41 organizations participated in these interviews.
Sample, Setting and Data Collection

Original key informant data were gathered using a purposive sample to ensure the degree of diversity and representation desired by the Council from the limited available sample. Interview selection criteria were the following:

1. The organization or its representative must have worked on global health issues as identified in the organization’s publicly available mission statement, scope of work or other form of formal communication; and

2. The individual must speak English.

No parameters regarding gender, ethnicity or race were used as deciding factors for interview participation. As broad a sample of respondents as possible with representatives from the widest possible set of organization types was the goal. As an organization with a “global” focus and membership base, diversity in demographic and conceptual characteristics was deemed important for gathering a comprehensive perspective during the strategic planning exercise. Because initial interviews only included U.S.-based respondents, a second set of interviews was conducted in June 2007 during the Council’s annual conference to capture perspectives of Council members from developing countries. The total sample size (n) of respondents from the external stakeholder key informant interview was 41.

Organization selection was loosely based on the typology presented in the study’s conceptual model (Figure 8) and attempted to capture both primary institutional function and relationship to the Council. An additional “hybrid” category emerged to capture organizations for which a single functional identity was not clear. In this instance, hybrid organizations may have been any combination of program, advocacy, policymaker and/or financier. Table 1 shows the
distribution of key informant interview participants based on these features. These organizations were drawn from master lists from: the Council’s official organizational membership database, coordinators of the Council’s AIDS memorial program, experts who consulted on the Council’s annual global health report series, U.S. policymaker contacts, fundraising contacts, global partnerships and personal relationships of Council leadership.

Table 1. Key Informant Interview Participants

<table>
<thead>
<tr>
<th></th>
<th>Program</th>
<th>Advocacy</th>
<th>Policymaker</th>
<th>Financier</th>
<th>“Hybrid”</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member</td>
<td>16</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>6</td>
<td>24</td>
</tr>
<tr>
<td>Affiliate</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>6</td>
<td>14</td>
</tr>
<tr>
<td>Non-Affiliate</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>TOTAL</td>
<td>17</td>
<td>5</td>
<td>3</td>
<td>1</td>
<td>12</td>
<td>38 + 3 uncoded transcripts = 41*</td>
</tr>
</tbody>
</table>

* Forty-one individuals participated in interviews. In one instance, two organizations interviewed together for a total of 40 interviews.

Figure 9 maps participating key informant organizations on this study’s conceptual model. This visual display of placement within the Council’s policy network served as a preliminary “hypothesis” of how organizations relate and function in the policy environment. It also helped to assess whether the Council’s functions and assumed paths of policy influence were accurate. As displayed in Table 1 and Figure 9, a majority of the respondents represented program-implementing organizational members of the Global Health Council. This over-representation of Council members and program implementers (and subsequent under-representation of organizations with looser affiliations and stronger policy functions) is reflected in the analysis and will be addressed in Chapter 5.
Figure 9. Key Informants – “Mapped” to Conceptual Model

*Thirty-four organizations are included on this figure. Six organizations were not identified by name when received for data analysis.

Respondent Confidentiality and Privacy

Specific respondent names, titles and organizational affiliations were stripped from transcripts before electronic copies of the files were transferred for analysis in this study. The Council’s consultant labeled transcript files using the schema in Table 2 to allow attribution of responses to a certain type of (but not specific) organization and generic relation to the Council. These categories were designed to aid in data analysis and categorization of themes by these organizational features, should variations in responses emerge. These coding labels are attached to specific quotations reported in Chapter 5.
Table 2. Transcript Coding Scheme

<table>
<thead>
<tr>
<th>Relationship to Global Health Council</th>
<th>Population Niche (i.e., primary organizational function)</th>
<th>Type of Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Member</td>
<td>1 Program</td>
<td>GA Government agency</td>
</tr>
<tr>
<td>B Affiliate</td>
<td>2 Advocacy</td>
<td>NGO Non-governmental organization</td>
</tr>
<tr>
<td>C Non-affiliate</td>
<td>3 Policymaker</td>
<td>INT International agency</td>
</tr>
<tr>
<td></td>
<td>4 Financier</td>
<td>UNIV University</td>
</tr>
<tr>
<td></td>
<td></td>
<td>FND Foundation</td>
</tr>
</tbody>
</table>

All electronic versions of the data were password-protected, with the password stored on a separate computer from the one housing the electronic files. In the written analysis and final reporting of the data results, any specific quotes or references are limited to generic identifying labels summarized in Table 2, such as "a program-focused Council member" or an "advocacy non-member partner." These generic labels have been used only to provide the context for the statement. Specific names or combinations of indirect identifiers were not used in an effort to minimize (but not guarantee protection against) risk of revealing specific individuals or organizations.

Data Quality

Because data were collected by a third-party, the quality of the interview data is beyond the control of this study. The Council’s consultant verified that she captured interview proceedings by simultaneously typing responses during the actual interview. Responses, however, were not recorded verbatim and, other than the consultant’s assurance, whether responses were otherwise edited during transcription could not be confirmed. Transcripts included notes logging when questions were asked out of order, answered elsewhere in the interview guide or not addressed (sometimes with an explanation). As a result, instead of exclusively reviewing the subset of policy-
specific questions from the interview guide as initially proposed, the full transcripts from all interviews were reviewed to ensure that all policy-relevant data revealed during the interview were captured.

Coding and Analysis

During the period October through December 2007, a thorough review of the strategic planning key informant interviews was conducted, as was a detailed content analysis of opinions and perspectives relating to the policy environment, relationships among global health actors and the Council’s policy activities and effectiveness. The content analysis facilitated the reduction of the large volume of data into meaningful themes and patterns for analysis (Patton 2002). To facilitate the data coding process, first, all of the transcripts were read without any specific structure for interpretation or preliminary themes. This initial reading allowed me to consider what commonalities and potential themes might be used to explore the study’s sub-research questions relating to the Council’s policy functions, policy environment and policy network. This followed the general guidance of “grounded theory,” introduced by Glaser and Strauss (1967), described in Patton, whereby theories can be generated and confirmed through exploration of the data (Patton 2002).

As themes emerged, words and phrases were identified as potential codes, noting them by hand along the margin of each transcript. At the conclusion of reviewing each transcript, notes, reflections and other commentary were recorded to capture any emerging trends or issues for future consideration. The coding techniques of Miles and Huberman served as a template – codes were identified, defined and tested for patterns and meaning (Miles and Huberman 1994). The initial codes were sorted among overarching themes – policy functions, policy environment and
policy network – drawn from the study’s primary research question and sub-questions. These codes were then used to create a codebook database that:

1. Assigned an acronym for rapid coding (e.g., FN = function | PN = policy network | EN = environment);
2. Identified the concept the code was designed to capture;
3. Provided a short and long definition, including reference to any specific questions from the key informant interview guide;
4. Outlined specific conditions for use, with examples; and
5. Captured any notes, such as revisions to the code or observations.

Once the codebook was complete, it was used in a second phase of transcript coding. Official codes were compared to the original hand coding of the 40 interview transcripts. Along the way, some original codes proved to not be useful or applicable and were removed. Justification for any code additions or deletions in the codebook database was recorded and any codes that were found to be duplicative or not fully descriptive were merged into a new code. The codebook database captured all coding related changes.

No other researchers were involved in the analysis of these data. Therefore, inter-rater reliability, cross-coding or other analyses to test data quality was not possible. However, to test the reliability of initial hand-codes, all interviews (and the codebook) were loaded into the text analysis software, Atlas.ti. This software package facilitates the storage, retrieval and other systematic organization of the interview data. In November 2007, approximately one month after original hand-coding, the interviews were coded a final time in Atlas.ti using the same codebook and coding criteria. As with the hand-coding, each interview was coded in a single session to ensure consistent code application. Notes and memos were recoded in the database immediately upon completion of the interview coding. Upon completion of computer-assisted coding, hand-coding and Atlas.ti-
coding results were compared to ensure consistency. The coding was, with rare exception, consistent. Inconsistent codes were reviewed and a reconciled final code was recorded in the Atlas.ti database.

In December 2007, once coding was complete, codes were grouped by major category (function, environment and network) for more detailed analysis. They were reviewed by category to generate initial descriptions of responses to key questions and research themes. Quotes were further segmented and analyzed by the type of organization and their relation to the Council. This additional segmentation was done to identify nuances of organizational perceptions that may have emerged based on organizations’ relationship to the Council or other institutional features. As specific trends began to emerge in the data, relevant literature was revisited to explore potential explanations for the data results. Once data analysis was completed, the major trends and unexpected results that emerged were used to generate conclusions about stakeholders’ perceptions of the policy environment and the Council’s policy roles. These conclusions served as the basis for recommendations for how the Council could best position itself in the changing global health policy environment as well as any unique considerations when relating to the diverse network of global health stakeholders. The coding results are described in Chapter 5.

Stakeholder Analysis

An environmental scan is a review of information about external issues that may influence an organization’s decision making process (Albright 2004). For the Global Health Council, an analysis of stakeholders is a key component of this scan. Council staff compiled a database that captured organizational characteristics of organizations in the Global Health Council’s current policy network. These organizations are those with whom the Council regularly interacts (by obligation or choice) and has some overlapping global health interests. The database was intended
to provide a data pool from which general descriptions and trends among relevant organizations could be drawn for this specific analysis and broader strategic planning. Information that was considered to be related to the Council’s policy interests was used for analysis. The database was built in June through October 2007.

Sample, Setting and Data Collection

The purpose of the information in the stakeholder database was to develop a typology of global health organizations, capturing: 1) their chief characteristics such as organizational age, focal issue areas, mission and primary business model; 2) how they relate to the Council, i.e., as a member, advocacy partner or otherwise; and 3) emerging organizational trends that might affect the Council’s future as a direct policy actor and policy broker. Table 3 lists the organizational characteristics recorded in the database.

Table 3. Organizational Characteristics Captured in Stakeholder Database

<table>
<thead>
<tr>
<th>General</th>
<th>Council Relationship</th>
<th>Organizational Demographics</th>
<th>Scope of Work</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location</td>
<td>Relation to Council</td>
<td>Age</td>
<td>Mission statement</td>
</tr>
<tr>
<td>Web site</td>
<td>Coalition participation</td>
<td>Membership-based</td>
<td>Issue area(s)</td>
</tr>
<tr>
<td>Type of organization</td>
<td>Event partnership</td>
<td># of staff</td>
<td>Primary activity</td>
</tr>
<tr>
<td></td>
<td>Other coalition</td>
<td>Budget size</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Funding Source</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Washington, D.C. office</td>
<td></td>
</tr>
</tbody>
</table>

To be included in the database, organizations must have satisfied the following criteria:

1. Existed as a current organizational members of the Global Health Council, as confirmed by an official June 2007 membership list; or

2. Listed as a member contact for one or more Council-convened (or Council represented) coalition partners, as confirmed by June 2007 master membership lists. The following coalitions were included: US Coalition for Child Survival, International Family Planning
Coalition, Global AIDS Roundtable, Malaria Roundtable, and Neglected Tropical Disease Roundtable; or

3. Listed as an organization with whom the Council had partnered on public events during the period 2005-2007, as recorded in a Council policy event database.

Initially, the goal was also to capture currently non-affiliated Washington, D.C.-based global health organizations (as defined by their mission statements, returned by an Internet search with key words “global health” and “Washington, D.C.” or publicly available on website). However, search returns were unreliable and did not accurately or exhaustively capture qualifying organizations. Therefore, further efforts to capture global health organizations not interacting with the Council through a documented or formal relationship were discarded. The complete database totaled 576 organizational records.

**Data Quality**

The stakeholder database was completed by third parties at the Global Health Council. There were meetings with the database architect to review ambiguous codes and a subset of records were randomly selected and cross-coded to ensure appropriate application of predetermined codes. However, it was not possible to verify original codes or cross-code all 24 data points that were collected for each of the 576 entries. As a result, data reliability and validity cannot be completely guaranteed, but the face validity of the material is high. The data were assumed to have been accurately coded based on the database coding criteria. Any variations recorded among the results are reported in Chapter 5.

**Coding and Analysis**

The stakeholder data were analyzed on two levels. First, selected organizational characteristics captured in the database were reviewed to establish frequencies among core
variables. The characteristics demonstrated, for example, the distribution of organizations by type (e.g., NGO, university, government agency, etc.), their relation to the Council (i.e., a member or non-member partner, as characterized in the study’s conceptual model) and primary issue areas. Second, a cross-tabulations of organizational traits was performed to demonstrate, for example, the distribution of specific features, such as an organization’s key institutional function (e.g., advocacy, program), by other features such as relation to the Council. All 576 organizational records were included in the analysis, with any missing data noted.

Data Summary

Three data sources converged to provide a pool of information from which a set of conclusions and recommendations addressing the research question could be generated. First, Chapter 2 described the substantial changes that have taken place in the global health policy environment over the past decade. Second, the Council’s strategic plan exercise outlined options for future organizational direction based on stakeholder feedback and internal dialogue. Finally, the organizational database constructed during the strategic planning period provided a general sense of the strategic direction of other global health stakeholder organizations currently operating through, with or against the Council in achieving identified policy goals.

By using multiple data sources, collection and analysis methods, limitations of each were compensated, in some way, by the strengths of the others (Miles and Huberman 1994; Yin 2003). Furthermore, taken together, the information gathered from these data sources constitute a stakeholder mapping source which enables organizations to appropriately categorize and respond to specific stakeholder interests (Freeman 1984). While the ability to interpret broadly the global health environment and its many stakeholders from this exercise is limited to the available data, these data do give the Council its first in depth insight into the stakeholders with whom they
currently engage. Because this study relied predominantly on data that had already been collected, it was not possible to control for all gaps and inconsistencies in the data. However, weaknesses are described in the analysis and report on findings in Chapter 5.

Institutional Review Board

CHAPTER 5

Chapter Overview

This chapter is divided into two sections. The first section uses key informant interview data to develop a set of themes about the Global Health Council and its policy identity. The second part constructs a picture of the Council’s policy network using data from its policy network organizational database. These sections are then merged into a summary of key themes at the end of the chapter.

Analysis

Informed by the literature and practical experiences at the Global Health Council, three categories of questions are identified to explore the interaction of the Council with its environment. These categories are Function, Environment, and Policy Network. Independently, the categories organize specific questions about the Council and the external global health environment. Together, they expose the dynamic interaction and relationship between the Council and this environment that must be considered when formulating a response to the primary research question – “How can the Global Health Council maximize the impact of its core policy functions to remain an effective policy actor?” The categories outlined in this section guided the analysis of data gathered in the course of this work as well as structured the recommendations that emerged (Figure 10).
Figure 10. Research Questions Organized by Analysis Categories

Research Question
How can the Global Health Council maximize the impact of its core policy functions to remain an effective policy actor?

POLICY ENVIRONMENT
SRQ-2.1: How has the global health environment changed?
SRQ-2.2: What is/will be the impact of these changes?

FUNCTION
SRQ-1.1: What are the Council’s core policy functions?
SRQ-1.2: How do these functions impact the policy network?
SRQ-1.3: How do these functions affect the policymaking process?

POLICY NETWORK
SRQ-3.1: What are the characteristics of organizations in the Council’s policy network?
SRQ-3.2: How do stakeholders perceive the Council in relation to other organizations in the global health policy network?
SRQ-3.3: Do views of the Council’s policy role differ among global health stakeholders in its policy network?*

*Discussion of this sub-research question is reflected in responses to other sub-research questions

The Function category was defined as the core set of activities the Council executes to achieve its policy goals. The Council has the ability to manipulate these activities and maximize their use over time. Based on personal experience as a participant-observer with the organization, the Council’s core policy functions were understood as being a direct policy advocate and as a broker of global health interactions and information. At the beginning of the writing of this dissertation, the Council had not formally confirmed these functions. Under the Function heading, three sub-research questions (SRQs) arose. The first question explored under this heading was, “What are the Council’s core policy functions?” (SRQ-1.1). Once these core functions were identified, how these policy functions impacted the Council’s policy network (SRQ-1.2) and how
they affected the policymaking process (SRQ-1.3) were explored. Data for this analysis was derived from key informant interview transcripts.

The Environment included conditions external to the Global Health Council that manipulate global health and its stakeholders, including the Council. The environment was defined as past, current and anticipated future changes in global health programs, policies, epidemiology, demographics and broader socio-political factors. Key informant interview transcripts were analyzed to understand stakeholder perceptions of how the environment has changed and the outcome of those changes (SRQ-2.1 and SRQ-2.2). Taken into consideration were changes over the past decade as well as those that are predicted to occur over the next five to 10 years. These past and future changes represented the pressures and trends of which the Council should be aware and to which the organization should be ready to adjust as it attempts to shape global health policy.

The Policy Network included questions about the set of organizations identified as global health and Global Health Council stakeholders (SRQ-3.1). As stakeholders, these organizations are expected to affect and be affected by the Global Health Council and its policy activities. Specifically, I examined the policy network in terms of stakeholder perceptions of the Council, its work and reputation among the set of organizations that comprise the broader policy network (SRQ-3.2). These organizations may serve as institutional models, policy competition or as having varying degrees of influence over the Council’s policy activities. Differences in stakeholder perceptions based on their institutional characteristics, (e.g., function, relation to the Council) informed the analysis (SRQ-3.3), as did key informant interview transcripts and a stakeholder database specific to these data.

The questions summarized in Figure 10 are meant to lead to the development of options for institutional and strategic changes the Council has if it wishes can make to maximize its future policy role and sustainability. The environment and policy network were assumed to have a direct
impact on these options. Over time, the environment and policy network were also impacted the extent to which the Council could implement those options. While a picture of the Council’s role and impact on global health policy emerged from key informant interview data, details about the network of organizations with which the Council interacts, cooperates and competes in its policy work remained unclear. This gap was addressed through the examination of characteristics and demographics of organizations in the Council’s current policy network. This exploration addressed sub-research question (SRQ) 3.1 – “What are the characteristics of organizations in the Council’s policy network?” A detailed discussion of the limitations of the data is included in Appendix D as “Data Caveats.”

Results

Function – Defining the Council’s Policy Identity

For the most part, key informants felt the Global Health Council was actively contributing to the improvement of global health and the advancement of policy goals. Stakeholders believed that the Council has evolved in recent years and is steadily growing stronger. A key informant representing an organizational member of the Council with a “hybrid” program-advocacy institutional focus stated, “I think the Council is playing an increasingly important role, particularly in the last five years or so. It hit a low point seven or eight years ago and now it’s coming back stronger than it ever was.” (NGO12A-2) A program-focused Council member also reflected on the organizations evolution saying,

“I knew them before they were the Council from a distance and I compliment them for having made it a sharper edge and enhancing its capacity to speak in the community. To have a voice. It has done that well – a respected voice that provides accurate information and has become something of a resource to enough policymakers in D.C.” (NGO1A-6)
Respondents frequently acknowledged the efforts of specific Council staff even when less familiar with the work of the overall organization.

