U.S. Global Health Assistance: Background and Issues for the 112th Congress

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Summary

U.S. funding for global health has grown significantly over the last decade, from approximately $1.7 billion in FY2001 to $8.8 billion in FY2012. During the George W. Bush Administration, Congress provided unprecedented increases in global health resources, especially in support of multi-agency initiatives targeting infectious diseases, such as the President's Emergency Plan for AIDS Relief (PEPFAR) and the President's Malaria Initiative (PMI). As support for global health increased, the 110th and 111th Congresses began to emphasize better coordination of all global health programs and efforts to strengthen health systems in recipient countries. In 2009, the Obama Administration announced the Global Health Initiative (GHI), proposed as a six-year, $63 billion effort to integrate existing global health programs and provide a comprehensive U.S. global health strategy.

Funding for FY2012 was signed into law on December 23, 2011 (P.L. 112-74). FY2012 appropriations for global health programs remained similar to FY2011, although these amounts were agreed to after prolonged debate over potential budget reductions. The 112th Congress is currently debating FY2013 funding for global health activities. The Administration's FY2013 budget request includes reduced funding for global health for the first time in over a decade. However, early debate and action on FY2013 appropriations by both the House and Senate suggests that Congress may not support these reductions.

While some policymakers and health experts argue that reductions in global health may be possible due to newly identified efficiencies in programming that could yield important savings, others have raised concerns about the impact of potential cuts on current U.S. global health activities and stated targets. Some groups contend that lower levels of U.S. assistance could

- limit U.S. agencies' ability to integrate their activities and implement innovative approaches to global health, as emphasized by GHI;
- threaten advances in eradicating diseases like polio and guinea worm and reverse progress made in preventing and treating diseases like HIV/AIDS, tuberculosis, and malaria;
- compel recipient countries to decrease spending on health issues that disproportionately affect the poor, like neglected tropical diseases and limit access to basic health services such as midwifery care, nutritional support, and vaccinations; and
- weaken U.S. efforts to encourage greater country ownership through multi-year funding plans.

This report provides a broad overview of U.S. global health assistance, including global health programs and global health initiatives, and analyzes some of the policy questions that the 112th Congress may consider as it oversees and debates funding for global health programs. For more detail on specific diseases and global health challenges, see related reports at http://www.crs.gov.

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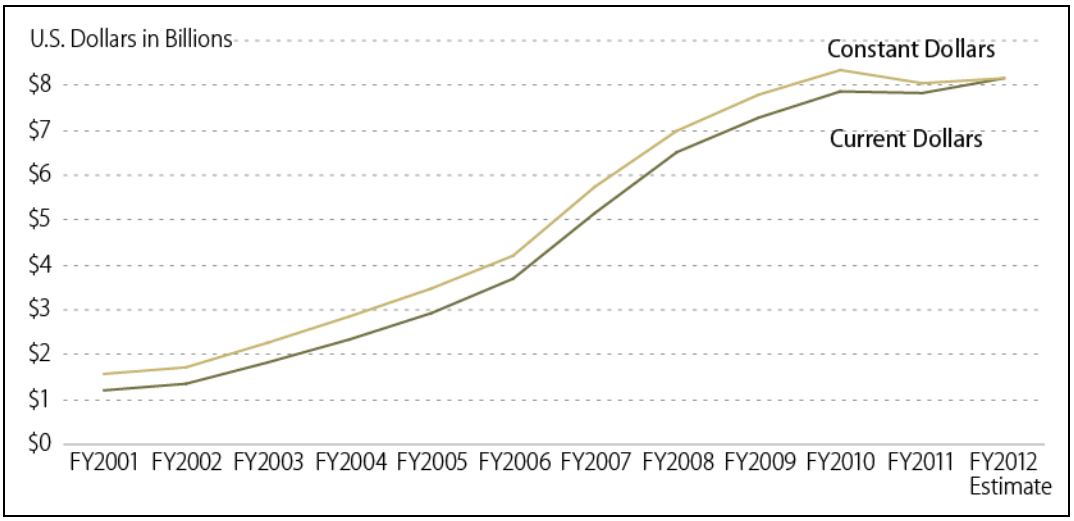
Introduction

Over the last decade, driven in part by recognition that global health efforts help bolster broader U.S. foreign policy goals, global health programs have received unprecedented attention and resources (**Figure 1**). U.S. support for global health has been rooted in humanitarian concerns, but since the 1990s, it has been especially motivated by concern over emergent and reemerging infectious diseases and the threats they pose to international development, stability, and security.