Advocacy

“It’s made a big difference. If we didn’t have all those voices out there, we wouldn’t be where we are now.” (INT124B)

“Advocacy” emerged as a clear theme among Global Health Council key informants. According to interview respondents, advocacy has played a “huge,” “important,” and “major” role in global health’s current public and political prominence. Direct policy advocacy and brokering policy interactions (by convening for policy dialogue and collective action as well as being a point of information/relationship exchange) define the Council’s current niche, and perhaps its institutional competitive advantage. Advocacy references were typically generic and without reference to specific policy strategies or attribution to specific policy actors including the Global Health Council. Informants acknowledged the new groups that have emerged and are engaging in global health advocacy. As one program-focused Council member described, “Advocacy groups that have worked both externally and internally have had an impact. Some groups have not historically been aligned with global health.” (NGO1A-3)

While the volume of advocacy has increased, key informants were concerned about the potential continuation of inequities in the distribution of global health resources and, therefore, interventions because of disease-specific advocacy rather than the promotion of the overall global health agenda. A program-focused Council member described the impact as “distorting,” stating that global health cannot have “18 most important themes…It’s a double-edged sword. It can loosen pocketbooks but it can also turn off donors.” (UNIV1A-4) To the Council’s credit, in the field of competing priorities, key informants viewed the organization as one of the few among
global health advocates that promotes both a disease-specific agenda and the overall global health perspective. This niche-defining theme of “comprehensive global health” is an important distinguishing characteristic of the Council.

Key informants identified advocacy as one of the Global Health Council’s central functions and, in recent years, a growing institutional strength. Today, the Council is seen as a credible and important voice in global health policy. Program-focused Council members, in particular, expressed appreciation for the advocacy work done on behalf of their programs and issues. One member said,

“[I] fully appreciate the importance of advocacy in the U.S. to support global health work. We as an organization don’t have the resources, contacts, know how. It is important for us to network with the Council to do this. We are already doing it, but the Council could reach out even more for U.S. advocacy initiatives.” (NGO1A-4)

Other key informants found value in the Council’s coordination of other advocates and its policy products including legislative analyses. While member and non-member organizations were equally likely to speak positively about advocacy in general and the Council’s specific impact, member organizations less often remarked on specific consequences of the Council’s advocacy work. Non-member organizations were often more enthusiastic about the Council’s advocacy coordination and convening role. This difference may have been due to member organizations’ likelihood of being program-focused and their inclination to rely on the Council for advocacy on their behalf rather than engaging in or evaluating the dynamics of the policymaking process directly.

In some instances, key informants stated that they did not know enough about the Council or its advocacy work to have an opinion. Appendix D discusses this and other data caveats.

According to key informants, advocacy in the form of direct engagement in the policymaking process is an institutional activity that the Council should continue. A representative of a policymaker-funding “hybrid” government agency summarized this dominant perception
stating, “One thing they are doing now that they should continue to do is serve as a voice in the policymaking area [as an advocate].” (GA34B-1) Informants recommended, however, that future advocacy activity incorporate additional strategies.

Key informants believed that the Council could enhance the quality of its advocacy by interacting with its members in a more intentional manner as it develops its advocacy agenda. A program-advocacy “hybrid” Council member qualified support for the Council’s current advocacy efforts stating, “They do this [advocacy] pretty well, but [need to] get more input from membership about key issues.” (NGO12A-2) This input would include greater and more direct interaction with Council members, particularly those operating in the global South. A program-focused Council member encouraged the Council to “…definitely ask developing nations what they need and base their priorities on those needs.” (NGO1A-7)

An advocacy sub-theme that may be labeled “proactivity” emerged among a minority of stakeholders. A few respondents, mostly non-members, believed that the Council could “drive more of the policy debate” (UNIV1A-3) and be more definitive in its agenda and policy positions. A non-member policymaking and funding government agency suggested that the Council could be “more aggressive in educating policymakers in the benefits and costs of government policy and existing and emerging need.” (GA34B-1) An advocacy-focused Council affiliate echoed this sentiment encouraging the Council to “focus on needs-based advocacy and be willing to raise the hard issues…lead rather than react…don’t compromise on things that matter.” (NGO2B-3) Even with this call for a louder, more assertive voice, key informants agreed that the Council must balance its “edge” with its reputation as a credible advocate welcomed in diverse policy dialogues. A program-focused Council member summarized this balance by saying, “There is a role for the very vocal position, but it is good for the Council to have a more moderate, yet critical voice.” (NGO1A-8)
Policy Broker

“One of the Council’s greatest strengths is that it is a convener. It can bring together lots of people. For “harmonization” and information sharing, can provide common context to possibly work toward some solutions.” (NGO1B-1)

The concept of a “policy broker” emerged as another dominant theme among key informants. In addition to direct advocacy, informants almost unanimously acknowledged the value of the Council’s role as a broker of policy interactions and exchanges among the growing network of global health stakeholders. This broker function manifested in two ways – first, as a convener of global health actors; second, as a point of exchange for policy information and relationships. Broker statements such as “bridging” and “convening” were one of the most consistent thematic references throughout interview transcripts.

Key informants regarded the Council’s advocacy coalitions (and its emerging sub-groups that focus on implementation and technical matters) as its greatest specific convening purpose and contribution to the policy network. Program and advocacy-focused organizations agreed that the Council “does a very good job in the [Washington] D.C. area of creating opportunities for [the] community to come together.” (NGO12A-2) Key informants characterized the Council as a neutral facilitator of needed policy dialogue among otherwise disconnected constituencies including government representatives, private and non-governmental stakeholders. Informants also looked to the Council to introduce new global health policy constituencies to existing actors. Outside of the coalition setting, informants referenced the Council’s annual conference as a primary convening mechanism of particular value among program-focused organizations.

In its second broker form, key informants perceived the Council as a reputable point of information exchange and a source of important relationships. Similar to the comprehensive nature of the Council’s advocacy, its policy reputation emerged as an important sub-theme. Key informants described the Council as “a good place to share experience, network, know trends,
According to key informants, stakeholders trust sharing with and receiving policy information from the Council. Current technologies such as email and listservs facilitate the dissemination and uptake of Council policy products including legislative updates and analyses. Key informants consistently recommended more advanced technology and stronger dissemination practices, including webcasting and face-to-face interactions outside of Washington, D.C., to reach the Council’s diverse and geographically dispersed stakeholders.

As an exchange broker, the Council is consistently viewed as serving a clearinghouse function. Minor trends emerged. For example, program-focused organizations appeared to value the Council’s ability to access key information and transmit it back to them. This arrangement allowed these organizations to receive important information without having to access original policy information on their own. A program-focused Council member explained, “Many organizations are smaller and don’t have an advocacy branch. That’s the role the Council plays.” The informant continued with another perceived strength of the Council, “Helping others to learn how to be effective advocates.” This sentiment is reminiscent of the traditional relationship among associations and their member constituents. These organizations were also most interested in access to policy updates, networking for potential relationships and policy activities on their behalf. Smaller organizations and those that lack an in-house advocacy function were most vocal about these perceived policy benefits. The value placed on the Council’s transmission of global health policy information was shared by international agencies and others whose primary interactions are not with a U.S. audience.

The Council’s communication style and content captured another important sub-theme when defining its policy broker identity. Advocacy organizations’ comments focused more heavily on the dissemination of policy strategy (versus issue or event summaries) and the importance of
specific policy interactions and outcomes based on exchanged information. These organizations value the “good information on the policy news that comes out, appropriations [annual federal funding].” (NGO2A-1) All organizations, regardless of institutional function or relation to the Council, emphasized the need for a mechanism to inform the Council’s advocacy agenda and facilitate interactions. An advocacy-focused Council member explained,

“They should function more as a membership organization and have a way to listen more to their members, rather than being so top down. It will allow them to be more opportunistic. They miss the interesting stuff. [They] need a collective base to define the priorities; find a way to incorporate members’ input in a timely manner; create a space to quickly learn about new and emerging opportunities.” (NGO2A-2)

As with the Council’s direct advocacy role, key informants limited the Council’s current policy broker impact to Washington, D.C., a possible result of the U.S. and Washington-dominated interview pool.

Is the Council’s Policy Role Unique?

“There are orgs [organizations] that have bits and pieces but none that has the same breadth of activities.” (GAIB-1 & UNIV1A-1)

According to key informants, the Global Health Council serves a unique function in the Washington, D.C. global health policy arena. Key informants identified no other organizations that were believed to perform the exact same role as the Council. Key informants believed, however, that the Council could learn from specific practices of certain organizations. Key informants made specific reference to Research!America, the Campaign for Public Health and the Trust for America’s Health as advocacy trendsetters from whom the Council could learn. Key informants specifically cited Médecins Sans Frontières, the World Economic Forum, and the international branches of the American Public Health Association and the Academy of Pediatrics as models of strong policy strategy or organization-constituent relations. Informants also mentioned other
groups including the American Lung Association, the Center for Global Development, the CORE Group, RESULTS, Save the Children, the ONE Campaign and the Academy for Educational Development as organizations that do work similar to the Council. According to informants, these groups, however, tend to work in a single issue area or aspect of policy activity (e.g., analysis, constituency mobilization). None focus “across all health” in substance or provide a full spectrum of advocacy functions as the Council does, thus preserving its functional niche.

While no other organizations were believed to be structured or function exactly like the Council, in the eyes of key informants, policy agendas and constituents often overlapped. As a result, a number of the organizations from which stakeholders believed the Council could learn also serve as potential competition. One example is InterAction, a Washington-based membership and advocacy organization that focuses on humanitarian and development assistance. While InterAction was identified as both an organizational model and potential competition, it was acknowledged that while policy functions are similar, constituencies and policy agendas differ enough to exclude characterizing the Council and InterAction as duplicative organizations. One program-advocacy “hybrid” Council member reflected on the distinction between the two organizations, explaining, “InterAction is not exactly [the Council], it’s broader, but they are similar in that it is a membership organization. There is overlap. But in my experience, they talk together and coordinate. The Council pushes health within InterAction.” (NGO12A-3) The same key informant highlighted the overlap with other organizations like the ONE Campaign. The respondent considered another potential competitor and explained, “The ONE campaign focuses more outside the beltway and is broader development, but usually there is someone from the Council there” demonstrating how closely the Council works with its partners and potential competition. Key informants consistently viewed the Council’s advocacy and convening roles as specific to global health which set it apart
from other advocacy groups. An advocacy-focused Council member captured this sentiment stating,

“This is a group that has done a lot. When you have so many groups, coordination is a real issue...The Council is able to convene so many players. The coordination is something they do very well. In addition to going out and implementing those advocacy strategies.” (NGO2A-1)

Expanding the Council’s Policy Functions

“They have an opportunity to be a voice, a check on policies that are being implemented, critique programs on effectiveness and effective use of resources, bridge between global health experts and policy makers and advocates, as well as the ultimate beneficiaries. Be the bridges to engage people in dialogue. They have the ability to shape future policy through their reach into communities that need services as well as lessons learned.” (GA34B-1)

Key informants identified a range of broader policy needs that the Council has the potential to fulfill. Informants suggested that the Council expand both its advocacy and policy broker functions. One direction in which the Council could expand its advocacy, according to stakeholders, would be to add new issue areas such as health systems strengthening and chronic diseases to its policy agenda. Key informants also advised the Council to expand its advocacy to new audiences. Within the U.S. government, respondents encouraged the Council to interact beyond Congress and engage with the regulatory and Executive branch agencies. Outside of government, informants also identified private industry and donors as important advocacy audiences. Reflecting a sentiment common among program-focused Council members, one responded explained, “One issue where many of us could use support is educating donors about our concerns.” (NGO1A-3) Key informants believed that these new audiences would be receptive to perspectives provided by the Council’s perceived neutral voice and use this information in developing their policy and funding agendas.

Second, according to key informants, “connectivity” is a significant gap and future need in the global health policy network. Key informants referenced the need for more links among actors,
access to the policymaking process and policy information. Many informants had already described the Council as fulfilling this role in the current policy environment. Informants viewed the Council as positioned to have a sense of the overall landscape — *i.e.*, who actors are, what they are doing, and make connections among parties as necessary and appropriate. They also believed the Council to have the network to disseminate information for the purpose of advancing the overall global health agenda.

Third, with the increase in global health resources, key informants cited the importance of adequate resource tracking and performance monitoring. The Council’s policy products including legislative updates and analyses have contributed to the organization’s reputation as a timely, reliable source of objective information — an important institutional trait for an organization trying to preserve a position of relevance and influence in a dynamic network and policy environment. Key informants suggested that the Council’s policy analyses be expanded to communicate additional information and analysis to further the global health policy agenda.

Finally, program-focused key informants encouraged the Council to share its advocacy expertise by providing technical assistance and training. A program-advocacy “hybrid” Council member explained,

“One challenge we’re looking at is how to build capacity in country offices to do advocacy. Where does the money come from for training, advocacy training staff? How do you build it into how you design programs as an integrated component of programs?” (NGO12A-3)

The respondent went on to describe the need for a mechanism to “share experiences across organizations and look for synergies in the field…to link people on common advocacy goals.” Key informants from developing countries unanimously requested this policy capacity-building resource from the Council. An advocacy-focused Council affiliate considered how this capacity-building might be achieved and wondered,
“If they were to hold workshops for advocacy groups in various African countries to help them improve domestic advocacy in various diseases, bring those advocacy groups over to the U.S. or to Europe to help them get their message across for what they need.” (NGO2B-2)

These specific requests for training were paired with a more general call for the Council to engage more directly and regularly with its members, particularly in setting its advocacy agenda.

Key informants believed that the Council’s policy work is effective at present and can be in the future. They agreed that the Council’s policy activities could be expanded, not just among new audiences and issues, but also to new locations. Key informants limited the Council’s current reputation and impact to U.S. global health policy issues and Washington, D.C. policy conversations. The Council’s presence and impact on the global level were considered but were perceived to be significantly weaker than its efficacy on the domestic level. While stakeholders agreed that the Council is a credible global health policy voice, particularly for U.S. audiences, the organization’s future global potential was undetermined and, as some stakeholders suggested, warrants serious consideration before pursuit. This perception may have been a result of the interview pool which was largely U.S. based and program-focused, limiting respondents’ familiarity with global policy conversations and actors. When endorsed, the Council expansion into global activities beyond representing U.S. perspectives was only modestly supported and weighted with heavy caveats. Table 4 presents a sample of the range of perspectives on the Council’s U.S. and global identity.
### Table 4. Stakeholder Perspectives on the “Global” Health Council

<table>
<thead>
<tr>
<th>Perspective</th>
<th>Stakeholder View</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S.-only</td>
<td>“The Council is a U.S. player, in no way would I see it as a global player. In some cases, it may be involved in some conversations…It isn’t yet a global player. It would be hard to be both an effective U.S. player and a global player at the same time.” (NGO1B-1)</td>
</tr>
<tr>
<td></td>
<td>“They are not a global player, they are a U.S. player. They should stick with the U.S. role. [They] need to do that better.” (NGO2A-2)</td>
</tr>
<tr>
<td></td>
<td>“They are not a global player and not well-served to be a global player, but should continue to represent U.S. interests/perspective in global health. Need to still get input from the south and work in global situations to [represent global health from a U.S. perspective in international forums].” (FND4B-1)</td>
</tr>
<tr>
<td></td>
<td>“Strategic issue: Should it be U.S. global health council, or global health council. Do you want to take on the European Union, etc.? As an advocacy group, stay where the power is. The most important focus is advocacy and should stay in D.C.” (UNIV1A-1)</td>
</tr>
<tr>
<td></td>
<td>“To be honest, they haven’t been that prominent in the discussions that I’ve been involved with. I would say they are not particularly big players in Europe and they haven’t been playing a role in the areas of WHO where I work. They are much more involved in the U.S. policy. That is probably where they have the biggest impact.” (UNIV1A-3)</td>
</tr>
<tr>
<td></td>
<td>“I don’t perceive it as a major player or stakeholder in global conversations. I haven’t encountered them. It is unclear who they are advocating for. I don’t know enough about who they want to help and how they want to help them. It is the wrong way to think about expanding global presence for the sake of that alone. If they have a specific goal and that goal requires a larger presence, then that is different. I’d be very happy to see them have a very small presence and a very big effect.” (NGO1A-7)</td>
</tr>
<tr>
<td></td>
<td>“Their mission is to influence people in this country. They have made an impact here in the U.S. by being a conduit from the third world. They translate things back. I don’t see them as leading the way in a global sense. They are valuable with access to information that they transmit back here. I don’t know whether they have impact with WHO, etc. But they are helpful here.” (INT124B)</td>
</tr>
<tr>
<td>Global Potential</td>
<td>“I haven’t seen the Council as a global player. They are seen as a U.S.-based entity. I think that this is an area for real strategic thinking.”(INT1B-1)</td>
</tr>
<tr>
<td></td>
<td>“It is an American organization. It could try to be more global, but it would take a significant revamping of resources and strategic direction.” (NGO124B-2)</td>
</tr>
<tr>
<td></td>
<td>“I don’t have much of a perception of it as a global player. Could be my lack of exposure to what they are doing. I could be completely wrong about this, but I think the membership of the Council is very much U.S. based organizations. How global could that be? (NGO1A-3)</td>
</tr>
<tr>
<td></td>
<td>“How global can and should the Council be? Given its focus on USAID funding, it has a U.S.-based personality and focus. It would be interesting to see if they could reposition themselves as more of a global organization, reaching out more to European and other international organizations.” (NGO1A-8)</td>
</tr>
</tbody>
</table>
“I’m not particularly familiar with them as a global player. I don’t know how much they do in terms of their own programming overseas (forums, meetings). They are U.S.-centric. They seem placed to connect with other international organizations.” (NGO12A-3)

“We do a lot of global work on health policy. I’m not aware that the Council is there. That is not to say that the Council should be…I haven’t seen the Council there- they may have been there… If they were to do more on the international arena, you need to be serious about it. Staffing and plenty of travel money.” (NGO12A-4)


“If they are truly going to get global, they haven’t made inroads into the health community in Europe and Asia. That would require some effort on their part to cause that to happen. It wouldn’t happen until they break out of the within the Beltway.” (GA1B-1 & UNIV1A-2)

“I’m only aware of the Council as it operates in the U.S. How does it operate as a really global institution. It’s an opportunity…I’ve tried to in my newsletter promote the the Council as a representative institution, but as far as someone in rural Kenya is concerned, there is no relevance. How does the Council address this?” (NGO1A-9)

“The Council has been the world’s largest alliance in global health generally. It has the quality of being global. They can play an important role in the lives of people to help people have access to information.” (NGO1A-5)

“It would be good for the the Council (I know they have international representation but my image is U.S.-based). They have drug company members. They are quite U.S.- based and good at representing the interests of their members. It would be good if they had more representation of southern countries, more of a voice.” (NGO2B-2)

To support the Council’s goal of becoming a more legitimate policy actor in the global arena, respondents suggested that the Council build upon the current international platforms of its member organizations – 40 percent of which are outside of the United States but not regularly engaged – by getting “input from the [global] South and work[ing] in global situations to represent
the U.S. (e.g., represent global health from a U.S. perspective in international forums).” (FND4B-1) Two program-focused Council members also encouraged the Council to “reach out to European NGOs and bilaterals” in an effort to establish the Council’s relevance in non-U.S. policy settings. Key informants were unsure whether the Council had the capacity and reputation for full global expansion. As with a domestic scale-up of advocacy activities, stakeholders warned that significant resources would be necessary if the organization were to pursue this location or other forms of expansion. As more than one key informant explained, “I can count their advocacy staff on one hand.” (NGO12A-3)

Although there was discussion of the Council’s current and future global policy presence, key informants were not clear what level of success the Council would have if it were to replicate or expand current policy activities outside of the U.S., or even domestically outside of Washington policy circles. An international Council affiliate summed up the diverse opinions about the global nature and potential of the Council saying, “I don’t have an opinion on what they should do. But there is a need for this type of organization in every country and the Council could help to stimulate this growth if it chooses to do so.” (INT1B-1) Current data do not offer sufficient information to predict the Council’s global replication success or generate a recommendation for or against this activity.