Figure 1. U.S. Global Health Spending, Global Health Programs (GHP) Account, FY2001-FY2012

(in billions of current and FY2012 constant dollars)



Source: Created by CRS from appropriations legislation and data received from the Office of Management and Budget (OMB).

Outbreaks of diseases like severe acute respiratory syndrome (SARS), pandemic influenza, and HIV/AIDS have led a succession of Presidents to give global health a high priority and to launch several health initiatives in response. In 1996, for example, President Bill Clinton issued a presidential decision directive (PDD) that deemed infectious diseases a threat to U.S. national and international security and called for U.S. global health efforts to be coordinated with those aimed at counterterrorism.[1] Following the release of the directive, President Clinton requested $100 million in 1999 to fund the Leadership and Investment in Fighting an Epidemic (LIFE) Initiative to expand U.S. global HIV/AIDS efforts.[2] President George W. Bush recognized the impact of infectious diseases on global security as well in his 2002 and 2006 national security strategy papers. Along with these statements, President Bush created several global health initiatives,

[1] The White House, *Infectious Diseases*, Presidential Decision Directive NSTC-7, June 12, 1996, http://www.fas.org/irp/offdocs/pdd/pdd-nstc-7.pdf.

[2] The LIFE target countries were India, Ethiopia, Kenya, Malawi, Mozambique, Nigeria, Rwanda, Senegal, South Africa, Tanzania, Uganda, Zambia, and Zimbabwe. For background information on early U.S. global HIV/AIDS programs, see CRS Report RL33771, *Trends in U.S. Global AIDS Spending: FY2000-FY2008*, by (name redacted).

including the President's Emergency Plan for AIDS Relief (PEPFAR), the President's Malaria Initiative (PMI), and the Neglected Tropical Diseases (NTD) Program.[3]

President Barack Obama also recognized the risk of infectious diseases and linked the capacity of developing countries to prevent and respond to disease outbreaks to U.S. national security. In 2009, President Obama announced the Global Health Initiative (GHI) to coordinate the health initiatives established during the Bush Administration as well as other United States Agency for International Development (USAID) and Centers for Disease Control and Prevention (CDC) bilateral health programs, increase investments in health areas that he deemed underfunded, and bolster the health systems of weak and impoverished states. Through the State Department's 2010 Quadrennial Diplomacy and Development Review (QDDR) and the 2010 National Security Strategy, the Obama Administration has emphasized the importance of coordinating defense, health, and development efforts and cited the strategic value of improving health around the world, particularly across the Middle East. The Administration sees the GHI as an integral part of a "smart power" approach to foreign policy, whereby diplomacy, development (including health), and defense are leveraged as mutually reinforcing tools.[4]

A Note on Abbreviations

In this report, the following abbreviations are used in relation to U.S. global health accounts and programs: GHI=Global Health Initiative, GHP=Global Health Programs account (formerly the Global Health and Child Survival (GHCS) account), MCH=Maternal and Child Health, FP/RH=Family Planning and Reproductive Health, VC=Vulnerable Children, OID= Other Infectious Diseases, NTD=Neglected Tropical Diseases, TB=Tuberculosis, GDD=Global Disease Detection, and PMTCT=Prevention of Mother to Child Transmission of HIV.

Congressional Priorities

During the Clinton, Bush, and Obama administrations, successive Congresses have demonstrated strong support for global health programs and have, for the most part, appropriated funds for global health in excess of presidential requests. Congressional priorities for global health have largely aligned with those of past administrations, though there has been debate about how certain programs should be prioritized and implemented.[5] In agreement with past administrations, Congress has aimed the majority of global health funding at HIV/AIDS. At the same time, since the launch of the Global Health Initiative, Congress has also supported calls by the Obama Administration to increase investments in health areas other than HIV/AIDS, particularly malaria, maternal and child health, and neglected tropical diseases.

Despite strong support by past Congresses for global health programs, some Members of the 112th Congress have questioned levels of non-security foreign aid in general and have argued for the

[3] For more information on PMI and the NTD program, see CRS Report R41644, *U.S. Response to the Global Threat of Malaria: Basic Facts*, by (name redacted); CRS Report R40494, *The President's Malaria Initiative and Other U.S. Global Efforts to Combat Malaria: Background, Issues for Congress, and Resources*, by (name redacted); and CRS Report R41607, *Neglected Tropical Diseases: Background, Responses, and Issues for Congress*, by (name redacte d).

[4] U.S. Department of State, *Leading Through Civilian Power: The First Quadrennial Diplomacy and Development Review*, 2010, p. 82 (hereinafter, *Leading Through Civilian Power: The First Quadrennial Diplomacy and Development Review*).

[5] For more information on these debates, see CRS Report RL34569, *PEPFAR Reauthorization: Key Policy Debates and Changes to U.S. International HIV/AIDS, Tuberculosis, and Malaria Programs and Funding*, by (name redacted); and CRS Report RL33250, *International Family Planning Programs: Issues for Congress*, by (name redacted).

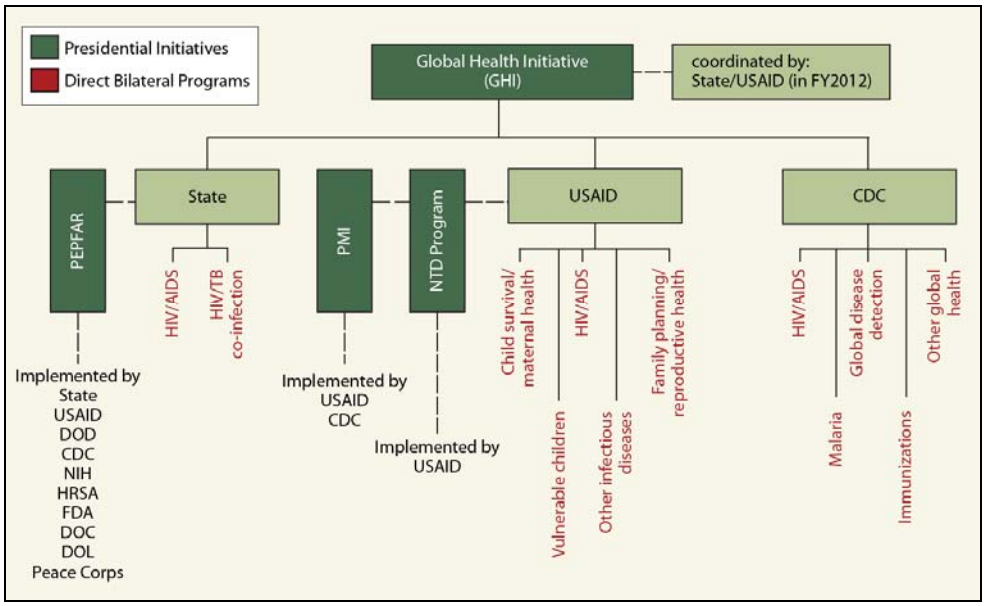
reduction or elimination of development and health assistance. Although some Members of Congress contend that cuts to these programs could yield important savings, others contend that such reductions would have little impact on the federal deficit but could significantly imperil the lives of vulnerable populations reliant on U.S. assistance.

U.S. Global Health Assistance

Congress funds bilateral and multilateral health assistance through three appropriations: State, Foreign Operations and Related Programs (State-Foreign Operations); Labor, Health and Human Services, and Education (Labor-HHS); and Department of Defense. These funds support global health efforts managed and conducted by USAID, CDC, and the Department of Defense (DOD) as well as PEPFAR-related efforts that are coordinated by the Department of State and implemented by several U.S. agencies (**Figure 2**). Under PEPFAR, the United States also supports multilateral efforts to combat HIV/AIDS, including through contributions to the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and the Joint United Nations Program on HIV/AIDS (UNAIDS).

The Obama Administration's Global Health Initiative represents an effort to improve the alignment and coordination of these various programs, and to track the multiple lines of funding for these programs under a comprehensive global health budget. The Obama Administration named the State Department the head of this effort until September 2012, when leadership of GHI is supposed to transfer to USAID if certain benchmarks are achieved.[6]

Figure 2. U.S. Bilateral Global Health Assistance: Agencies and Programs



Source: CRS analysis and design.