Environment – Capturing the Impact of Past and Predicted Changes

Key informants agreed that global health is currently enjoying a period of favor both in the eyes of the public and in the political arena. Key informants reflected on developments over the past decade and outlined scenarios for changes over the next five to 10 years.
Global Health’s Recent Rise to Prominence

“There has been a tremendous change over the last decade. More money and political will now. From it comes some other things; doing things at bigger scale.” (NGO12A-2)

Recent changes in the global health environment cited by key informants mirrored trends characterized by Kingdon’s “multiple streams” framework presented in Chapter 2, including changes in problems, policy and politics (Table 5). Key informants highlighted the following trends that have contributed to the opening of the current policy window for global health:

1. **Problems**: Key informants referenced a range of global health issues that have emerged in recent years, including specific health threats such as infectious diseases and changes in population demographics (e.g., aging and “youth bulge”). In addition, stakeholders discussed the context in which health challenges increasingly occur. Violence, urbanization, migration and underlying issues such as inequities and health systems were commonly observed changes and increasingly important factors in global health programming and outcomes.

2. **Policies**: Key informants identified a number of policy changes in recent years that have been favorable for global health. Funding, in the context of significant increases in U.S. government spending and a comparable increase in philanthropic support, has been a major development. Key informants also reference a number of new innovative international funding mechanisms including the Global Fund to Fight AIDS, Tuberculosis and Malaria and GAVI, a global alliance for the development and delivery of vaccines and immunizations. Informants also discussed the “politicization of public health decisions” identifying AIDS as the primary driver and recipient of increased resources.
3. **Politics:** According to key informants, general awareness, public visibility and interest in global health has increased markedly in recent years. Awareness was commonly associated with increased funding and threats of infectious diseases including AIDS, avian influenza and malaria. As a program-advocacy “hybrid” Council member described, “In policy, the major change is the increasing importance that AIDS has been given as a funding priority and in the national interest.” (NGO12A-3)

Respondents also discussed the emergence of new players and their notable impact on global health. These new stakeholders included international partnerships, innovative funding mechanisms, private industry and non-health sectors that increasingly influence network dynamics and global health policy decisions. Among the many players, key informants unanimously acknowledged the role of the Bill & Melinda Gates Foundation as “a force in setting the agenda and providing additional resources.” (GA1B-1 & UNIV1A-2) Finally, stakeholders considered humanitarian emergencies such as war and international conflict to be issues that add to global health’s prominence. These situations were most relevant in terms of competing resources and political priorities.

Key informants representing program-focused organizations tended to supplement their remarks with mention of epidemiological and technical changes. Beyond this slight variation in how key informants framed their responses, no major differences in opinion emerged when past changes in the global health environment were analyzed by type of organization, relation to the Council or primary institutional function.
Table 5. Recent Global Health Events that Conditioned Respondents’ Statements and Answers

<table>
<thead>
<tr>
<th>Problems</th>
<th>Policies</th>
<th>Politics</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Infectious disease threats</td>
<td>• Increased global funding</td>
<td>• Public awareness &amp; support</td>
</tr>
<tr>
<td>• AIDS treatment</td>
<td>• U.S. global AIDS initiative</td>
<td>• New “players” including:</td>
</tr>
<tr>
<td>• Aging population &amp; “youth bulge”</td>
<td>• Innovative global financing mechanisms, including:</td>
<td>-- Private industry</td>
</tr>
<tr>
<td>• Migration, including urbanization</td>
<td>-- Global Fund</td>
<td>-- Non-health sectors</td>
</tr>
<tr>
<td>• Lifestyle diseases</td>
<td>-- GAVI</td>
<td>-- Philanthropic donors</td>
</tr>
<tr>
<td>• Weak health systems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Violence &amp; conflict</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inequities including:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-- Regional</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-- Class (poverty)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This interpretation is suggested by Kingdon’s Multiple Streams framework

Adapting to the Future Global Health Policy Environment

“Sustaining resource commitments and that is about demonstrating results.” *(NGO12A-2)*

In the coming years, key informants believed that as global health continues to be in the public eye, the field will face more complex dynamics. This sentiment supports the impression that public and private support of global health is growing rather than at a peak, plateau or moving out of favor. Key informants outlined a set of issues – funding, constituency, technical and substantive – that either currently exist and will need to be addressed, or issues that are likely to emerge based on recent trends. Opinions were often expressed in the context of the recent sharp elevation in interest in and activity around the global health agenda and concern whether current levels of political commitment, donor support and program activity will continue and to what end. Table 6 summarizes some of the factors that structured the responses of the informants.
Table 6. Factors in Global Health’s Future Anticipated by Respondents

<table>
<thead>
<tr>
<th>Funding</th>
<th>Constituencies</th>
<th>Technology</th>
<th>Topics</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Investment impact</td>
<td>- Public-private partnerships</td>
<td>- Scientific</td>
<td>- Epidemiological shifts</td>
</tr>
<tr>
<td>- Resource allocation</td>
<td>- Existing agency evolution</td>
<td>- -- vaccines</td>
<td>- -- Aging population</td>
</tr>
<tr>
<td>- Public-private donor balance</td>
<td>- World Health Organization</td>
<td>- -- health system management</td>
<td>- -- Urbanization</td>
</tr>
<tr>
<td>- Donor monopolies</td>
<td>- -- USAID</td>
<td>- Communication &amp; Information</td>
<td>- -- Lifestyle diseases</td>
</tr>
<tr>
<td></td>
<td>- New stakeholders</td>
<td>- -- mobile phones</td>
<td>- Non-health</td>
</tr>
<tr>
<td></td>
<td>- -- Faith-based</td>
<td>- -- GPS</td>
<td>-- Climate change</td>
</tr>
<tr>
<td></td>
<td>- -- Non-health sector</td>
<td></td>
<td>-- Trade</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>-- Microfinance</td>
</tr>
</tbody>
</table>

Given recent increases in global health funding and financing, key informants outlined four areas of uncertainty for global health financing. First, key informants questioned the future impact of current investments and investment strategies, particularly given the concentration of resources in specific disease areas such as AIDS. Some argued, “There is enough money, but capacity to use the resources is limited.” (NGO1A-11)

Second, key informants were unsure whether current financing would continue over time, and if so, at what levels and through which mechanisms. A government agency representative explained, “There is going to continue to be a tension between disease specific funding versus broad, multilateral development capacity building assistance. It will come back to the issue of long-term sustainability. Are we responding to emergencies or building long-term capacity?” (GA34B)

Third, informants offered few specific predictions regarding future financing and program support. A program-focused Council member compared past funding trends with the unknown future, describing, “Twenty years ago, USAID, WHO, UNICEF and to some extent bilaterals provided the bulk of the funding. Now the money is increasingly coming from the private sector.”
Informants stressed the importance of continued funding, but uncertainty as to its source.

Fourth, an unexpected number of respondents expressed concern over the potential imbalance between public and private sources. For example, it is anticipated that the Bill & Melinda Gates Foundation will be a major factor in determining the balance or lack thereof of future resources in the future. Concerned that “Gates is driving the agenda [here]...So many of the bilateral [organizations] have vacated the space of defining the public health agenda.” (NGO12A-6)

Key informants discussed the possible concentration of power and the organization’s potential to drive other public and private supporters away from global health. Finally, while most comments focused on donor resources, some key informants were hopeful that “developing countries will assume a much more important role in their own health [and] increasingly ‘call the shots’.” (NGO1A-7)

Key informants anticipate new constituencies and stakeholders will likely influence global health in the future. Public-private partnerships, emerging constituencies such as faith-based groups and new government donors – including those that were formerly recipients of international aid – were perceived as having influence over global health’s future trajectory. In addition, informants expected key U.S. and international health programs and agencies to evolve. Key informants referenced the unknown, but important future of the U.S. Agency for International Development (USAID), which has been experiencing significant policy and programmatic change. On the international level, informants discussed evolving leadership and strategy within multilateral agencies including the World Health Organization (WHO). International agencies and funding/donor organizations had a particular interest in leadership among developing country governments and in the development of the future cadre of public health professionals. Informants believed that the pool of global health stakeholders will continue to grow. The roles and impact of
these constituencies and the relationship among them will be important, but are currently undetermined.

On the practical side of the practice of global health, key informants determined that technology will be an important factor. Informants anticipated that medical science and technology advances resulting from recent philanthropic investments will materialize. Vaccines and other new diagnostic and treatment “tools” are also expected to play a role. Informants highlighted the management context and systems through which these scientific advances will be delivered as critical to sustainable access. Despite technological promise, informants cautioned against “overdependence on technology while neglecting locally available resources,” claiming that this approach diminishes local capacity and ultimately reduces the sustainability of projects. (GA34B-1)

Information and communications represented a second form of technology that informants believed will also play an important role in global health’s future. Informants identified mobile phones, global positioning system (GPS) technology and the Internet as important future tools used to address global health challenges and support global health professionals.

Finally, with respect to future changes, key informants expected that anticipated funding, new constituencies and technologies will apply to a range of global health topics that reflect emerging trends in population demographics and disease epidemiology. These topics included, but were not limited to, the aging global population and “youth bulge,” geographic trends such as migration and urbanization, the increasing burden of lifestyle diseases in developing countries and the importance of strengthening developing country health systems. Non-health-specific factors such as climate change, trade and microfinance were also referenced, reinforcing the interplay of global health with other international development and foreign policy issues.

Similar to perceptions about past global health changes, key informant responses varied little when examined according to their organizations’ primary institutional function or relationship
to the Global Health Council. University respondents tended to speak more broadly about the future, citing more general factors and trends including issues such as conflict, religion, aging, sustainable financing and information and communication technology as priorities. Government agencies more often referenced policy concerns such as the potential challenge of disease-specific funding and the need for developing country leadership in health. International agencies more frequently commented on specific country-level issues and the general importance of health systems. The views among non-governmental organizations (NGOs) varied and were not exclusive or limited based on their type.

Policy Network – Defining Critical Relationships

The activities and perceptions of organizations in the Global Health Council’s policy network are expected to influence the Council’s policy outputs and outcomes. Key informant interviews explored stakeholder perceptions about the Council and other organizations in the policy network. In addition, data capturing demographic characteristics of organizations with which the Council works also revealed important information about its policy network and stakeholders. These data are drawn from the stakeholder database described in Chapter 4.

The Council’s Policy Network Solidified

As of May 2007, the Global Health Council’s formal policy network consisted of at least 576 organizations. Organizational members, coalition partners and organizations with which the Council has co-hosted policy event comprise the Council’s policy network and are listed in Appendix E. These are the organizations with whom the Council has closest access and are most likely to interact in its policy activities. In this section, organizations are described based on their
relation to the Global Health Council, key organizational demographics and dominant policy interactions.

Organizational Relation to the Global Health Council

The Global Health Council’s policy network is comprised of organizations that are affiliated with the Council as organizational members (GHC), advocacy and policy event partners (PART) or not at all (NAFFL). Figure 11 shows the distribution of organizations in the Council’s network. Organizational members comprised more than half (58 percent) of the Council’s policy network. Forty-one percent of organizations engaged with the Council as non-member partners.

![Figure 11. Distribution of Organizations in Council Policy Network](chart)

- GHC: Global Health Council member organizations
- PART: non-member partner organizations
- NAFFL: non-affiliated organizations
- UNCODED: organizations without affiliation code

Partner activities were largely defined by participation in a disease-specific advocacy coalition or, in fewer cases, co-sponsorship of a global health policy event such as a congressional policy briefing or public technical presentation. The affiliation of 1 percent of organizations was unknown. Two
organizations in the database were labeled as non-affiliated. Organizations coded as non-affiliated in the Council’s matrix would have been, upon closer inspection, more appropriately labeled as partner organizations, although interactions were infrequent. While the database distinguished organizations by their relation to the Council, affiliation (e.g., member or non-member) did not imply the extent to which the Council interacted with specific organizations. This point-in-time data did not capture the Council’s frequency of interaction with organizations in its network.

The Council’s policy network represents a diverse set of organizations engaged in global health activities and relating to the Council in some way (Figures 12a).

Figure 12a. Policy Network Organizations by Type

- NGO: Not-for-profit non-governmental organization
- PRIV: Private industry
- UNIV: University or academic institution
- ASSOC: Membership or professional association
- FND: Philanthropic foundation
- OTHER: Unspecified organizational type
- GOV: Bilateral U.S. government agency
- GOV-M: Multilateral government agency

13 These organizations were likely miscoded. Truly non-affiliated organizations were not captured in the matrix because the Council does not currently have a strategy or mechanism to identify organizations engaged in global health but with which the Council does not formally interact.
Non-governmental organizations made up the bulk of Global Health Council colleagues (42 percent). Private companies (12 percent), universities (11 percent) and associations (11 percent) comprised the next largest pool of network contacts. Foundations (7 percent), governments (4 percent) and “other” unspecified organizations (3 percent) were least likely to interact with the Council. The presence of governments and policymakers was likely underestimated as specific government contacts including congressional offices and individual staff were not included in the matrix. The demographics of this policy-specific category of stakeholders (and primary advocacy target audience) are, however, important for the Council to explore and understand.

Closer inspection of the policy network revealed that the Council’s relationship with certain types of organizations varied. In the policy network, foundations, non-governmental organizations (NGOs) and universities were more likely to be members of the Global Health Council than informal partners. Associations were equally likely to be members of the Council and non-members with no obvious difference between associations that had chosen to join the Council versus those which interacted solely through coalitions or policy events. Government agencies, private companies and other, unspecified organizations were more likely to associate with the Council as non-binding partners. In practice, governments are a primary policy interaction. Low representation of government agencies in the database may have been because those interactions were less formally carried out and government agencies typically do not invest in dues-paying relationships with non-governmental institutions. Each type of organization lends a unique perspective and potential resource to global health and the Council’s policy agenda. Figure 12b shows the distribution of policy network organizations sorted by type of organization and relation to the Council.
The Council’s policy network is dominated by program-focused organizations (Figure 13a). One-half of organizations in the Council’s policy network focused on global health programming, largely in the form of direct service delivery, technical assistance and academic or scientific development. One-fifth of organizations dedicated their efforts to advocacy. Five percent of organizations were funding organizations and just one percent represented policymaking bodies. As with organizational type, the low percentage of policymaking bodies was likely a result of the selection of organizations included in the matrix rather than a lack of interaction with
domestic and international policymaking bodies. These interactions tend to be less formal and, therefore, less frequently documented and acknowledged.

A new category of “hybrid” organizations — those that have multiple institutional functions and are not clearly dominated by one form of organizational activity — emerged during data coding. Program-advocacy organizations were the most common and were likely underestimated in the stakeholder database as this category was not initially expected and coded for. The emergence of these hybrid institutional identities highlights a question raised in Chapter 3 regarding the potential niche expansion of this previously unidentified population. Because this database captured point-in-time information specific to the Council’s network as of May 2007, it is unclear whether this population of organizations is new, growing or otherwise changing. Relating back to the study’s conceptual model (Figure 8, page 40), these organizations would be most likely to bridge the program and advocacy quadrants and operate in the overlapping Council member and non-member advocacy coalition space. Increased opportunity for engagement in the policymaking process and an influx of resources for advocacy revealed in the literature review and key informant interview responses suggest that previously unengaged organizations may be adding advocacy or policy functions as a central business practice or at the very least working with organizations that currently serve these roles. Although current data cannot confirm this trend, this hybrid group is likely expanding.
The most significant difference that arose when organizations’ functions were organized by relation to the Council was found among program-focused and advocacy organizations. Program-focused organizations were more likely to be members of the Council (Figure 13b). The heavy program presence in the Council’s membership corresponded to its large NGO membership base which includes organizations that traditionally dedicate resources to direct program and service delivery. Advocacy organizations were more than twice as likely as program-focused organizations to engage with the Council as non-member partners. Currently, the Council does not systematically vary its policy interactions based on an organization’s membership status. Policy
Figure 13b. Policy Network Organizations by Primary Institutional Function and Relation to Council

- Program: program-focused organization, delivery of services or goods
- Advocacy: global health advocate or policy organization
- Funder: Private, philanthropic donor organization
- Policy Maker: government agency
- Religious: faith-based organization

Priority is largely assigned by individual staff or the team with a basic intent to service member needs first, with subjective deference given to relevance in the policymaking process over membership status. This difference between program and policy organizations has serious implications if the Council decides to limit or otherwise prioritize its policy interactions to members versus non-members. Reduced interaction with non-member advocacy organizations who are major actors in the policymaking process may compromise the Council’s relevance in critical stages of the policymaking process and shift the Council’s policy priorities in a direction that makes the organization more responsive to its program-focused members but less relevant in time-sensitive policy situations. Without appropriate nuance, shifting focus from the policy context to
membership status may weaken the Council’s policy impact. Difference in membership status among other organizations is minimal.

Primary Issue Area(s)

Issue area interests of organizations in the Global Health Council’s policy network are largely assumed by the Council based on personal relationships, institutional reputations and interactions over time. The Council does not currently have a reliable description of its members’ or partners’ primary issue areas, nor is there a system to capture them. Absence of this information prevents the Council from being able to quickly refer to organizations beyond a subset of those most frequently contacted when it is in need of disease- or sector-specific insights into a policy situation. This organizational disconnect was highlighted by numerous key informant interview participants. Despite a review of institutional profiles on organizations’ web sites, nearly 30 percent of organizations’ primary issue areas were not obvious enough to be assigned a specific code for the organizational database used in this analysis. When the database was constructed, issue areas were labeled as a best guess of coders based on available data rather than organizations’ self-report.