Notes: The chart above reflects funding for bilateral global health programs. It is important to note that the United States also contributes funds to multilateral organizations working on global health.

[6] *Leading Through Civilian Power: The First Quadrennial Diplomacy and Development Review,* p. 217.

Abbreviations: President's Emergency Plan for AIDS Relief (PEPFAR), President's Malaria Initiative (PMI), Neglected Tropical Disease Program (NTD Program), United States Agency for International Development (USAID), Department of Defense (DOD), Centers for Disease Control and Prevention (CDC), National Institutes of Health (NIH), Health Resources and Services Administration (HRSA), Food and Drug Administration (FDA), Department of Commerce (DOC), and Department of Labor (DOL).

Nearly 90% of U.S. global health programs are funded through the Global Health Programs (GHP) account (formerly called the Global Health and Child Survival (GHCS) account) in State-Foreign Operations appropriations. Funding through the GHP account supports bilateral and multilateral global health programs managed by USAID and HIV/AIDS programs coordinated and managed by the Department of State under PEPFAR. Charts outlining global health spending provided through State-Foreign Operations and Labor-HHS are included in the **Appendix**. Congress also makes funds available for global health through other accounts within State-Foreign Operations, including the Development Assistance and the Economic Support Fund accounts. Appropriators do not, however, specify how much should be made available for global health activities through these accounts.

Through Labor-HHS appropriations, Congress finances bilateral health programs implemented by CDC, and provides resources to support international HIV/AIDS and malaria research conducted by the National Institutes of Health (NIH). Congress has historically supported an additional contribution to the Global Fund through Labor-HHS appropriations, although beginning in FY2012 the contribution has come from State-Foreign Operations appropriations alone. Defense appropriations fund HIV-prevention efforts conducted by DOD and provide resources to DOD to support global malaria research.

In addition to funds Congress provides specifically for global health, U.S. agencies and departments may use other portions of their budgets on global health programs. For example, CDC uses some of its funds to support global TB programming, although it does not receive a direct appropriation to do so. U.S. agencies and departments also transfer funds among each other. For instance, the Department of State transfers the majority of the funds it receives from Congress for global HIV/AIDS activities to implementing agencies such as USAID and CDC. Likewise, USAID may transfer funds to CDC for field research and evaluation of global health programs.

U.S. agencies also receive funds to implement programs that simultaneously address development and health challenges. These efforts may include improving access to clean water, addressing the negative consequences of climate change and rapid urbanization, supporting the vulnerable in conflict or post-conflict environments, and responding to natural emergencies.

In light of these different funding streams and a lack of consensus on exactly which programs and activities constitute global health assistance, estimates of U.S. global health spending by U.S agencies, think tanks, and other observers vary. A number of advocacy groups, for example, consider water and sanitation activities as part of global health assistance. Similarly, the websites of some U.S. agencies and departments describe a broader view of global health aid than what is provided through congressional appropriations. For example, USAID cites its work related to health system strengthening and environmental health as global health activities. CDC also includes collaborative responses to global health emergencies, such as cholera outbreaks and pandemic influenza, with international organizations like the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) among its global health work.

Funding Under the Global Health Initiative

The Global Health Initiative (GHI) acts as a "whole-of-government umbrella" to coordinate existing U.S. government global health efforts. As such, the GHI budget counts a number of existing funding streams for various global health efforts at several U.S. agencies. However, GHI does not include all U.S. global health programs, nor does the GHI budget count all U.S. funding for global health programs. The Administration includes the following as part of the GHI budget:

- funding through the Global Health Programs (GHP) account for State Department and USAID global health activities;
- funding for U.S. Contributions to the Global Fund;
- funding for global HIV/AIDS activities and research at other U.S. agencies, including CDC, NIH, and DOD; and
- funding for global malaria activities and research at other U.S. agencies, including CDC, NIH, and DOD.