Organizations for which priority issue areas were more clearly documented were most frequently characterized in general terms such as “health-related” (17 percent) or “global health” (11 percent) without an obvious single issue priority. Among organizations with clear issue priorities, commitment to AIDS was most apparent (9 percent). Reproductive health (5 percent), general infectious diseases (4 percent), research and development (4 percent), health systems (4 percent) and child survival and health (4 percent) served as issue priorities for a modest number of organizations. In practice, the reported distribution of organization by primary topic is underestimated for many issues, as highlighted by the case of tuberculosis. This apparent data flaw highlights the importance of standardized collection of network organizations’ policy information.
The disease-specific priorities of organizations in the Council network are important to understand, particularly should the Council rely on time-sensitive policy activity based on its membership’s issue experiences and expertise. Knowledge of these issue priorities would also be important should the Council decide to exclusively embrace the policy priorities of its members or other important stakeholders in its policy network (Figure 14).

Figure 14. Policy Network Organizations by Primary Issue Area

Organization Age

The Council’s organizational database matrix captured the year of organizations’ founding for roughly three-quarters (n=414) of the organizations in its policy network. Founding dates were included for 95 of the 114 advocacy organizations in the stakeholder matrix. Twenty-eight organizations were founded before 1972, the year the Council was established. Sixty-seven
advocacy organizations were founded in or after 1972. Of advocacy organizations founded since 1972, 28 were established during the period 1997-2007, which corresponds to the policy window examined in this dissertation and supports claims of the increase in actors engaging in the policymaking process. As an advocacy organization and established before two-thirds of the advocacy organizations (67 percent) in its policy network, the Global Health Council might be considered, in theory, sufficiently established compared to similar organizations (Figure 15). The cross-sectional database did not capture information that would reveal the kinds, frequency or impact of network organizations’ advocacy activities. These advocacy activity details may have equal or more influence over organizations’ survival through periods of change versus organizational age.

Figure 15. Policy Network Advocacy Organizations, Year Founded
Network Interactions

Coalitions

Stakeholders who participated in the Global Health Council’s strategic planning key informant interviews frequently referenced the quality and value of the Council’s policy broker activities, typically in the form of convening stakeholders and disseminating policy information through advocacy coalitions. However, the stakeholder database revealed that 55 percent of organizations in the Council’s policy network (315 organizations) were affiliated with a coalition (Figure 16a).

Stakeholders in the Council’s policy network were most active in infectious disease coalitions, all of which are convened by the Council. AIDS (32 percent), malaria (28 percent) and the neglected tropical diseases (4 percent) comprised 64 percent of all coalition activity. Stakeholder participation in the child health (21 percent) and international family planning (15 percent)

---

14 In October 2007, the Council initiated a tuberculosis coalition similar to its malaria and AIDS advocacy collaborations. Data regarding the TB coalition are not included in this analysis.
coalitions was more modest. Both of these coalitions are convened by organizations other than the Council.

Most organizations in the Council’s policy network that engaged in collective activities limited their involvement to one coalition. Only 15 percent of organizations participated in more than one coalition, although a majority of organizations in the Council’s policy network were labeled with broad issue areas such as “global health” or “health-related” (Figure 16b).

Figure 16b. Policy Network Organizations Participating in Multiple Advocacy Coalitions

The global AIDS coalition served as the common coalition among multiple coalition affiliations. Three-quarters of organizations that participated in multiple coalitions were associated with the global AIDS coalition. Organizations that participated in more than one coalition were most likely to participate in multiple infectious disease coalitions (49 percent), AIDS and malaria for example. Beyond the infectious diseases, there was little overlap between disease-specific coalitions even though policy agendas and targets were related. For example, no organizations
were affiliated with both the child health and international family planning coalitions, although the health of mothers and children is clearly linked in global health programming and both issue areas have been under-funded in comparison to infectious disease programs.

Organizations’ coalition affiliations were gathered from coalition membership or listserv distribution lists as of May 2007. The utility of these data are limited by three features. First, it is likely that groups have joined and left each of these coalitions since these data were collected, underscoring the dynamic nature of network relations and the need for continuous monitoring. Aside from occasional meeting RSVP lists and sign-in sheets, active participation was not systematically tracked at the time of this analysis.

Second, an organization’s affiliation with a coalition does not indicate the organization’s level of engagement, i.e., as an active advocacy partner or as a passive recipient of policy updates and related information. This fact is reinforced when coalition affiliation is analyzed by the organizations’ primary institutional functions. The majority of organizations participating in advocacy coalitions are identified in the database as program-focused rather than advocacy-focused. Key informant data presented above suggested that program-focused organizations were more likely to value policy updates and have advocacy performed on their behalf while advocacy organizations were more likely to directly engage in the development and execution of policy strategy.

Finally, the database only includes coalitions with which the Council is actively engaged. A number of other health-specific and health-related coalitions are convened by other organizations. The Council is aware of most of these coalitions, but does not currently monitor these coalitions nor actively participate in them, due to a lack of staff capacity and perceived benefit. Instead, Council staff rely on listserv updates and informal interactions with close external colleagues who do participate in these other coalitions. Within those coalitions, stakeholders develop relationships
and strategies that may impact the Council’s own work on the global health policy agenda. As advocacy conveners, these organizations also serve as potential policy function competition.

Policy Events

During the period January 2005 to May 2007, the Global Health Council partnered with 50 organizations on policy events, all in Washington, D.C. (Figure 17). These events included congressional briefings, technical updates for global health professionals and by-invitation-only policy dinners. The Council collaborated with program-focused organizations for two-thirds of its policy events during this period and funding organizations for another 10 percent of events. The Council was most likely to host events on AIDS (14 events). It was least likely to host events on emerging global health issues (one event).

Figure 17. Policy Events by Event Topic and Partners’ Relation to the Council

- AIDS
- CSH
- ED
- HR
- HSS
- ID
- MAL
- OTHER
- RH
- TB
- R&D

Event Topic
- HIV/AIDS
- child survival & health
- emerging diseases
- health related
- health systems strengthening
- infectious diseases
- malaria
- other health topics
- reproductive health
- tuberculosis
- research & development
The Council was just slightly more likely to partner with non-members than member organizations. The Council partnered with six of the 50 organizations on more than one occasion. Five of six of these organizations were non-members. The organizational database revealed a diverse set of organizations that interacted with the Council (and presumably each other) in a variety of ways. While these cross-sectional data do not capture the dynamic nature of this global health policy network, even static data provide an important baseline to monitor relationships and network trends.

Chapter Summary

This chapter described the analysis of two data sources. These data sources combine to offer a comprehensive view of the policy environment in which the Global Health Council currently operates. Key informant interview data supported the use of functions, environment and policy networks as organizing categories of the Council’s work. The structuring of the questions into these categories proved useful and confirmed them as overarching themes in and of themselves. The stakeholder database and documentary classification information established a general description of the pool of organizations with which the Council currently works or has the potential to interact in its policy activities. This information provided a view of the Council from the inside looking out to its network. Within each of the primary function, environment and policy network categories, major and minor themes emerged.

In terms of function, the Council has a distinct identity as an entity with an equally effective disease-specific and comprehensive global health perspective. The reputation of the Council is almost universally positive in its assumed role as a direct policy advocate and a policy broker that serves as an information and relationship bridge. Specific to environment, global health has risen to prominence. The favorable environment is expected to continue although long-term sustainability
is subject to a variety of policy and non-policy factors. Finally, the Council does appear to make a unique contribution to its policy network. Based on these successful contributions, expansion is an option and welcomed by network stakeholders. This expansion, however, must be approached with the confirmed knowledge of an incredibly diverse and increasingly active network over which the Council currently has cursory insight. Much remains to be learned about this network which is driven by multiple interactions that are not well documented or understood among a set of organizations for which a consistent taxonomic structure is lacking.

The themes that emerged from this data analysis provide a more nuanced view of the Global Health Council and serve as the basis for a set of practical recommendations. Stakeholder database findings combine with key informant responses to generate recommendations for how the Global Health Council can maximize its policy functions, starting with its existing network, to remain effective over time. These recommendations, outlined in Chapter 6, will be shared with Council leadership.
CHAPTER 6

Chapter Overview

Findings suggest that the Global Health Council has established a tangible impact on policy in the current global health environment. However, the environment continues its rapid evolution. The literature suggests that the Council would benefit from a strategy that would help the organization retain the policy activities and relationships that are working in the current environment and build upon them to have a positive impact on global health over time. Function, environment and policy network emerged as fundamental factors and dominant themes in the data analysis. The key policy and organizational concepts introduced in Chapter 3 were used to translate findings into practical strategies for the use of the Global Health Council’s leadership in strategic planning and evaluation (Table 7). The recommendations also align with the study’s themes.

Table 7. Recommended Strategies to Maximize the Global Health Council’s Policy Impact

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Key Concept(s)</th>
<th>Maximizes Council Impact on Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Function</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Articulate organizational policy identity</td>
<td>• Specify parameters of competitive advantage</td>
<td>• Outline institutional value in policymaking process, policy network</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Establish standard stakeholder expectations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Strategic allocation of scarce institutional resources</td>
</tr>
<tr>
<td>2. Monitor core policy functions</td>
<td>• Maintain institutional benefits in stable environment</td>
<td>• Reinforce institutional contribution to policymaking process, policy network</td>
</tr>
<tr>
<td>• Advocacy Broker -- convening</td>
<td>• Guard against</td>
<td></td>
</tr>
</tbody>
</table>


Specifying Parameters of the Council’s Competitive Advantage

Data suggest that the Global Health Council’s policy functions are not provided by other organizations with the same focus, scope or impact in the current environment. Yet, many stakeholders are unfamiliar with the Council’s specific policy activities and results. Policy resources, including issue-specific advocacy coalitions, remain untapped by more than one-half of the Council’s membership. These gaps in stakeholder knowledge and resource under-use undermine the Council’s reputation as being valuable and, to some extent, rare in the policymaking process and policy network. As outlined in Chapter 3, these elements of the Council’s reputation are critical to a sustained competitive advantage. It is, therefore, in the Council’s interest to ensure that its policy contributions are known by stakeholders.
Recommendation 1: Articulate Organizational Policy Identity

In an environment already saturated by policy voices, the Global Health Council must be clear in who it is and consistently communicate that identity. As a first order of business in a revision of its policies, the Council must brand itself as a preferred policy actor among the many network options. This communication should be directed to key audiences including staff, members, advocacy partners, financiers and policymakers. The function-specific themes of *advocacy* and *policy broker* that emerged from key informant interviews provide a logical presentation framework. By proactively expressing its core policy functions, the Council can put itself into a position to more clearly establish its added value to the policy network and policymaking process.

The benefits of clearly communicating the Council’s policy identity are four-fold. First, by outlining its specific policy-influencing strategies and impact, the Council can establish an explicit boundary for the organization. A clear scope of work will help to set expectations for internal and external stakeholders. The Council would then be better able to prioritize scarce policy resources among those activities that clearly fall within its policy purview. It would also help the Council to guard against attempts to imitate and substitute its policy activities which are two threats to a sustained competitive advantage. Second, clearly communicating its policy identity could help the Council to improve and shape stakeholder knowledge about the Council’s policy approach and impact, as suggested by key informant interviews. Third, clear communication could also address the common sentiment among key informants who were less concerned with what the Council did in the policy arena than in a clear statement and successful execution of any policy agenda. Finally, the Council could use its clarified policy identity as a framework to guide internal strategy discussions. In this way, the organization should be better poised to keep track of progress, impact and outcomes that are linked to specific activities. This information will also help address the lack of attribution or misattribution for the Council’s past and current policy efforts. It will also
demonstrate a more distinct return on investment by key stakeholders, including the Council’s membership and current and potential financiers of the Council’s policy activities. Perceived value will be important to the organization’s long-term reputation and status as the preferred institution for creating global health policy change.

As a small organization with a modest budget, it is unlikely that the Council will have the resources to undertake a formal, large-scale public relations campaign to promote its policy identity. Instead, the organization might rely upon existing mechanisms including the policy activities at its annual conference, annual report, web site and various publications that include a policy perspective. The Council’s advocacy function can be reinforced by continuing direct engagement in the policymaking process, and communicating progress and results through ongoing policy updates. The Council can perpetuate the value of its broker activities by continuing to be the source of access to information and relationships that, without it, external policy actors would not otherwise have. The value of this broker function could be communicated through existing channels, including invitations to exclusive policy interactions and the timely dissemination of policy opportunities, analyses and other salient information. These existing channels offer an immediate and relatively low-cost way for the Council to begin to express its policy identity.

Should the Council pursue this strategy, the organization should be aware of potential ramifications resulting from the articulation of its policy functions. First, stakeholders – particularly member organizations – that have not to date made use of the Council’s policy services may begin to request advocacy representation, input into the Council’s policy platform development, additional policy updates and other products or policy assistance. The Council must carefully consider the implications of increased stakeholder policy demand. A mechanism to manage these requests and expectations as well as criteria upon which to accept, reject, incorporate or otherwise address stakeholder input and feedback will be useful. If there is an increased demand
for policy services, the Council must also prioritize and increase its resource commitments (financial, technological and human) to these core policy functions. This recommendation responds to perceived needs outlined in key informant interview responses. Second, the Council must know that a public explanation of these functions may serve as a model to other organizations that seek similar influence over global health policy. If other organizations can successfully replicate these functions for the same or a new set of issues or policy audiences, the Council’s unique contribution to the policymaking process and policy network may be threatened over time. This threat presents the Council with a test of its sustained competitive advantage – *i.e.*, do its policy functions constitute a unique contribution and can they persist amidst competition.

Maximizing Critical Policy Functions to Preserve Institutional Benefits

The Global Health Council has established its policy identity in the current global health environment by consistently applying its advocacy and broker functions to a variety of global health issues. These activities currently serve as an organizational benefit. However, as described in Chapter 3, what serves as a benefit in a stable environment may threaten the organization’s viability when inflexibility, or structural inertia, develops over time as the organization implements the same functions without variation or sensitivity to changes in the environment. To guard against structural inertia, the Council should consider a strategy that involves routine and clear documentation of its advocacy and policy broker activities, criteria that signal variation in the environment’s receptivity to these functions and adaptation options.

Recommendation 2: Monitor Policy Functions

The Global Health Council must be aware of how its core policy functions are being implemented and their impact on the policymaking process and the policy network. Changes in the
Council’s policy impact as measured by actual policy outcomes or stakeholder perceptions should prompt periodic internal reviews to assess whether these activities remain institutional advantages. The Council must recognize and be ready and able to adjust when the environment becomes less receptive to its contributions. A weakened connection between the Council and its environment may threaten its sustained relevance and impact. If properly identified, however, connections can be reestablished and strengthened. The Council’s advocacy and policy broker functions highlight how this approach might work.

Advocacy

Under ideal circumstances, the Council’s advocate-policymaker interaction would proceed along the following path: first, Council policy staff provide information and analysis of policy options and potential impacts of policy decisions through informal and formal policy interactions that occur by in person, by phone or through electronic mail; second, policymakers request/accept policy input in the form of advice, draft legislative language or evidence based on global health programming; and third, policymakers incorporate Council inputs into a final policy product (Figure 18). A successful progression through this cycle reinforces the advocate-policymaker relationship and drives policymakers back to the Council as the reliable and preferred source of policy information described in key informant transcripts. A positive reputation for the Council and regular policy interactions reinforce important policy relationships over time. Part of the Council’s strategy to protect this core policy function is to track this cycle, paying attention to variations in policy interactions and outcomes.
As described in Chapter 2, the policymaking process is rarely predictable or direct. A number of factors determine whether the process described above proceeds as outlined. Variations in these factors indicate a failure in the advocacy function or advocate-policymaker interaction. These failures serve as triggers that can, if promptly and accurately perceived, lead the Council to revise its advocacy strategies to retain its effectiveness in a changed environment. If, for example, policymakers with whom the Council has had a solid relationship began to decline meeting requests or fail to respond to inquiries or offers for assistance, the Council might consider whether the organization has made an actual or perceived political miscalculation or if a policymaker has changed his stance on an issue. The Council might undertake the same analysis if it provided policy input, but policymakers incorporate others’ advice instead of the Council’s. A number of factors
could explain a shift in policymakers’ preference toward advocacy input from other sources. Internally, this outcome could result from a poor policy recommendation on the Council’s part. Externally, a new, preferred policy actor may be emerging or the Council’s policy reputation may have been somehow compromised. Drawing from the competitive advantage concept, policymakers’ affinity to other advocate input may suggest that the uniqueness of the Council’s advocacy strategies or content has declined or that competing policy actors have been able to somehow imitate Council functions or substitute their own, thus compromising the Council’s competitive advantage. Each of these scenarios has important implications for the Council’s advocacy role and should be explored as possible circumstances to which the Council would benefit from developing a proper adaptive response.

The Council will have varying levels of influence over the factors that impact its policy effectiveness. The quality and responsiveness of its policy input are under the organization’s direct control. The Council is not, however, able to control a sudden shift in public or political opinion that closes the policy window of opportunity for that issue. Both possibilities should prompt Council policy staff to consider revising its approach to policy or redistributing its advocacy effort toward less costly issues and relationships. The political circumstances surrounding advocacy are sensitive. The Council should analyze them carefully before making significant changes in its approach.

In practice, policy interactions proceed quickly and are often invisible outside of formal structures and relationships. Therefore, the Council would need to be somewhat flexible as it monitors policy interactions. Over-structuring analyses of interactions or developing complex adaptation strategies for each advocacy interaction promises to overburden policy staff and draw resources away from important policy activities. General trends should be noted and shared with senior Council managers who may have insight into other internal and external trends influencing
the Council’s advocacy processes and impact. The Council’s government relations team is the primary driver of its direct advocacy relationships and policy interactions and should, therefore, continue primary responsibility for these monitoring activities.

Policy Broker

The Council’s current policy broker model is to serve as a hub where policy relationships and information meet or are transferred. Advocacy coalitions, other policy-focused events and communications mechanisms including listservs and publications support this convening role and exchange of information and relationships. As outlined in Chapter 3, by serving this function, the Council occupies a powerful position and is able to influence policy and drive the direction of collective policy action.

As a Convener

As a direct advocate, the Global Health Council shapes policy. However, as a broker, the Council’s value is defined by the neutral meeting space it provides where like-minded global health stakeholders (e.g., malaria advocates), currently non-affiliated stakeholders that would mutual policy benefit by working together (e.g., the family planning and child survival communities) or otherwise non-affiliated stakeholders with distinct differences in policy opinion (e.g., conservative U.S. policymakers and global AIDS activists) can come together. By bringing these parties in contact, the Council plays a central role among these stakeholders (Figure 19). Through the Council, these stakeholders have at least a temporary and indirect relationship with each other. To protect its role as a convening policy broker, the Council must maintain this strategic position.