Currently, the GHI budget does not include CDC funding for other global health activities, as detailed in this report, nor does it include funding for global health activities that flows through other USAID accounts, including the Economic Support Fund (ESF) account, the Development Assistance (DA) account, and the Assistance for Europe, Eurasia, and Central Asia (AEECA) account. Funding counted under the Global Health Initiative from FY2009 through FY2013 can be found in **Table A-1**.

The section below describes bilateral health activities funded by Congress. This includes global health programs implemented by USAID and CDC as well as interagency presidential global health initiatives including the President's Emergency Plan for AIDS Relief (PEPFAR), the President's Malaria Initiative (PMI), the Neglected Tropical Disease Program (NTD Program), and the Global Health Initiative. While the presidential initiatives are described, activities conducted by each agency as part of these initiative are not detailed here, such as PEPFAR-related efforts by DOD and NIH. Likewise, funding for multilateral organizations, like the Global Fund, is not discussed in detail.[7]

USAID Global Health Programs[8]

Through State-Foreign Operations appropriations, Congress supports the following overarching USAID global health program areas:[9]

- **Saving Mothers and Children**, which includes programs focusing on maternal and child health, malaria, nutrition, family planning and reproductive health, and social services (vulnerable children). This portfolio aims to save the lives of women and children through reduced morbidity and mortality from common diseases and undernutrition; provide services to vulnerable children and orphans; increase access to family planning and reproductive health; and improve awareness about birth spacing, contraception, and sexually transmitted diseases.
- **Creating an AIDS-free Generation**, which aims to prevent, treat, and address the impacts of HIV/AIDS—particularly among vulnerable populations such as

[7] For more on the Global Fund, see CRS Report R41363, *The Global Fund to Fight AIDS, Tuberculosis, and Malaria: Issues for Congress and U.S. Contributions from FY2001 to FY2013* , by (name redacted) and (name redacte d).

[8] For more information on USAID's global health programs, see CRS Report RS22913, *USAID Global Health Programs: FY2001-FY2012 Request*, by (name redacted).

[9] The categorization of these program area comes from the FY2013 Department of State Congressional Budget Justification, Volume 2, Foreign Operations.

women, girls, and orphans—through voluntary counseling and testing, awareness campaigns, and supplying antiretroviral medicines, among other activities.

- **Fighting Other Infectious Diseases**, which aims to address a number of diseases and resultant outbreaks, including through programs targeting tuberculosis (TB), pandemic influenza and other emerging threats, and neglected tropical diseases (NTDs).

CDC Global Health Programs[10]

Through Labor-HHS appropriations, Congress supports the following CDC global health program areas:

- **HIV/AIDS**, which aims to improve capacity in laboratory services and health systems; strengthen in-country capacity to design and implement HIV/AIDS surveillance systems and surveys; and support host-government capacity to monitor and evaluate the process, outcome, and impact of HIV prevention, care, and treatment programs.
- **Parasitic Diseases and Malaria**, which aims to reduce death and illness caused by parasitic diseases, including malaria, through the enhancement of vector control, case management, surveillance, monitoring and evaluation, and capacity building, as well as laboratory research to develop new tools and strategies to prevent and control malaria.
- **Global Disease Detection (GDD) and Emergency Response**, which aims to strengthen and support public health surveillance, training, and laboratory methods to detect and contain disease threats; build in-country capacity; and provide support for humanitarian emergencies.
- **Global Immunization**, which aims to immunize children younger than five years old against polio and measles, and other vaccine-preventable diseases.
- **Global Public Health Capacity Development**, which aims to build public health capacity among country leaders, particularly ministries of health.

Although Congress does not appropriate funds to CDC specifically for global tuberculosis and pandemic influenza preparedness and response efforts, CDC allots a portion of its overall TB and pandemic preparedness funds for international assistance.

State Department Global Health Programs

In FY2003, the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (Leadership Act, P.L. 108-25) authorized the creation of the Office of the Global AIDS Coordinator (OGAC) at the U.S. Department of State. The mission of this office includes coordinating and overseeing all bilateral HIV/AIDS programs (see "President's Emergency Plan for AIDS Relief (PEPFAR)") and U.S. contributions to multilateral HIV/AIDS organizations. As a coordinating office, OGAC transfers the majority of funds it receives from Congress to

[10] For more information on CDC's global health programs, see CRS Report R40239, *Centers for Disease Control and Prevention Global Health Programs: FY2001-FY2012 Request*, by (name redacted).

implementing departments and agencies (including USAID and CDC) and to multilateral groups like the Global Fund and UNAIDS. The State Department also engages to a small extent in programming at the country level.[11]

Presidential Global Health Initiatives

The bulk of U.S. global health assistance is aimed at mitigating the impact of infectious diseases, especially HIV/AIDS, through three presidential initiatives: PEPFAR, PMI, and the NTD Program.[12] The Global Health Initiative became the first U.S. global health effort that was not aimed at a particular disease or at a set of related diseases, such as the NTD Program. Instead, GHI intends to coordinate activities supported by ongoing presidential global health initiatives and other bilateral health efforts through USAID and HHS. Each of these initiatives has served to garner attention and resources for the targeted diseases or programs.

President's Emergency Plan for AIDS Relief (PEPFAR)[13]

In January 2003, President Bush announced PEPFAR, a government-wide initiative to combat global HIV/AIDS. PEPFAR supports a wide range of HIV/AIDS prevention, treatment, and care activities and is the largest commitment by any nation to combat a single disease. In FY2004, through the Leadership Act, Congress authorized $15 billion to be spent over five years in support of bilateral and multilateral HIV/AIDS programs. In 2008, through the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008 (P.L. 110-293), Congress authorized $48 billion for bilateral and multilateral HIV/AIDS, TB, and malaria efforts, including $4 billion for TB and $5 billion for malaria, for five years.

PEPFAR is overseen by the Office of the Global AIDS Coordinator at the State Department. In this capacity, the State Department distributes the funds it receives from Congress to support global HIV/AIDS programs implemented by several U.S. agencies and departments, including USAID, HHS and its implementing agencies (CDC, NIH, U.S. Food and Drug Administration, and U.S. Health Resources and Services Administration), DOD, Department of Commerce (DOC), Department of Labor (DOL), and the Peace Corps, as well as multilateral organizations (including the Global Fund and UNAIDS).

President's Malaria Initiative (PMI)[14]

In June 2005, President Bush announced PMI in order to expand and coordinate U.S. global malaria efforts. PMI was originally established as a five-year, $1.2 million effort to halve the

[11] Personal communication with representative from the Office of the Global AIDS Coordinator, State Department.

[12] In FY2012, approximately 83% of all Global Health Initiative spending was aimed at these initiatives.

[13] For more information on PEPFAR, see CRS Report R41645, *U.S. Response to the Global Threat of HIV/AIDS: Basic Facts*, by (name redacted); and CRS Report R41802, *The Global Challenge of HIV/AIDS, Tuberculosis, and Malaria*, by (name redacted).

[14] For more information on PMI, see CRS Report R41644, *U.S. Response to the Global Threat of Malaria: Basic Facts*, by (name redacted); and CRS Report R41802, *The Global Challenge of HIV/AIDS, Tuberculosis, and Malaria*, by (name redacted).

number of malaria-related deaths in 15 sub-Saharan African countries[15] through the expansion of four prevention and treatment techniques: indoor residual spraying (IRS), insecticide-treated nets (ITNs), artemisinin-based combination therapies (ACTs), and intermittent preventative treatment for pregnant women (IPTp). The Obama Administration expanded the range of PMI to include Nigeria, the Democratic Republic of the Congo, Guinea and Zimbabwe, and augmented the goal of the initiative to include halving the burden of malaria (including morbidity and mortality) among 70% of at-risk populations in Africa by 2014.

PMI is led by USAID and jointly implemented by USAID and CDC. PMI is overseen by the U.S. Malaria Coordinator at USAID, who is advised by an Interagency Steering Group that includes representatives from USAID, HHS, the Department of State, DOD, the National Security Council (NSC), and the Office of Management and Budget (OMB).