An important trigger in this convening scenario would be if the previously disconnected parties (A and B, Figure 19) pursued their own direct relationship rather than interacted with and
through the Council. The Council might adapt by strengthening its role as convener. In this way, the Council might maintain greater control over communications between the parties while also preserving a meaningful role in the now expanded relationship. Alternatively, if the new, direct relationship among other stakeholders has already been established, the Council might identify additional disconnected groups \((D, E, F, \text{ etc.})\) that can be brought together using the same convening model.

Figure 19. Council Convening Broker Function: Preferred Interactions and Adaptation Triggers

The Council could also capitalize on its access to policy elites and selectively invite stakeholders to gatherings featuring these dignitaries, thus maintaining control over valued relationships and interactions. This alternative adaptation demonstrates a scenario in which the Council can equally maximize its convening broker function by expanding either topics or audiences. Both expansion paths are just as legitimate niche preservation strategies as replicating the function with the same issue and audience(s) over time.
As an Exchange Broker

The Global Health Council is presently a trusted recipient of privileged and valued policy information from many sectors. The organization disseminates that information to chosen audiences as it sees fit. Information flows in two directions. Political intelligence and policy decisions such as U.S. global health funding allocations and important policy announcements flow from policymakers, through the Council, to a larger audience including the Council’s membership or participants in its advocacy coalitions. This “trusted and well-informed” broker role is of particularly high value to policymakers who rely on exchange brokers to disseminate critical information for them. Information also flows from the Council’s membership base (program implementers, for example) through the Council to selected policymakers who may use the information in their policy decisions. In both scenarios, the Council consolidates information that is not otherwise widely available and communicates it to specific stakeholder audiences. This model of indirect interaction allows stakeholders to influence each other without expending much of their own resources (Figure 20). As described in Chapter 5, this type of passive interaction is valued among many in the policy network.

Figure 20. Council Exchange Broker Function: Preferred Interactions and Adaptation Triggers

*Inspired by Carpenter et al. (2004)*
Two important trends would lead the Council to adapt its exchange broker function under this model. If the original sender (A, Figure 20) and receiver (B) of policy information began to communicate and influence each other’s activities directly, the Council’s utility as an information broker would be compromised. If either the original sender or receiver began to work through an alternate hub (D), the Council’s role would be similarly threatened. If the former situation were to arise, the Council could attempt to adapt by strengthening its relationship with the sender and receiver (A and B), re-establishing necessary trust and perceived value in the broker relationship. In the latter situation, the Council might explore the origins, scope of work and constituency of the competing broker (D). Insight into this new actor will help the Council determine the level of competitive threat provided or if there might be a benefit in collaboration. In this case, actor D may be a known organization already in the Council’s policy network or it may be a new actor with whom the Council has no working history. Actor D represents Path 3b in the study’s conceptual model (Figure 8, page 40), whereby network affiliates work through other brokers to influence global health policy. Familiarity with established and potential competitors to the Council’s broker role will be useful as the Council monitors the environment and its own strategies.

If interaction patterns shift, the Council might revisit its internal strategies to determine if factors such as the timeliness, quality, newness and relevance of information and relationships have been in any way compromised. These variables have been found to influence stakeholder receptivity to the exchange broker role (Carpenter, Esterling, and Lazer 2004). Adaptation may be as simple as a more rapid distribution of policy information and confirming information quality. The Council has direct and immediate control over many of these factors and can adjust with modest organizational effort. To avoid costly adaptations that may not fully address the environmental challenge, the Council would likely benefit from exploring internal solutions before attempting to significantly revise external relationships and processes.
Managing Relationships within the Dynamic Policy Network

Should current global health trends persist, the network in which the Global Health Council carries out its advocacy and policy broker activities will continue to expand. Having an in-house advocacy function is no longer unique as evidenced by the increase in the number of advocacy organizations since the Council’s founding (Figure 15, page 89) and the unexpected presence of program-advocacy “hybrid” organizations in the Council’s policy network. Having access to elite contacts is also growing less unique as others’ policy strategies become more sophisticated and the paths of network interaction and alternative policy influence (conceptual model Paths 3b and 4, page 40) increase.

As other organizations gain policy skills and relationships, the Council is likely to retain one non-policy organizational feature that may protect or enhance its unique contribution to the policymaking process and policy network – its U.S. and international membership base. Data in this study confirm that the Council takes only partial advantage of the resources and relationships at its immediate disposal. The Council’s network, although currently underutilized, is perhaps the organization’s greatest potential advantage in the changing environment. If used properly, Council members and policy network partners may be pivotal to the Council’s efforts to maximize its policy impact and sustain its competitive advantage.

Recommendation 3: Identify and Prioritize Stakeholders

The current global health policy network includes at least 576 organizations to which the Global Health Council has ready access. However, the high number of “uncoded” and miscoded organizational features in the stakeholder database, plus the number of “don’t know” or “not familiar enough” responses from member key informants suggests that, despite these affiliations, the Council has only a superficial relationship with and knowledge of many of these organizations.
Cross-tabulations of stakeholder affiliation with policy activity further revealed that the Council’s interactions with organizations in its network were largely subjective. This fact is demonstrated by the tendency of the Council to include non-member organizations in its advocacy coalitions and to partner with non-member organizations for policy events. The Council’s policy coalitions and events are the primary forums in which the Council develops and promotes its policy agenda. In theory, this agenda reflects the experiences and priorities of its membership. However, a majority of Council members do not participate in its coalitions. Those members that do participate rarely serve as a clear majority in any of these forums. If member organizations view coalitions and policy events as ways to promote their programs and policy agendas, the Council’s essentially equal tendency to work with non-members and members may lead some stakeholders to question the benefit of membership. Practical experience with the Council as a participant observer in this study confirms that the organization does not currently have a systematic approach to differentiate interactions with stakeholders of different types. This functional gap presents significant challenges for the Council as a membership-based advocacy organization.

The Value of Knowing Who’s Who

As mentioned above, the Council’s knowledge of key institutional features and priorities of organizations in its policy network is weak. To retain the integrity of its claim to represent the policy interests of its membership, the Council must enhance its connection to its core constituent base. The Council’s current official membership database does not include basic policy information on its member organizations. Key informant interviews demonstrated that member organizations’ policy opinions are often communicated by their non-policy staff. The first and most important step therefore, is to identify member organizations’ primary policy contacts.
Under the Council’s current membership benefit structure, a predetermined number of contacts within member organizations receive Council correspondence. If not designated as a primary institutional contact, policy staff in the organizations may not receive Council policy updates and invitations for policy input. Without specific policy contact information, the Council’s government relations team has no structured way to contact members’ policy liaisons to ascertain opinions on a policy topic or to provide an opportunity for time-sensitive policy influence. Lacking a direct system of contact, Council staff interact with established personal contacts in the policy arena regardless of membership status. This is an understandable strategy in a time-sensitive policy environment. However, this approach also undermines the policy benefits of membership and may threaten the Council’s reputation of representing the policy interests of a large constituent base.

Once member policy contacts are identified, the Council should work with these liaisons to gather the basic policy information that is missing in the stakeholder database, including organizations’ primary issue areas and dominant institutional function. With this knowledge – to the benefit of its members – the Council’s policy team can then tailor communications and policy activities based on members’ expertise or priority interests. These tailored activities will contribute to stakeholders’ perceived value to the Council. This first wave of information should be gathered immediately. Over time, the Council would benefit from identifying similar information from affiliates (central ring in Figure 8, page 40) and currently non-affiliated organizations (outermost ring of Figure 8) that engage in the global health policymaking process. Policy information might be best housed in the existing membership database system. Council policy staff should have ready access to this information and the information should be updated at regular intervals. The stakeholder assessment, or “mapping,” suggested here is a classic first step toward effective stakeholder management.
Prioritizing Stakeholders

While all stakeholders have some influence over and are influenced by the Global Health Council’s policy decisions, not all stakeholders have equal status. As a membership-based organization, priority (largely in terms of service) is, in theory, given to dues-paying members. However, to date, the Council’s policy-focused activities and products have not been highlighted as a membership benefit. The demand for policy services will likely increase if the Council incorporates Recommendation 1 to more clearly and more broadly articulate its core policy functions. As an advocacy organization, however, priority is often and understandably given to politically-relevant issues and actors regardless of their membership status. The Council’s coalition structure, which does not currently limit participation based on membership status, illustrates this fact. In fact, in practice the Council is both a membership-based and politically-minded organization and must, therefore, reconcile under what circumstances and to whom it will give policy priority.

Who Matters Most

The Global Health Council’s expansive policy network can serve as a great resource in advancing the Council’s policy goals. However, the sheer size of the network presents a challenge. Engaging equally with all stakeholders that operate within the network is not feasible nor would it be a strategic use of resources. Given its dual identity, the Council has a few ways it can distinguish its relationships between members and active non-member policy supporters. One way is to give priority to organizations based on their affiliation with the Council. Under this traditional association member-service scenario, member organizations’ positions and needs would be met first. The opinions and requests of non-member partners and other loosely affiliated stakeholders would carry less weight. Another way to distinguish relationships is based on policy relevance.
This scenario gives more weight to politically active and influential stakeholders who may or may not be Council members. In the dynamic and sensitive policy environment that has been documented in this dissertation, the Council constantly seeks a balance between the two relationship scenarios.

As discussed in Chapter 3, a number of typologies have been developed to determine which relationships carry the most influence. The Council could draw from these general principles of stakeholder saliency to classify the kinds of organizations and opportunities that warrant heightened or sustained attention. The Council might draw from the saliency test presented by Mitchell et al. (1997) to prioritize its stakeholder interactions. This test measures stakeholders in terms of their power, urgency and legitimacy (Table 8).

Table 8. Measures of Council Stakeholder Saliency

<table>
<thead>
<tr>
<th>Power</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the stakeholder have significant financial or other resources that may shape this issue/opportunity?</td>
<td></td>
</tr>
<tr>
<td>Do the stakeholder’s resources present a threat to the Council’s activities?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Urgency</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this issue time-sensitive?</td>
<td></td>
</tr>
<tr>
<td>Is this a critical global health policy issue?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Legitimacy</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Are the activities/interactions proposed by the stakeholder appropriate, i.e., do they make sense?</td>
<td></td>
</tr>
<tr>
<td>Does the stakeholder’s position have significant influence over other network actors’ decisions or activities?</td>
<td></td>
</tr>
</tbody>
</table>

Organizations with just one of these characteristics would rarely change the Council’s established course of action on an issue. However, as organizations illustrate multiple characteristics in Table 8, their influence increases. Organizations’ membership status should be incorporated into the
Council’s interpretation of these saliency criteria or considered in addition to ensure that members— the constituency critical to the Council’s financial and policy future— receive adequate attention.

In practice, general calculations similar to these saliency criteria are already intuitively made by Council policy staff. These considerations provide an initial filter when staff are presented with a policy opportunity or request. However, further formalizing these calculations by assigning static saliency labels to the over 500 specific organizations the Council may encounter in its policy work would require significant resources and constant reevaluation. A rigid and over-designed system of this nature would ultimately be artificial and limited in its utility in a dynamic policy environment. Even a first cut of saliency features will leave the Council to manage a large pool of stakeholders. A second filter, perhaps based on whether an external request will reinforce the organization’s competitive advantage, will be necessary.

Although imperfect, this recommendation demonstrates the importance and challenge of reducing a large and active network into somewhat predictable interactions. The Council must organize its many relationships so it can simultaneously provide service to its membership base, advance its own policy goals and preserve its institutional identity in the policymaking process and policy network. Should the Council find general value in this recommendation, executives might consider conducting an internal exercise to identify categories of organizations (by type, affiliation or otherwise), policy activities or desired policy outcomes they believe should have strong bearing on the organization’s policy decisions. These calculations will remain somewhat ambiguous. Yet, similar to the way that the complex policymaking process has been reduced, and perhaps oversimplified, to stages and categories of actors, grouping the Council’s many stakeholders into logical categories will help the organization to make generally informed decisions in a constantly fluctuating environment.
Recommendation 4: Establish Mechanism for Stakeholder Policy Input

If the Global Health Council is to incorporate and effectively use input from policy
network stakeholders, a system to collect and manage stakeholder policy perspectives starting with
its membership will be necessary. Research and experience as a participant-observer at the Council
reveal that the Council’s current management of stakeholders is concentrated among a handful of
Council staff and is largely ad hoc in nature. To increase the Council’s effectiveness, this
management task should be standardized. Member organization key informants repeatedly
requested that the Council establish a better system of communication with its base to keep
stakeholders informed and involved in the development and execution of the Council’s policy
agenda.

Currently, the Council’s most frequent membership policy interactions are through its
annual conference and advocacy coalitions. Both interactions take place in Washington, D.C..
The Council’s official member relations are managed out of the organization’s Vermont-based
administrative and member services office, separate from the Council’s Washington-based policy
division and a majority of the organization’s external policy contacts. When, for example, a policy
opportunity presents itself, the Washington policy staff must work through the Vermont
membership liaison to identify relevant organizations to contact and the appropriate person to make
the contact. As discussed above, policy details, including basic contact information for a majority of
member organizations, does not presently exist. As a result, policy requests are sent to generic
organizational contacts with no guarantee that policy contacts will receive or respond to the
information. This system is inefficient, particularly in a time-sensitive policy setting. As the
Council incorporates member perspectives into its operations, it is important that this input

15 Although the conference technically offers a series of policy sessions, this once yearly gathering is based on participant program-
focused abstracts rather than U.S. or international policy platforms.
process does not limit the organization’s ability to flexibility engage in time-sensitive, highly political processes.

Resources permitting, the Council might dedicate a staff person, based in the Washington office, to manage the organization’s growing member policy needs. This “membership policy liaison” could manage the policy information of member organizations and serve as a first-line contact for basic member inquiries for policy updates and advocacy technical assistance (as suggested in key informant interviews and experienced in practice). This representative function would allow other policy staff to concentrate on the execution of the Council’s more technical advocacy and policy activities. The liaison could proactively poll members on policy opportunities periodically and mobilize the Council’s membership for time-sensitive policy action. Depending on the level of staffing, the liaison could also convene one or more of the growing number of program-focused coalitions, supporting the organization-defining convening activities that are currently carried out by two staff.\textsuperscript{16}

Over time, relations between stakeholders will be affected by many factors including changes in the external environment, strategic choices on the part of the Council and its stakeholders and general variations inherent in all relationship processes. Because the Council’s identity and policy success are dependent on an environment and relationships for which change is fundamental, thoughtful relationship management will be important. The proactive member management activities outlined here might add both authenticity to the Council’s reputation and a unique identity based on its membership. These efforts have a good potential to feed the Council’s potential sustained competitive advantage.

\textsuperscript{16} Program focused coalitions were initiated by the Council in the summer of 2006. Unlike existing policy-focused coalitions, these groups were targeted to Council member organizations with the purpose of gathering input from scientific and technical staff performing actual program delivery, research and evaluation. These coalitions served a convening and exchange broker function similar to the Council’s policy/advocacy coalitions. Technical knowledge was used in the development of policy positions. These program-focused coalitions were among the first efforts of providing policy-related benefits exclusively to Council members.
Guarding Against Structural Inertia by Detecting Environmental Change

Consistent among the recommendations in this chapter is the need for sensitivity to the inevitable changes that will occur in the environment external to the Council. To be effective, the Council should consider implementing a practice of proactively monitoring its environment. Doing so includes tracking specific global health policy issues and actors. The Council must remain sensitive to trend changes that may impact the organization’s policy effectiveness and be prepared to respond to these environmental pressures in a timely manner.

Recommendation 5: Monitor the Global Health Environment

The Global Health Council has just completed a five-year strategic planning exercise and will likely not undertake another extensive exploration of environmental trends and perceptions for some time. The key informant transcripts from the strategic planning exercise offer a rich data source of policy opportunities and environmental challenges. The Council’s leadership should review these data (summarized, in part, in this dissertation) to identify potential issue priorities and areas for policy expansion. As suggested by key informant interviews, demand for advocacy and policy broker activities in these areas is likely to occur. These new issue areas may offer a way for the Council to continue to implement its core functions as existing issue areas become saturated with other policy actors.

In addition, the Council might consider, periodically, an abridged version of its strategic planning feature to do key informant outreach. As this research has revealed, the organization has at least 576 organizations within its network. The recently completed strategic planning exercise interacted with only 7 percent, or 41, of those stakeholders through key informant interviews. The Council should draw upon its constituents in greater numbers to identify topics of concern where the organization’s presence is desired or could have an impact.
Global Health Issues

If the Council decides to broaden its policy platform, it should be systematic in its solicitation of input, particularly if it adopts Recommendation 1 to promote its core policy functions. As discussed, if invited to provide input, stakeholders will expect their priorities to be reflected (at least to some degree) in the Council’s advocacy platform and broker exchanges. These expectations must be managed. A more passive way the Council could monitor the external environment for new issues is to review environmental scans conducted by other organizations and foundations that are increasingly commissioning studies of a similar nature to inform their grant making and programmatic activities.

As the Council identifies new issues, its leadership will need to determine which opportunities warrant an organizational response and of what nature. Council leaders must consider such factors as the evidence base, political and stakeholder feasibility, institutional capacity and desired outcome. These categories reflect the factors that frequently qualified key informant responses about the future global health policy environment. Suggested criteria that would aid the Council’s decision to engage in a new issue area are outlined in Appendix F.

As a small organization with finite financial and human resources, additional structures, task teams and processes will only add to the administrative burden. New opportunities are, therefore, best considered within existing management structures and careful planning approaches. A discussion of environmental changes and opportunities should take place, for the most part, in established management settings such as weekly executive team meetings, bi-weekly division directors’ meetings or quarterly all-directors meetings.
Global Health Stakeholders

A notable shortcoming of the Council’s strategic planning exercise (reflected in the data used in this dissertation) was that the organization did not incorporate, to the extent possible or desirable, the opinions or activities of global health stakeholders who were currently not affiliated with the organization. These stakeholders represent the outermost ring of Council relations and Path 4 of policy influence in the study’s conceptual model (Figure 8, page 40). As a result, the organization’s future is currently only informed by its most immediate stakeholders – a less than 10 percent subset of this pool. Arguably, these stakeholders should provide the most influence. They do not, however, necessarily constitute the most significant network for having policymaking impact.

The question remains, “Who are the global health stakeholders currently not affiliated with the Global Health Council?” The Council would benefit from understanding who these organizations are, their policy goals, the strategies they execute to achieve them, the actors that comprise their policy network and the extent to which they overlap with the Council’s policy functions and audiences. The Council might start by exploring the non-affiliated organizations that were identified by key informants as potential institutional models.

Competing and Displacing Policy Activity

Anticipating change in the environment, the Global Health Council should monitor external events and interactions for increased levels of advocacy or policy broker activity by other global health stakeholders. Clearly, the Council cannot be the sole global health advocate or broker in the policy network. However, the sustainability of its competitive advantage is contingent upon being among the most effective advocates and a preferred broker as indicated by reputation, audience loyalty and stakeholder demand. If the Council notices an increase in other organizations’
activity, visibility and credit in these areas, it should review internal policy strategies to assess if institutional approaches have changed or if the changes are occurring in the policy environment. A temporary spike in activity by other policy actors should be of modest concern. A sustained increase in policy activity levels by these stakeholders or the obvious displacement of the Council as a preferred advocate, convener or exchange broker should prompt a revision of organizational strategy.

By instituting a system to monitor the global health environment for changes, the Council increases its chances of being among the first to recognize, and ideally respond to, changes in global health issues and actors. This proactive monitoring approach would respond to stakeholders’ suggestion that the organization be less responsive and more trendsetting. This approach could also help the Council to identify the issues and audiences where its core functions can be expanded or replicated, thus expanding the organization’s footprint in global health policy.

Implementation Considerations

This dissertation is the first deliberate articulation of the Global Health Council’s policy identity. The Council’s advocate and broker functions plus its membership network serve as the basis for the Council to continue its positive global health policy influence. Council leadership must now ask, “Is this the policy identity the organization wants to perpetuate?” If affirmed, then its leadership can consider the institutional adjustments necessary for successful implementation.

Is this the Council’s Ideal Policy Identity?

In public statements, the Global Health Council anchors its policy legitimacy in its membership base. Yet, historically and as currently structured, the organization is a policy actor that operates fairly independent of its membership base. Activities and decisions are informed, but
not instructed, by a subset of its engaged membership – the majority of whom are only moderately engaged with the operations and decision making of the Council. To date, this approach has worked. However, other organizations are threatening to displace the Council in some policy activities. The experiences and expertise generated by the Council’s membership base appear to be what will keep the organization’s policy contributions distinct. Although increasingly articulated by the Council as its unique contribution to the policymaking process and network, a genuine stakeholder-driven policy approach generated from the Council’s membership base is presently more aspiration than actual experience. This identity has yet to be fully implemented or tested.

This dissertation has outlined recommendations designed to maximize the Council’s policy impact. Of the recommendations, Number 2, focusing on the advocacy and broker functions, aims directly toward that goal and can be implemented with minimal institutional adjustment. Recommendations 3 and 4, which prioritize stakeholders and establish a system for interaction, will require the greatest systems change. Therefore, they warrant additional consideration before they can be implemented. Council leadership must determine what it intends to gain – enhanced member service, added legitimacy to its “representative” claim, stronger policy impact or some combination of the three – by more intentionally incorporating stakeholder perspectives (specifically, its membership) into its policy work. It must also consider whether the benefits generated from routine constituent interactions offset the costs of more directly engaging with this large and diverse pool of stakeholders. Benefits to the Council would be defined as member-driven policy products and added authenticity to the Council’s representative claims. Costs would be calculated as time, staff resource, systems set-up and management and reconciling differing policy opinions and priorities within its constituency. Assuming that the benefits outweigh the costs, the Council can then determine the best methods to better incorporate this potentially advantage-preserving feature into its ongoing policy activities.
Practical Application

As the Council integrates its membership base more clearly into its policy work, changes in internal structure and external relationships will occur. Policy platforms may be revised and the pace of policy activity may be slower due to the process of gathering stakeholder input. The distribution of internal policy resources dedicated to member services (as in traditional association-member relationship) versus active policy shaping may also shift. The Council must monitor these changes closely to ensure that this shift in institutional orientation feeds, and does not undermine, the overarching goal which is to remain a unique and influential global health policy actor.

Operationally, the organization will need to rearrange and reorient current resources, culture and systems. Existing resources will need to be reallocated or new ones secured to support the advocacy and broker activities that comprise the Council’s basic competitive advantage. The Council may look to some of the organizations cited as models by key informants to understand how to reallocate its institutional resources should it choose to go in this direction. Current policy relationships that are based on history or subjective interaction decisions will need to be adjusted to comply with newly instituted policies that guide interactions based on organizations’ relation to the Council and other saliency criteria. Council leadership must clearly document institutional policies to support front-line staff who communicate these positions. In addition, the organization must commit to building a sustainable, well-managed and user friendly system to track the Council’s policy activities and manage critical stakeholder policy information. The Council should pursue these institutional adjustments only if it is convinced of the benefit and is committed to the longevity of these policy activities.

As a final consideration, the Council must be sensitive to tensions that might arise between the organization’s advocacy and broker functions. The findings in this dissertation suggest that demand for these activities is expected to increase. Council leadership must determine whether
these core policy activities are of equal importance and execution for the organization. Leadership must also keep in mind that that the broker function is valued by stakeholders because it is perceived to be neutral and objective. Yet, the advocacy function is expected to be agenda setting and decision-shaping. The Council must have internal clarity and be consistent in external communications (along the lines of Recommendation 1) when it is serving one function versus the other. This role delineation will help the Council to avoid stakeholder misperceptions and unintentional harm to its reputation in each role.

Areas for Further Study

This dissertation has documented a common challenge faced by organizations as they work to retain their identity and influence in a changing environment. In the process, a set of issues specific to global health and global health policy has emerged. Additional study of the nature of network-based policymaking, the role of associations as policy actors and the need for policy leadership by non-governmental organizations can advance global health policy understanding and activities in the future.

Network-Based Policymaking

Advocacy is playing an increasing and increasingly important role in global health. It is no longer done ad hoc or as an activity involving a limited set of actors. New policy actors are emerging every day. Existing organizations are adding advocacy and policy functions. Yet, the mere presence of these actors and functions does not equate to effectiveness. The global health community would benefit from additional studies of its growing advocacy role and policy activities. These studies should seek to understand how different organizations define advocacy, what specific activities they undertake in its name, and what intended, or unintended, outcomes these actions
generate. Specific attention should be paid to how advocacy works in a networked environment. Effective policy and advocacy models could be produced and perhaps replicated. Knowledge of what defines effective policy advocacy would be helpful to policy actors as well as grant makers who are contributing upward of $1 billion in current advocacy support for global health initiatives. Advocacy organizations and donors could tailor financial support to those activities demonstrating the most impact at the lowest cost and with the fewest unintended side effects. New knowledge could sharpen global health advocacy strategies so they are even more effective in the current favorable environment and over time, as other competing priorities emerge.

Related to the increase in global health advocacy, it is no longer sufficient to simply be an advocate or conduct basic policy analysis. The size of the global health policy network alone makes traditional approaches outmoded. Basic advocacy and policy functions that have served previously to define institutional advantages are becoming less unique. Other organizations should consider identifying their best contribution to the policymaking process and the policy network, as has been done here for the Global Health Council. As suggested by an organizational ecology framework, if organizations do not secure a definite and distinct role for themselves, it is likely that the global health environment will see the emergence and disappearance of countless organizations that were not proactive in defining their specific contributions to the field.

Although it provides what is essentially a cross-sectional view of the global health policy environment during the 2006-7 time period, this dissertation suggests a highly dynamic process of policymaking that persists across many years. The changes that are predicted to occur in the future reinforce the need to closely monitor the current environment. Organizations will also benefit from observing how other organizations respond to environmental pressures for change. A system or model to use in monitoring the environment to expedite transformation would be a valuable contribution to the field. This dissertation has provided monitoring and adaptation examples as they
relate to the advocacy and broker functions of one specific organization. In addition to systems, global health stakeholders might monitor specific trends such as the behavior of “hybrid” organizations – organizations that perform a policy or advocacy function along with their other activities. The population of this type of organizations seems to be growing. However, details of this growth, the policy structures and strategies of these organizations and their effect on global health policy remain unknown.

Membership Associations as Policy Actors

This case study of the Global Health Council sheds light on the population-level trend of membership-based organizations as they work to resolve their changing role as policy actors. This work reveals three institutional challenges that most politically active associations are likely to face. These challenges include: the need to reconcile the traditional service orientation of associations with a proactive and largely autonomous policy role; understanding constituent policy interests; and competing with issue- and audience-specific policy actors.

Associations have always had a historic focus toward member services such as professional development and building relationship networks. As described in Chapter 2, until the late 1970s and early 1980s, in at least the social sectors, a few large national associations were the primary non-governmental actors in the policymaking process. Today, there are significantly more associations and they are more politically-focused and engaged. Membership associations are now working to merge their sometimes competing identities as member-focused, service-oriented institutions with their role as proactive and independent policy actors. The recommendations in this dissertation are based on the assumption that the Council wishes to balance these two identities. The broader association sector might benefit from understanding how politically active associations, including the Council, are testing these assumptions and how well they direct
institutional their priorities toward member service, political activity or some practical balance of both.

This dissertation did not venture into the dynamics of association-member relations. As a result, we do not know whether constituents’ desires for greater policy engagement through associations is universal or is specific to a particular field, or issue domain, or is unique to the Council. As more actors are able and willing to participate directly in the policymaking process, associations must be proactive in understanding the policy expectations of their membership. Some organizations will look to associations to facilitate increased policy engagement. Others will remain satisfied with the representation afforded by the traditional association-member relationship. Associations must recognize and manage the variation in constituent policy expectations.

As described in Chapter 2, over time major membership-based groups like the American Medical Association have lost policy ground as more focused discipline- and population-specific associations have drawn away constituents attracted to policy activity focused on a narrower set of interests. This fracturing does not appear to have occurred yet for global health associations. However, the rise in disease- and population-specific policy groups may pose a similar threat as the rise in issue-specific medical or health-related associations has. Due to the changed policymaking process, non-association groups are equally able to influence policy in ways that only associations previously could. Membership associations will always retain the advantageous claim of representing a constituency, but they must learn to better manage the policy-specific aspects of the association-member relationship. In today’s policy environment, associations must determine what balance between rhetorical claim and genuine member engagement is most conducive to maximum policy impact and then remain vigilant as their constituent members may start looking elsewhere for engagement.
Civil Society Policy Leadership Development

Each of the previous discussion points leads to a final area for future development – the need for politically astute managers and executives who are facile at working in global health policymaking as it is operationalized today. The global health policy environment is complex. Executive or management status does not qualify one for navigating the policy field associated with the organization. The nuanced activities that make stakeholders effective in a politically charged environment cannot be simply mimicked if policy effectiveness is to be sustained. If not innate to them, executives must develop and refine a set of policy skills and relationships. This might take the form of formal training.

Accurate perceptions of and responses to environmental pressures will determine organizations’ policy successes. As policy becomes a central organizational strategy, the field would benefit from identifying and studying the policy skills and strategies that underlie successful organizational policy leadership. This need holds particularly true for civil society and non-governmental organizations (NGOs) that are typically small and have not until recently engaged intensively in the policymaking process. Executives and managers with these skills and strategies will be more likely to make appropriate institutional judgment regarding actual policies, the delegation of internal policy authority and the most appropriate use of resources to bring about desired policy outcomes. The need for policy leadership within global health is an area worth additional research and professional development investment.

Conclusion

Despite the description of current experiences and opinions in global health presented here, this dissertation does not venture a guess about how long global health’s contemporary golden age will endure. Long after policymaker and public preference has turned to other issues,
the need for funding, policies and programs for global health will continue. Therefore, so will the need for global health advocacy. Perhaps the greatest practical take home lesson from this research is the advantage that can be attained when an organization is vigilant and proactive in reviewing institutional processes and positioning itself strategically during favorable times. Many organizations rest during this period. Those organizations that are “riding the wave” of global health today will not remain effective (if even in existence) once the surplus attention and energy subsides. Once these actors vacate the stage or are rendered ineffective in a changed global health policy environment, progress often stops. Serious policy actors, such as the Global Health Council, will have taken the steps to identify fundamental strategies, essential relationships and forward-looking environmental options that will enable their policy agenda to move forward absent the current momentum.

Organizations that recognize the inevitability of environmental change and prepare for it are most likely to remain effective over time. Not all organizations will be able to undertake an extensive strategic planning exercise. Nor can policy case studies be performed on each organization affected by and attempting to affect the external environment. However, this dissertation demonstrates the institutional benefit inherent in articulating a core set of issues and activities that define an organization’s identity and are most likely to withstand different environmental scenarios. The experience of the Global Health Council in the still-evolving global health policy environment offers many lessons. These lessons can be summarized as the need for an organization to be proactive, rigorous and nimble in its policy approach. By integrating the lessons learned here with its current policy strategies, the Global Health Council is likely to remain one of the premier global health policy authorities now and in the future.
The American Medical Association’s Changing National Policy Experience

The political clout and credibility of umbrella organizations depend heavily on their claim to represent the views of a broad and unified constituency. This claim is most often validated by the organization’s membership levels. The American Medical Association (AMA) provides one example of the recent challenges that membership associations have faced. In the mid-1990s, a combination of low membership levels, staff turnover, a changing industry and policy environment and a slipping reputation among policy makers forced the AMA to reevaluate its claim as the principal representative of America’s medical profession (Carney 1998; Zeller and Serafini 2002). At its peak, the AMA represented four in five physicians in America. However, beginning in the late 1960s, membership began to decline. In 2004, the AMA’s membership registered at 245,000 which captured roughly one in four of the nation’s physicians (Hood 2006). At least two significant trends explained the decline in the AMA’s membership. First, the number of specialty societies that specifically represented the interests of physicians’ areas of expertise or practice began to increase at the expense of the broader medical profession agenda of the AMA. Specialized physicians were less inclined to join the AMA, preferring to interact and support the activities of the specialty-focused organizations (Carney 1998; Moore 1996; Zeller and Serafini 2002). In addition, these specialty federations were not inclined to sacrifice their autonomy to join the AMA as organizational members.

Second, the AMA was increasingly unable to attract and maintain the membership of young physicians. This decline in membership was explained in part by high annual membership fees as well as the outdated image of the AMA as older, white males rather than the increasingly diverse face of newer physicians (Carney 1998; Moore 1996; Romano 2003;
Zeller and Serafini 2002). The AMA’s dependence on funding from private medical drug
and device companies further contributed to a diminished reputation among young physicians
(Walker 1991). Low membership coupled with changing policy trends forced the AMA to
question whether it was the legitimate – or solely the self-appointed – guardian of the
American medical profession.

Over the past decade, the AMA has spent upward of $15 million on consultants to
evaluate its internal and external challenges as well as a large-scale membership and public
relations campaign to reassert its position as the organization of America’s physicians
(Romano, 2003). Even with minimal gains in membership and relatively stable revenue in
recent years, the AMA recognizes its continuous vulnerability to the changed industry and
policy environment (Carney 1998). The literature on the AMA’s membership and political
The experience of the AMA highlights the vulnerability of even well-established organizations
when faced with a changing environment without sufficient strategy to retain its policy role
or a willingness to identify a new one.
### APPENDIX B
Policy Stream Data Sources

#### B.1 Global Health Hearings, 105th – 110th* Congress

<table>
<thead>
<tr>
<th></th>
<th>105th</th>
<th>106th</th>
<th>107th</th>
<th>108th</th>
<th>109th</th>
<th>110th, 1st session</th>
</tr>
</thead>
<tbody>
<tr>
<td>Global Health</td>
<td>2</td>
<td>4</td>
<td>5</td>
<td>9</td>
<td>16</td>
<td>14</td>
</tr>
<tr>
<td>International Health</td>
<td>5</td>
<td>6</td>
<td>6</td>
<td>3</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Child Survival</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Global AIDS</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Global HIV/AIDS</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Other Infectious Diseases</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Malaria</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>10</td>
<td>12</td>
<td>1</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>4</td>
<td>5</td>
<td>4</td>
<td>10</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>Tropical Diseases</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Neglected Tropical Diseases</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Maternal Health</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Family Planning</td>
<td>10</td>
<td>3</td>
<td>9</td>
<td>4</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Reproductive Health</td>
<td>2</td>
<td>0</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

*110th Congress includes 1st session only, covering the period January – June 2007

**Notes:**

1. Data were collected from the LexisNexis® Congressional Database.
2. An “advanced search” was performed by each key term by individual Congress.
3. Returns were provided exactly as entered.
4. There is likely double counting across key terms due to overlapping legislation and multiple reporting of annual appropriations bills.
5. Returns include domestic and international bills; no further distinctions were made.
### Congressional Record Global Health Statements, 105th – 110th* Congress

<table>
<thead>
<tr>
<th>Category</th>
<th>105th</th>
<th>106th</th>
<th>107th</th>
<th>108th</th>
<th>109th</th>
<th>110th, 1st session</th>
</tr>
</thead>
<tbody>
<tr>
<td>Global Health</td>
<td>19</td>
<td>45</td>
<td>48</td>
<td>72</td>
<td>87</td>
<td>64</td>
</tr>
<tr>
<td>International Health</td>
<td>27</td>
<td>41</td>
<td>64</td>
<td>57</td>
<td>47</td>
<td>16</td>
</tr>
<tr>
<td>Child Survival</td>
<td>51</td>
<td>84</td>
<td>72</td>
<td>82</td>
<td>61</td>
<td>17</td>
</tr>
<tr>
<td>Global AIDS</td>
<td>5</td>
<td>35</td>
<td>90</td>
<td>192</td>
<td>109</td>
<td>36</td>
</tr>
<tr>
<td>Global HIV/AIDS</td>
<td>0</td>
<td>11</td>
<td>42</td>
<td>107</td>
<td>39</td>
<td>17</td>
</tr>
<tr>
<td>Other Infectious Diseases</td>
<td>12</td>
<td>29</td>
<td>34</td>
<td>56</td>
<td>31</td>
<td>3</td>
</tr>
<tr>
<td>Malaria</td>
<td>55</td>
<td>119</td>
<td>172</td>
<td>255</td>
<td>157</td>
<td>52</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>97</td>
<td>224</td>
<td>279</td>
<td>317</td>
<td>177</td>
<td>62</td>
</tr>
<tr>
<td>Tropical Diseases</td>
<td>6</td>
<td>7</td>
<td>11</td>
<td>8</td>
<td>4</td>
<td>12</td>
</tr>
<tr>
<td>Neglected Tropical Diseases</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Maternal Health</td>
<td>24</td>
<td>37</td>
<td>69</td>
<td>53</td>
<td>44</td>
<td>5</td>
</tr>
<tr>
<td>Family Planning</td>
<td>259</td>
<td>231</td>
<td>146</td>
<td>144</td>
<td>132</td>
<td>35</td>
</tr>
<tr>
<td>Reproductive Health</td>
<td>93</td>
<td>109</td>
<td>85</td>
<td>115</td>
<td>87</td>
<td>15</td>
</tr>
</tbody>
</table>

*110th Congress includes 1st session only, covering the period January – June 2007

**Notes:**

1. Data were collected from the Library of Congress, Thomas.loc.gov database.
2. A basic search was performed by each key term by individual Congress.
3. Returns included references reported from the House, Senate, Daily Digest and Extension of Remarks.
4. There is likely double counting across key terms due to overlapping legislation and multiple reporting of annual appropriations bills.
5. Returns include domestic and international bills; no further distinctions were made.
B.3 Global Health Legislation, 105th – 110th Congress