Neglected Tropical Disease (NTD) Program[16]

In response to FY2006 appropriations language that directed USAID to make available at least $15 million for combating seven NTDs,[17] the agency launched the NTD Program in September 2006. Originally, the NTD Program aimed to support the provision of 160 million NTD treatments to 40 million people in 15 countries. President Bush reaffirmed his commitment to the program in 2008 and proposed spending $350 million from FY2008 through FY2013 on expanding the fight against the seven NTDs to 30 countries. In 2009, the Obama Administration amended the targets of the NTD program and called for the United States to support halving the prevalence of NTS among 70% of the affected population. Under GHI, the program aims to be in 30 countries by 2014.[18]

The Global Health Initiative

In May 2009, President Obama announced the Global Health Initiative, a six-year plan projected to cost $63 billion.[19] GHI attempts to provide a comprehensive U.S. global health strategy for existing U.S. global health programs, including many of the programs and initiatives outlined above. GHI calls for shifting the U.S. approach to global health from one focused on specific diseases to one that comprehensively addresses a variety of health challenges through strengthening health systems and improving coordination and integration of existing global health programs. GHI outlines several targets for improving global health, which include the following:

[15] The original 15 PMI focus countries were added over the course of three fiscal years. PMI began operations in Angola, Tanzania, and Uganda in FY2006, in Malawi, Mozambique, Rwanda, and Senegal in FY2007, and in Benin, Ethiopia, Ghana, Kenya, Liberia, Madagascar, Mali, and Zambia in FY2008.

[16] For more information on the NTD Program, see CRS Report R41607, *Neglected Tropical Diseases: Background, Responses, and Issues for Congress*, by (name redacted).

[17] The seven most common NTDs are: three soil-transmitted helminthes, schistosomiasis, lymphatic filiariasis, trachoma, and onchocerciasis.

[18] USAID, *Foreign Operations FY2010 Performance Report and FY2012 Performance Plan*, April 25, 2011, p. 386, http://www.usaid.gov/performance/apr/APR2010-2012.pdf.

[19] GHI funding consists largely of funding for existing State, USAID, and HHS global health programs.

- **HIV/AIDS:** support the prevention of more than 12 million new HIV infections; treatment for more than 4 million people;[20] and care for more than 12 million people, including 5 million orphans and vulnerable children.
- **Malaria:** halve the burden (morbidity and mortality) of malaria for 450 million people, representing 70% of the at-risk population in Africa.
- **Tuberculosis:** contribute to the treatment of a minimum of 2.6 million new TB cases and 57,200 cases of multi-drug-resistant TB, and contribute to a 50% reduction in TB deaths and disease burden relative to the 1990 baseline.
- **Nutrition:** reduce child undernutrition by 30% across assisted food-insecure countries, in conjunction with the President's Feed the Future Initiative led by USAID.
- **Family Planning and Reproductive Health:** prevent 54 million unintended pregnancies, reach a modern contraceptive prevalence rate of 35%, and cut the proportion of women who have their first birth before age 18 from 24% to 20% across assisted countries.
- **Maternal Health:** reduce maternal mortality by 30% across assisted countries.
- **Child Health:** lower under-five mortality rates by 35% across assisted countries.
- **Neglected Tropical Diseases:** halve the prevalence of seven NTDs among 70% of the affected population and contribute to the elimination of onchocerciasis in Latin America and the elimination of lymphatic filariasis, blinding trachoma, and leprosy worldwide.[21]

GHI also proposes a set of core principles to guide programming in each of these areas and coordination between the various global health agencies. These core principles are to

- focus on women, girls, and gender equality;
- encourage country ownership and invest in country-led plans;
- build sustainability through health system strengthening;
- strengthen and leverage key multilateral organizations, global health partnerships, and private-sector engagement;
- increase impact through strategic coordination and integration;
- improve metrics, monitoring, and evaluation; and
- promote research and innovation.

As of spring 2012, 29 "GHI Plus" countries have been chosen to receive additional resources and technical assistance to accelerate implementation of GHI and to serve as "learning laboratories"

[20] On World AIDS Day in December 2011, President Obama announced that the United States was committing to a new target of providing treatment to six million people by the end of 2013. For more information, see the "Maintaining HIV/AIDS Commitments" section.

[21] For a complete list of GHI targets, see Annex A in *The United States Government Global Health Initiative: Strategy Document*, 2011, pp. 16-19, http://www.usaid.gov/ghi/documents/GHI_Strategy.pdf.

for best practices (GHI plans to ultimately be implemented in every country receiving health assistance).