<table>
<thead>
<tr>
<th>Congress</th>
<th>105th</th>
<th>106th</th>
<th>107th</th>
<th>108th</th>
<th>109th</th>
<th>110th, 1st session</th>
</tr>
</thead>
<tbody>
<tr>
<td>Global Health</td>
<td>8</td>
<td>9</td>
<td>23</td>
<td>23</td>
<td>30</td>
<td>12</td>
</tr>
<tr>
<td>International Health</td>
<td>8</td>
<td>19</td>
<td>54</td>
<td>25</td>
<td>47</td>
<td>6</td>
</tr>
<tr>
<td>Child Survival</td>
<td>32</td>
<td>52</td>
<td>48</td>
<td>54</td>
<td>45</td>
<td>27</td>
</tr>
<tr>
<td>Global AIDS</td>
<td>0</td>
<td>5</td>
<td>18</td>
<td>29</td>
<td>30</td>
<td>20</td>
</tr>
<tr>
<td>Global HIV/AIDS</td>
<td>0</td>
<td>1</td>
<td>14</td>
<td>24</td>
<td>25</td>
<td>19</td>
</tr>
<tr>
<td>Other Infectious Diseases</td>
<td>8</td>
<td>18</td>
<td>31</td>
<td>59</td>
<td>27</td>
<td>11</td>
</tr>
<tr>
<td>Malaria</td>
<td>24</td>
<td>43</td>
<td>89</td>
<td>105</td>
<td>84</td>
<td>27</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>36</td>
<td>72</td>
<td>113</td>
<td>124</td>
<td>104</td>
<td>36</td>
</tr>
<tr>
<td>Tropical Diseases</td>
<td>2</td>
<td>0</td>
<td>12</td>
<td>11</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Neglected Tropical Diseases</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Maternal Health</td>
<td>2</td>
<td>14</td>
<td>44</td>
<td>37</td>
<td>24</td>
<td>11</td>
</tr>
<tr>
<td>Family Planning</td>
<td>91</td>
<td>104</td>
<td>48</td>
<td>61</td>
<td>80</td>
<td>32</td>
</tr>
<tr>
<td>Reproductive Health</td>
<td>21</td>
<td>21</td>
<td>42</td>
<td>33</td>
<td>36</td>
<td>17</td>
</tr>
</tbody>
</table>

*110th Congress includes 1st session only, covering the period January – June 2007

Notes:

1. Data were collected from the Library of Congress, Thomas.loc.gov database.
2. A basic was performed by each key term by individual Congress.
3. Returns included references reported from the House and Senate.
4. There is likely double counting across key terms due to overlapping legislation, House and Senate versions and multiple reporting of annual appropriations bills.
5. Returns only confirm that bills were introduced; does not identify bills passed into public law.
6. Not all returns are relevant (e.g., a wildlife bill returned related to family planning).
7. Returns include domestic and international bills; no further distinctions were made.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Global Health</td>
<td>3</td>
<td>2</td>
<td>6</td>
<td>7</td>
<td>6</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>10</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>International Health</td>
<td>2</td>
<td>4</td>
<td>1</td>
<td>9</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>5</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Child Survival</td>
<td>5</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Global AIDS</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Global HIV/AIDS</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Other Infectious Diseases</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Malaria</td>
<td>1</td>
<td>2</td>
<td>6</td>
<td>9</td>
<td>5</td>
<td>3</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>6</td>
<td>10</td>
<td>17</td>
<td>23</td>
<td>10</td>
<td>8</td>
<td>12</td>
<td>9</td>
<td>15</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Tropical Diseases</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Neglected Tropical Diseases</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Maternal Health</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Family Planning</td>
<td>10</td>
<td>6</td>
<td>9</td>
<td>12</td>
<td>7</td>
<td>5</td>
<td>6</td>
<td>2</td>
<td>7</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Reproductive Health</td>
<td>2</td>
<td>3</td>
<td>5</td>
<td>10</td>
<td>5</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>

*2007 covering the period January – June 2007

Notes:

1. Data were collected from the GAO web site.
2. An advanced search was performed by each key term in one year increments, January – December.
3. Returns were only requested for GAO reports.
4. There is likely double counting across key terms due to overlapping terms and report topics.
5. Returns include domestic and international bills; no further distinctions made.
<table>
<thead>
<tr>
<th>Report</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advancing Quality Improvement Research: Challenges and Opportunities, Workshop Summary</td>
<td>May 23, 2007</td>
</tr>
<tr>
<td>Preventing HIV Infection among Injecting Drug Users in High Risk Countries: An Assessment of the Evidence</td>
<td>Sep 15, 2006</td>
</tr>
<tr>
<td>The Impact of Globalization on Infectious Disease Emergence and Control: Exploring the Consequences and Opportunities. Workshop Summary</td>
<td>Mar 03, 2006</td>
</tr>
<tr>
<td>John R. La Montagne Memorial Symposium on Pandemic Influenza Research: Meeting Proceedings</td>
<td>Sep 12, 2005</td>
</tr>
<tr>
<td>Quarantine Stations at Ports of Entry Protecting the Public's Health</td>
<td>Sep 01, 2005</td>
</tr>
<tr>
<td>Microbial Threats to Health: The Threat of Pandemic Influenza</td>
<td>Jul 17, 2005</td>
</tr>
<tr>
<td>Healers Abroad: Americans Responding to the Human Resource Crisis in HIV/AIDS</td>
<td>Apr 19, 2005</td>
</tr>
<tr>
<td>Review of the HIVNET 012 Perinatal HIV Prevention Study</td>
<td>Apr 07, 2005</td>
</tr>
<tr>
<td>The Threat of Pandemic Influenza: Are We Ready? A Workshop Summary</td>
<td>Nov 16, 2004</td>
</tr>
<tr>
<td>Saving Lives, Buying Time: Economics of Malaria Drugs in an Age of Resistance</td>
<td>Jul 20, 2004</td>
</tr>
<tr>
<td>Scaling Up Treatment for the Global AIDS Pandemic: Challenges and Opportunities</td>
<td>Jul 07, 2004</td>
</tr>
<tr>
<td>Learning from SARS: Preparing for the Next Disease Outbreak. Workshop Summary</td>
<td>Jan 27, 2004</td>
</tr>
<tr>
<td>New Frontiers in Contraceptive Research: A Blueprint for Action</td>
<td>Jan 21, 2004</td>
</tr>
<tr>
<td>Improving Birth Outcomes: Meeting the Challenge in the Developing World</td>
<td>Nov 04, 2003</td>
</tr>
<tr>
<td>Reducing Birth Defects: Meeting the Challenge in the Developing World</td>
<td>Nov 04, 2003</td>
</tr>
<tr>
<td>The Resistance Phenomenon in Microbes and Infectious Disease Vectors: Implications for Human Health and Strategies for Containment- Workshop Summary</td>
<td>Apr 10, 2003</td>
</tr>
<tr>
<td>Microbial Threats to Health: Emergence, Detection, and Response</td>
<td>Mar 18, 2003</td>
</tr>
<tr>
<td>Microbial Threats to Health: Emergence, Detection, and Response</td>
<td>Mar 18, 2003</td>
</tr>
<tr>
<td>Report</td>
<td>Date</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>Considerations for Viral Disease Eradication: Lessons Learned and Future Strategies</td>
<td>Jul 19,2002</td>
</tr>
<tr>
<td>The Emergence of Zoonotic Diseases: Understanding the Impact on Animal and Human Health - Workshop Summary</td>
<td>Apr 16,2002</td>
</tr>
<tr>
<td>High-Energy, Nutrient-Dense Emergency Relief Food Product</td>
<td>Feb 27,2002</td>
</tr>
<tr>
<td>Biological Threats and Terrorism: Assessing the Science and Response Capabilities</td>
<td>Jan 29,2002</td>
</tr>
<tr>
<td>Neurological, Psychiatric, and Developmental Disorders: Meeting the Challenges in the Developing World</td>
<td>May 08,2001</td>
</tr>
<tr>
<td>Emerging Infectious Diseases from the Global to the Local Perspective: Workshop Summary</td>
<td>Apr 03,2001</td>
</tr>
<tr>
<td>Ending Neglect: The Elimination of Tuberculosis in the U.S.</td>
<td>May 01,2000</td>
</tr>
<tr>
<td>Managed Care Systems and Emerging Infections: Opportunities for Strengthening Surveillance, Research, and Prevention</td>
<td>2000</td>
</tr>
<tr>
<td>Public Health Systems and Emerging Infections: Assessing the Capabilities of the Public and Private Sectors</td>
<td>2000</td>
</tr>
<tr>
<td>Assessment of Future Scientific Needs for Live Variola Virus</td>
<td>Mar 01,1999</td>
</tr>
<tr>
<td>Chemical and Biological Terrorism: Research and Development to Improve Civilian Medical Response</td>
<td>Dec 01,1998</td>
</tr>
<tr>
<td>Control of Cardiovascular Diseases in Developing Countries</td>
<td>1998</td>
</tr>
<tr>
<td>Antimicrobial Resistance: Issues and Options</td>
<td>1998</td>
</tr>
<tr>
<td>Orphans and Incentives: Developing Technologies to Address Emerging Infections</td>
<td>1997</td>
</tr>
</tbody>
</table>
APPENDIX C
Key Informant Interview Materials

C.1 Participant Invitation

Dear __________,

The Global Health Council is undertaking a strategic planning exercise to understand how it may best serve its members and contribute to the advancement of the global health agenda. As an important stakeholder in the global health community, I write to invite you to participate in a 30 to 45-minute interview [by phone or in person] to explore this issue.

The Council is working with an external consultant, [consultant name], to gather more information about the changing environment and how the Council can best address emerging trends and issues in global health over the next five to ten years.

[Consultant] will contact you soon to schedule a time to meet with you or call you that is mutually convenient. The interviews will be confidential and will serve as input into the strategic planning process directly and will be used to inform the design of a series of focus group discussions with other global health stakeholders.

A summary of the interviews and focus groups will be available to participants within two months. Key informant interviews and focus group results will be used to inform the Council’s broader strategic planning exercise. Some data from the focus groups will also be analyzed by a Council staff member as a part of an unrelated academic exercise.

Please confirm your interest and availability to participate with [consultant name] via email at [consultant email address] or by phone at [consultant phone number] by January 23, 2007. We greatly appreciate your valuable input and look forward to your participation in this exercise.

Sincerely,
<table>
<thead>
<tr>
<th>Name of key informant:</th>
<th>__________________________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title/position:</td>
<td>__________________________________________</td>
</tr>
<tr>
<td>Organization/affiliation:</td>
<td>__________________________________________</td>
</tr>
<tr>
<td>Date:</td>
<td>_______________________</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>_______________________</td>
</tr>
<tr>
<td>Email:</td>
<td>__________________________________________</td>
</tr>
</tbody>
</table>

**Name of interviewer:** [GHC consultant]

This interview seeks your input for an environmental scan that has been initiated by the Global Health Council in an effort to ensure that the Council’s work strategically addresses emerging global health trends and issues over the next five to ten years. The Council’s mission will continue to be to ensure that all who strive for improvement and equity in global health have the information and resources they need to succeed.

The global context is rapidly evolving as disease control priorities shift, technology evolves and the social and political context present opportunities and challenges in governance, management of and access to information, services and other resources, the global economy, religious and ethnic conflict, violence and migration, and other opportunities and challenges. The Council is interested in gathering input from leading experts in the field like you. The interviews will be entirely confidential. The results of all the interviews will be consolidated, summarized, and then shared and analyzed with members of the GHC team. Your input will be a part of the whole picture.

Please be as honest and open as you can be and feel free to ask me any questions at any point during the interview. The interview should take about 30 to 45 minutes to complete depending on how much you have to say.

Would you like to proceed with the interview? Yes No Comment: __________________________________________

**Information about Interviewee**

- What is your current position at [your organization]?
- How would you describe your current role as it relates to global health?

**Trends and emerging issues that will impact on global health**
• Over the last decade, what major changes have you observed in global health?

• What are the top three to five major global trends or emerging issues that you believe will most impact on global health over the next decade? Why?

• What epidemiologic and demographic changes are occurring or are likely to occur in the near future that may shift current health priorities?

• What major policy issues are likely to affect global health over the next five to ten years?

• What new (or existing) technologies will play important roles in improving health?

• What funding sources and health care financing schemes are likely to support (or detract from) health programs and policies over the next five to ten years?

Implications of global trends and emerging issues for those working in global health

• What are the major challenges that people working to improve global health will face over the next five to ten years?

• What types of support will organizations working to improve global health need to help them address these emerging challenges, issues and trends?

• What are potential new opportunities, resources and support that may be emerging that organizations working in global health could tap into?

Global Health Council goals & priorities

• What are the top three emerging opportunities that GHC should take advantage of in order to most effectively advance improvement and equity of global health?

• Currently, the Council’s priorities focus on addressing the core global health programs that the US government funds such as AIDS, malaria, TB, diarrheal disease, etc. However, there are a number of alternative ways to frame the Council’s strategic priorities (for example, by focusing on cross-cutting issues such as strengthening health systems, increasing equity of access to information and services, including chronic diseases and conditions, etc.). On what three to five priorities do you think the Council should focus its agenda over the next five to ten years, to best achieve its mission and remain a relevant voice in the changing environment?

• What other organizations do you know of that have similar roles and goals to those of GHC? How would you compare them to GHC? What is GHC’s current “value added” to the field?

• In what area do you think the Council could demonstrate its leadership over the next five to ten years? Why?

• What should the Council not do? Why?

• What do you think the Council should be doing differently over the next 5 to 10 years to increase its contribution to improving global health?
How the Council can work most effectively

• What do you think the Council does exceptionally well now? What are its current strengths?

• What do you think the Council could do more effectively?

• Who do you think the Council should actively recruit as new members for the Council to be most effective? Why?

• What types of services should the Council provide to its members, partners and other constituencies? Why?

• What types of technology should the Council consider using to better serve its members, partners and other constituencies?

Additional comments/questions

• Who else do you think the Council should contact for input into the strategic planning process?

• What additional comments and/or questions do you have, if any?

Thank you so much for taking the time to provide valuable input into GHC’s strategic planning process. We will provide you with a report that summarizes the results of the key informant interviews and focus groups when all the interviews have been completed and the results have been consolidated. If you have any questions or would like to add, clarify or omit anything to this interview, please feel free to contact me at [consultant phone number] or by email at [consultant email address].
Key Informant Interviews

As outlined in the Methods section of Chapter 4, this analysis focused on a set of 40 interview transcripts representing 41 organizations. The interviews were conducted during the period February-June 2007. To protect informants’ organizational identity, transcripts were assigned generic labels in April and June 2007 before they were received for data analysis. A November 2007 review of a spreadsheet with original organization names matched to generic labels revealed that two organizational labels may have been incorrect. However, because original organizational names could not be matched with specific transcripts, it was not possible to make reliable corrections to transcript labels. Instead, the labels were preserved as originally assigned. Shortcomings in data validity are acknowledged in data reporting. Although some interviews were abbreviated or incomplete, the full texts of all 40 transcripts were analyzed for policy-related reference. Major findings were organized by major theme and related sub-research questions (see Figure 10).

Two important trends emerged during data analysis. First, 24 of the 41 respondents were, as of February 2007, dues-paying members of the Council. However, in 24 transcripts, respondents said that they were not familiar with the Council, did not know the organization well enough or lacked clarity about the Council’s work to comment on its activities and impact. Despite this lack of familiarity, informants provided responses for most questions. This suggests that some opinions and recommendations were informed by a general understanding of what the Council was rather than a working knowledge of the Council. Individuals varied according to the degree they had any vested interest in its future. These should be taken into consideration when interpreting these opinions. This trend also suggests that the Council may consider if, within key
organizations, it is interacting with the appropriate contacts, particularly when working on policy-related matters.

Second, a majority of recommendations about future activities were framed as “it depends” or “the Council needs to decide/define/figure out/make a choice…” Although, stakeholders generally valued the Council, responses suggest 1) at present, confusion over the Council’s priorities, strategies and boundaries and 2) ultimately, a preference toward the clear selection, articulation and execution of the Council’s agenda and direction over the details of either. Responses suggested that, even before designing future policy strategies, the Council’s immediate priority should be a clearer expression of the organization’s scope, strategies and impact.

Organizational Database

As also outlined in the Methods section of Chapter 4, the analysis is based upon a 576-organization stakeholder database compiled by two policy interns at the Global Health Council during the period May-December 2007. Although there was regular review of potentially ambiguous organizational characteristics and attempted to randomly double code data to ensure the appropriate application of codes, formal analysis revealed a handful of potentially mistaken codes in the final database. This included a number of subjective code assignments made by interns when, because code categories were not always mutually exclusive, an organization could have accurately been assigned to more than one code. In those cases, interns were advised to label the organization based on the dominant characteristic. A second coder could have legitimately interpreted a different dominant code and accurately labeled otherwise. It was not feasible to confirm the data quality of all 24 variables for each of the 576 organizations in the database by double-coding or recoding all data. As a result, coding errors exist. Obvious errors were corrected prior to analysis. Once data analysis began, newly detected errors were not corrected, as changes would have
disturbed already completed analysis. Additional errors in the database are noted and these shortcomings are mentioned where appropriate throughout the analysis presented in Chapter 5.
## APPENDIX E
**Policy Network Database Organizations**

- Abbott
- ABT Associates
- Academic Alliance Foundation
- Academy for Educational Development
- Action AID
- Adventist Development & Relief Agency Int’l
- Advocates for Youth
- Aeras Global TB Vaccine Foundation
- Afghans for Civil Society, Inc.
- Africa Action
- Africa Fighting Malaria
- African Communities Against Malaria
- African Heritage International
- African Medical and Research Foundation, Inc.
- African Union
- African Youth Alliance (AYA)/UNFPA
- African Youth Development Foundation
- Africare
- Agnes Scott College
- AIDS Accountability International
- AIDS Action
- AIDS Alliance in Nigeria
- AIDS Institute
- AIDS Project Los Angeles
- AIDS Vaccine Advocacy Coalition (AVAC)
- AIDSSETI
- Aidspan
- Aksion Plus
- Albert B. Sabin Vaccine Institute
- Albert Schweitzer Fellowship
- Alcohol & Drug Abuse Prevention Team
- All Nations Associates Ltd.
- Alliance for Microbicide Development
- Alliance for the Prudent Use of Antibiotics
- Alliance Rights Nigeria
- Alternate Visions LLC
- Amansan Aid Ghana
- American Civil Liberties Union
- American College of Nurse-Midwives
- American College of Obstetricians and Gynecologists
- American Council on Science and Health
- American Dental Association
- American Foundation for AIDS Research (amfAR)
- American Humanist Association
- American International Health Alliance
- American Jewish World Service
- American Leprosy Missions
- American Medical Association
- American Medical Student Association
- American Mosquito Control Association
- American Osteopathic Association
- American Public Health Association
- American Red Cross
- American Refugee Committee
- American Society of Tropical Medicine and Hygiene
- American Zinc Association
- Americans for UNFPA
- Americares Foundation
- AmericaShare
- Analysis, Information Management & Communications
- ASEAN Institute for Health Development
- Asian Forum of Parliamentarians on Population and Development
- Associacao Grupo AIDS: Apoio, Vida, Esperanca (AAVE Group)
- Association for Reproductive Health
- Association of Nurses in AIDS Care
- Association of Ontario Health Centres
- Association of Public Health Laboratories
- Association of Specialized Medical Societies of Kyrgyz Republic
- Association RAMA
- Axios Foundation
- Axios International
- Ayushi Biotech
- Baba Foundation
- Badilika STI/HIV/AIDS Project
- Balaji Medical and Educational Trust
- Balm In Gilead, Inc.
- Bangladesh Caucus
- BASF Corp.
- Basic Education Coalition
- Basics II Project
- Bayer Environmental Science
- Becton Dickinson & Co.
- Ben Gurion University - Columbia University Medical School for Int’l Health
- Best Practices
- Bhutan Health Organization
- Bickford-Land Clinic for Mothers and Children
- Bill & Melinda Gates Foundation
- BIO Ventures for Global Health
- Birthing Project
- Bloomberg School of Public Health, John Hopkins
- Books of Hope
- Booster Program for Malaria Control in Africa
- The World Bank
- BOSS & CIPCA Organization, CASOI
- Boston University
- Boston University School of Public Health- Dept of International Health
- Brandeis University/ The Heller School
- Bread for the World
- Brigham Young University
- Bristol-Myers Squibb Foundation
- BroadReach healthcare
- Brookings Institute
- Brush Foundation
- Burness Communications, Inc
- Burnet Institute
- Bwafwano Community Home Based Care Organization
- Care for Life
- CARE USA
- Carter Center
- Catholic Health Association of India
- Catholic Medical Mission Board
- Catholic Relief Services
- Catholics for Choice
- Cedar Spring, Inc.
- Center for AIDS Prevention Studies - UCSF
- Center for Environment and Population
- Center for Global Development
- Center for Health and Gender Equity (CHANGE)
- Center for International Environmental Law (CIEL)
- Center for International Health
- Center for Islamic Pluralism
- Center for Reproductive Rights
- Center for Strategic & International Studies
- Center for Women Policy Studies
- Centers for Disease Control & Prevention
- Centre for African Family Studies
- Centre for Health and Social Research
- Cera Products, Inc.
- Cervical Barrier Advancement Society
- CHABHA Inc. (Children Affected By HIV/AIDS)
- Charity Network Services
- Chautauqua Institution
- Chembio Diagnostic Systems, Inc.
- Chemonics International
- Child Family Health International
- Child Health Foundation
- Child Survival Consultant
- Children's Heart Link
- Children's Medical Ministries
- Choice USA
- Christian Children's Fund
- Christian Community Development Burundi
- Christian Connections for International Health (CCIH)
- Church of Christ in Nigeria
- Church World Service
- Civic Enterprises LLC
- Collins and Company
- Columbia University, Mailman school of Public Health
- Columbia University Institute for Human Nutrition
- Commonwealth Initiative
- Communications Consortium Media Center
- Communications Consultant
- Communications Strategies for Policy Change
- Community Health Information Education Forum
- Community Health Link
- Congress of Racial Equality
- CONRAD
- Conrad N. Hilton Foundation
- Constella Futures
- Core Group
- Core Malaria Working Group
- COTN Tanzania
- Crosslink
- Cultural Practice, LLC
- Curatio International Foundation
- Dalberg
- Dartmouth College
- DATA—Debt, AIDS, Trade, Africa
- Deaconess Parish Nurse Ministries
- DeBeers
- Deepam Educational Society for Health
- Department of Health and Human Services
- Department of Health, Eastern Cape South Africa
- Developing the Family Together
- Development Finance International
- Dialogue International for Southern Africa Region
- Dimagi Inc.
- Discovery Channel Global Education Partnership
- Disease Control Priorities Project (World Bank)
- DKT International
- Doctors for Global Health
- Doctors of the World
- Doctors Without Borders/ Medecins San Frontieres (MSF)
- Doris Duke Charitable Foundation
- Drinker Biddle Gardner Carton
- Duke University Global Health Institute
- Dunk Malaria
- DynCorp International
- Earth Institute at Columbia University
- Eden Home Health Centre
- Edington, Peel & Associates, Inc.
- Elizabeth Glaser Pediatric AIDS Foundation
- Emerging Markets Group
- Emory University. Rollins School of Public Health
- Emory Vaccine Center at Yerkes
- Emunio Aps
- Engender Health
- Episcopal Church
- Episcopal Relief and Development
- EPOS Health Consultants USA
• ESE- Benin
• Esperanca Inc.
• Estonian Association Anti-Aids
• Evangelical Lutheran Church in America
• Every Child by Two
• Exxon Mobil
• Eziukwu 1 Community Partners for Health
• Families USA
• Family Care International
• Family Focus International/ Ghana
• Family Health International
• Family Planning and Sexual Association of Lithuania
• Family Violence Prevention Fund
• Female Cancer Program
• Female Health Company
• Feminist Majority Foundation
• Fistula Foundation
• Fogarty International Center, National Institutes of Health
• Food for the Hungry
• Forum One Communications
• Foundation for Advancement of International Medical Education and Research
• Foundation for Health Research & Development
• Foundation for Human Horizon
• Francois - Xavier Bagnoud Center for Health & Human Rights
• Francois Xavier Bagnoud USA
• Friends of the Global Fight Against AIDS, TB and Malaria
• FSG- Social Impact Advisors
• Fundamental Human Rights and Rural Development
• Funders Concerned About AIDS
• Future Generations
• GAVI Alliance
• GAVI Fund
• Genesis360 LLC
• George Washington University
• George Washington University, Department of Microbiology, Immunology and Tropical Medicine
• GlaxoSmithKline Biologicals
• Global Action for Children
• Global Action for Children
• Global Health Education Consortium
• Global Health Initiative
• Global Health Strategies
• Global Health Through Education, Training & Service
• Global Justice
• Global Reach- UI of M Med School
• Global Vision Tanzania
• GlobeMed
• GMMB
• Good Works Group
• Grassroot Soccer
• Grounds for Health
• Guttmacher Institution
• Halt AIDS
• Harvard School of Public Health
• Headwaters Productions
• Health and Development International
• Health for Humanity
• Health GAP
• Health Metrics Network
• Helen Keller International
• Hesperian Foundation
• Himalayan Cataract Project
• HIV Medicine Association
• HIV Vaccine Trials Network
• HLSP Institute
• Homes Fountain
• Hope for a Healthier Humanity Foundation
• Hope for AIDS Outreach
• HOPE Worldwide Nigeria
• HospiVision
• Housing Works, Inc.
• Howard Delafield
• Howard University
• Howard University School of Pharmacy
• Human Capital Foundation
• Human Rights Watch
• Ibis Reproductive Health
• IDA Foundation
• Identity, Merge, and Action (AIM)
• Indonesian Forum of Parliamentarians on Population & Development
• Infante Sano
• Infection Control Society of Pakistan
• Infectious Diseases Society of America
• INMED Partnerships for Children
• Institute for Health Care Research and Policy (Georgetown University)
• Institute for Reproductive Health Georgetown University Medical Center
• Institute of Medicine/National Academy of Sciences
• Integrated Malaria Management Consortium (IMMC Inc.)
• Integrated Rural Development Programme

145
- InterAction
- InterChurch Medical Assistance
- International AIDS Vaccine Initiative
- International Association for the Study of Pain
- International Association of Medical Colleges
- International Center for Equal Healthcare Access (ICEHA)
- International Center for Research on Women
- International Centre for Diarrhoeal Disease Research Bangladesh
- International Eye Foundation
- International Federation of Medical Students’ Associations
- International Health Ministries, Presbyterian Church, USA
- International HIV/AIDS Alliance (USA)
- International Justice Mission
- International Medical Corps
- International Partnership for Microbicides
- International Planned Parenthood Federation, International Office
- International Relief and Development
- International Rescue Committee
- International Trachoma Initiative
- International Women’s Health Coalition
- Internews
- INTRAHEALTH
- IPAS
- Izaak Walton League of America
- James R. Jordan Foundation
- Jay Weiss Center for Social Medicine and Health Equity
- Jeeri Neotech International
- JHPIEGO
- John Hopkins University
- John M. Lloyd Foundation
- John Snow, Inc.
- Johnson & Johnson Company
- Jomelos Save-Life Organization
- Joshua Foundation
- Josiah Macy, Jr. Foundation
- Kaiser Family Foundation
- Kamuzu College of Nursing
- Kara Counseling and Training Trust
- Kenya United Christian Churches
- Kgotelopele Health Care Services
- Kisumu Ministry of Health or Kisumu Medical Training Corps
- La Leche League International
- Latin American Working Group
- LearnWell Global Low-cost Health Initiative
- Life Link Organization
- LifeMessengers
- LifeWind International
- Lillian Carter Center for International Nursing
- Livelihood NGO
- LLEGO
- London School of Hygiene & Tropical Medicine
- Love Our Children, USA
- LSM Puskokatara
- M+R Strategic Services
- Maine Medical Center, Division of International Health Improvement
- Malaria No More
- Malaria Vaccine Initiative
- Management Sciences for Health
- Manoff Group, Inc
- MAP International
- March of Dimes, Global Programs
- Marlboro College
- Marriage Grace International
- Mary Wohlford Foundation
- Mathare Youth Sports Association
- MBAs Without Borders
- McGehee Strategies
- Medical Bridges
- Medical Care Development Inc.
- Medical Education Cooperation with Cuba (MEDICC)
- Medical Mission Sisters
- Medicines for Malaria Ventures
- Mennonite Central Committee
- Merck & Co., Inc.
- Mercy Corps
- Ministry of Basic Education, Sport and Culture: HIV and AIDS Management
- Minnesota International Health Volunteers
- Moriah Fund
- Muduuma Widows Association
- Mutual Advancement & Reconciliation in Society (MARS)
- Naral Pro-Choice
- National Abortion Federation
- National Academies of Science
- National Alliance of State and Territorial AIDS Directors
- National Association of Science Writers
- National Association of Social Workers
- National Bureau of Asian Research, Center for Health and Aging
- National Council of Jewish Women
- National Family Planning and Reproductive Health Association
- National Malaria Control Programme, Nigeria
- National Organization for Women
- Nepal Medical College
- Nets for Life
- Network for Children, Youth, and Women Infected and Affected
- Network of PLWAs in Nigeria
- Network: Towards Unity for Health
- New Lifestyle Resource Centre
- New York University's Masters Program in Public Health
- Nine Muses International
- Norwegian Embassy
- Novartis
- Ohio State University College of Medicine
- OmniMed
- One Campaign
- One Tribe Foundation
- Open Society Policy Center
- Operation Blessing
- Operation Smile International
- Oregon Health and Science University
- Pact
- PAHEF
- Pakistan Voluntary Health and Nutrition Awareness (PAVHNA)
- Pan American Health Organization
- Pangaea Global AIDS Foundation
- Parents of Kids with Infectious Diseases
- PATH
- Pathfinder International
- People for the American Way
- Per Ankh, Inc.
- Pesticide Action Network North America
- Pfizer Inc.
- Physicians for Human Rights
- PLAN International
- Planet Aid, Inc.
- Planned Parenthood Global Partners
- PneumoAdip
- Population Action International
- Population Connection
- Population Council
- Population Foundation of India
- Population Institute
- Population Media Center
- Population Reference Bureau
- Population Services International
- Population Services Pilipinas Incorporated
- Positive Women's Network
- Primary Health Care and Health Management
- Procter and Gamble
- Project Concern International
- Project Hope
- Project Inform
- Prolife AIDS League
- Public Health Institute
- Quality Medical Health Care
- Quarry Integrated Communications
- Quotiden Nokoue
- Radiant Communications Inc.
- Rajprachasamai Foundation
- Realizing Rights: The Ethical Globalization Initiative
- Relief International
- Relief Network Ministries
- Religious Action Center of Reformed Judaism
- Religious Coalition for Reproductive Choice
- Reproductive Health Technologies Project
- Reprotect
- Republican Majority for Choice
- Rescue Arms Network
- Research Triangle Institute
- Research!America
- RESULTS
- Rift Valley Voluntary Counselors
- Roll Back Malaria Partnership (Secretariat)
- Rural Educational and Environmental Development Society (REEDS)
- Rural Health Promotion Initiative
- Saint Michael's College
- San Francisco AIDS Foundation
- Save the Children
- Scarlett Consulting International
- Scientific and Productive Center for Preventive Medicine
- Seldon Laboratories
- SIECUS
- Sierra Club
- Sky Health Influence
- Social Research Institute
- Society for Awareness of Human Development and Rights
- Solidarity Center
- SOS Foundation
- Southern African Development Community
- Spectrum Bioscience
- Sree Mayapur Vikas Sangha
- Stay Alive
- Stephen Lewis Foundation
- Student Campaign for Child Survival
- Student Partnership Worldwide
- Sumitomo Global Vector Control
- Support Nepal
- SWAA (Society for Women and AIDS in Africa)
- Takoradi Fund - Vermont Community Foundation
- Task Force for Child Survival and Development
- TB Alliance
- The African World
- The Center for Development and Population Activities
- The Children's Trust
- The David and Lucile Packard Foundation
- The Ford Foundation
- The International Community of Women Living with HIV and AIDS (ICW)
- The John D. & Catherine T. MacArthur Foundation
- The Raben Group
- The Robert Wood Johnson Foundation
- The Rockefeller Foundation
- The Washington Group
- Thundermist Foundation
- Touro University - California
- Treatment Action Group
- TropicalClinics, Inc.
- Trust for Voluntary Organizations
- UCLA Global Health Training Program
- UCSF Medical Center
- UN Foundation
- UNAIDS
- UNICEF
- Unitarian Universalist Association
- United Methodist Church - The General Board of Church and Society
- United Nations Association- USA
- United Negro College Fund Special Program Corporation
- United Science of Africa (USA)
- United Youth Front International
- Universidad Peruana Cayetano Heredia, Global Health Peru Program
- University Coalitions for Global Health Resource Group
- University of Alabama Birmingham
- University of Benin Public Health Education Department
- University of Denver Graduate School of International Studies
- University of Iowa Global Health Studies Program
- University of Kuopio
- University of Maryland- Baltimore - Division of International Health
- University of Maryland, School of Medicine
- University of Michigan
- University of Nairobi - Institute of African, Anthropology and Gender Studies (formerly Institute of African Studies)
- University of New Mexico School of Medicine
- University of North Carolina, Office of Global Health, School of Public Health
- University of Northern Florida, School of Public Health
- University of Pennsylvania, Center for Global Health and Medical Diplomacy
- University of Pennsylvania - School of Medicine
- University of Pennsylvania - School of Nursing
- University of the Witwatersrand AIDS Research Institute
- University of Vermont
- University of Virginia Center for Global Health
- University of Washington, Dept. of Global Health
- University of Washington, School of Public Health and Community Medicine
- US Coalition for Child Survival
- US Fund for UNICEF
- USAID
- Usman Danfodio University Medical Student Association
- UIW Medex Northwest PA Program
- Venture Strategies for Health and Development
- Vermont Council on World Affairs
- Vestergaard Frandsen Inc.
- Vulcan Productions
- Vwawa District Hospital
- Wake Forest University
- Washington National Cathedral
- Washington Office on Africa
- Washington Office, Presbyterian Church (USA)
- Wellstart International
- West African Framework for Global Health
- Westat
- White Ribbon Alliance for Safe Motherhood
- William and Flora Hewlett Foundation
- Williams & Jensen, PLLC
- WilmerHale
- Wilsken Agencies Ltd
- Women of Reform Judaism
- Women's Action & Resource Initiative (WARI)
- Women's Commission for Refugee Women & Children
- Women's Edge Coalition
- Women's Environment and Development Organization
- Woodworth Fund, Norwich Congregational Church
- Workplace Dignity Institute/Gauteng Dept. of Health
- World Alliance for Youth Empowerment
- World Bank
- World Health Organization
- World Learning
- World Relief
- World Vision
- Worldwide Fistula Fund
- Yale University, school of Public Health, Global Health division
- Youthful Initiatives for Econ., Env., Educ., & Large-Scale Development (YIELD)
- Zambia National Response To AIDS
- Zienzele Foundation
APPENDIX F
New Issue Area Criteria

As the Global Health Council identifies new issues and opportunities, leadership will need to determine whether an organizational response is required. Council leaders must consider factors including the evidence base, political and stakeholder feasibility, institutional capacity and desired outcome. These categories reflect the factors that frequently qualified key informant responses about the global health policy environment. These factors include:

**Evidence**
- Is there a sufficient evidence base to engage on this issue?
- How do we characterize this issue – urgent, legitimate or powerful\(^{17}\)?

**Environmental Feasibility – Political**
- Is there a political, policy or legislative solution?
- How complex is this issue – controversial? Partisan considerations?
- What is the current spectrum of political opinion?
- What is the current level of political activity?
- What is the forecast on this issue?

**Environmental Feasibility – Stakeholders**
- What is the current spectrum of stakeholder opinion?
- What proportion of the Council’s membership does this issue impact?
- What is the current level of stakeholder activity?
- Is there a stakeholder desire for the Council’s policy contributions via advocacy or brokering?
- What is the forecast on this issue?

**Institutional Capacity – Resources**
- Does this topic constitute an institutional priority?
- Does the Council currently have the resources – financial, staff – to adopt a new issue?
- Are there existing resources that will be reallocated to support this issue?
- Are there potential new resources (donors, members)?
- Does the Council currently or in the future have access to necessary stakeholders including key representatives of government, public and private sectors to advance the issue?

**Institutional Capacity – Implementation**
- Will this new issue area be in addition to or in place of an existing issue/topic?
- Will the Council apply both of its core policy functions to this issue?

\(^{17}\) See discussion of stakeholder saliency in Chapter 3 and Chapter 6.
• Upon what additional organizational functions/capacities will this issue draw?
• Will this be a time-limited or long-term policy effort?
• What will be the short-term indicators that this is an appropriate investment?

**Desired Outcome**
• Who are the intended beneficiaries (e.g., GHC members, the generic global health agenda)?
• What will define Council success?
• What factors will trigger a re-visitation of this topic?

These specific questions reflect some of the concerns about global health priorities and the policy environment. They are provided only as examples. Council leadership should base actual criteria on its internal and external priorities.

In practice, new issues frequently arise in the rapidly changing policy environment. It will be unlikely that the Council will be able to undertake this decision exercise for every issue it faces. The organization should, however, use these or other preferred criteria if it encounters an issue with which it may engage over time or dedicate institutional resources. For more time-sensitive issues and opportunities, Council leadership may consider an abridged version of this decision-making exercise based on the top-line criteria categories of evidence, feasibility, capacity and outcome.
REFERENCES