GHI is currently coordinated by an executive director at the Department of State who reports to both the Secretary of State and the GHI Operations Committee, which comprises the USAID Administrator, the Global AIDS Coordinator, and the Director of CDC. The Operations Committee is charged with oversight and management of the initiative. Leadership of GHI is expected to transition from the State Department to USAID in late FY2012, should USAID meet a set of benchmarks related to management capacity, outlined in the Quadrennial Diplomacy and Development Review.[22] The State Department will continue to lead PEPFAR, even after USAID assumes leadership of GHI.

The section below highlights actions that the government is undertaking to improve the implementation of U.S. bilateral health programs and meet GHI targets and principles.[23]

Coordination and Integration: The State Department, USAID, and CDC, in partnership with national governments, are completing multi-year joint strategic plans for each GHI Plus Country. These strategic plans aim to identify unnecessary programmatic duplications, find opportunities for integration, and better align U.S. programs with the priorities of national governments. These plans are not intended to replace current disease- or initiative-specific strategies, but rather to serve as an overarching strategic guide under which each program will operate.

Prioritization of Broad Challenges: Most U.S. global health assistance is provided through disease-specific initiatives (PEPFAR, PMI, and the NTD Program). While these initiatives are core components of GHI, the Obama Administration has also signaled that the United States will increasingly respond to broader-based health challenges. GHI has a particular emphasis on health-system strengthening, including efforts to improve health-worker training and retention, strengthen laboratory capacity, enhance supply-chain mechanisms, and bolster information systems. Likewise, the Obama Administration supports increased attention to women and girls, including through integrated services that can respond to multiple health issues ranging from HIV/AIDS, TB, and malaria, to obstetric care and nutrition.

Results-Oriented Programming: The Obama Administration has indicated that it will begin to reallocate its global health resources to the activities that maximize health impact. In this regard, the United States is shifting toward a more evidence-based and results-oriented approach to global health, rather than one focused on input or expenditure. The Obama Administration has stated that it will support efforts to scale up proven interventions, and that it will phase out activities that have not yielded positive results. GHI places new emphasis on monitoring and evaluation of global health programs to better assess outcomes, and it supports scale-up of operational and implementation research to identify best practices in the field. U.S. agencies have begun this process through the use of updated evaluation indicators and new attention to measuring program quality.

[22] For a list of the benchmarks, see Appendix 2 in State Department, *Quadrennial Diplomacy and Development Review*, 2010, pp. 217-219, http://www.state.gov/documents/organization/153142.pdf.

[23] More detail about these actions can be found in the *United States Government Global Health Initiative Strategy*, 2011, 2011, http://www.usaid.gov/ghi/documents/GHI_Strategy.pdf.

FY2012 Funding

On December 23, 2011, the President signed the Consolidated Appropriations Act, 2012 (P.L. 112-74). In spite of the prolonged debate over potential cuts to global health programs, the act demonstrated continued congressional support for global health programs. The act made $8.2 billion available to USAID and the State Department for global health activities through the Global Health Programs (GHP) account, roughly $336 million more than FY2011 funding levels (**Figure 3**). Compared to the FY2011 levels, the $8.2 billion included level or increased funding for most global health programs. In particular, the act included $2.6 billion for USAID global health programs (+$127 million) and $1.3 billion for the U.S. contribution to the Global Fund through the State Department (+$551 million).[24] In contrast, the act included $4.2 billion for State Department HIV/AIDS programs (-$343 million), a decrease from FY2011 levels.

FY2013 Budget Request

The President's FY2013 budget request includes $8.5 billion for global health activities under the GHI, including $7.9 billion through the GHP account. The request represents a 3.8% decrease in GHI funding from FY2012-enacted levels and marks a potential shift in global health funding trends, which has seen increases for more than a decade.

Compared to FY2012 funding levels, the request for funding through the GHP account includes decreases for almost every global health program area. Notable decreases include

- $3.7 billion for State Department HIV/AIDS programs, down 12.8% from FY2012;
- $578 million for USAID maternal and child health programs, down 4.6% from FY2012;
- $619 million for USAID malaria programs, down 4.8% from FY2012;
- $224 million for USAID tuberculosis programs, down 5.1% from FY2012; and
- $67 million for USAID neglected tropical diseases programs, down 24.7% from FY2012.

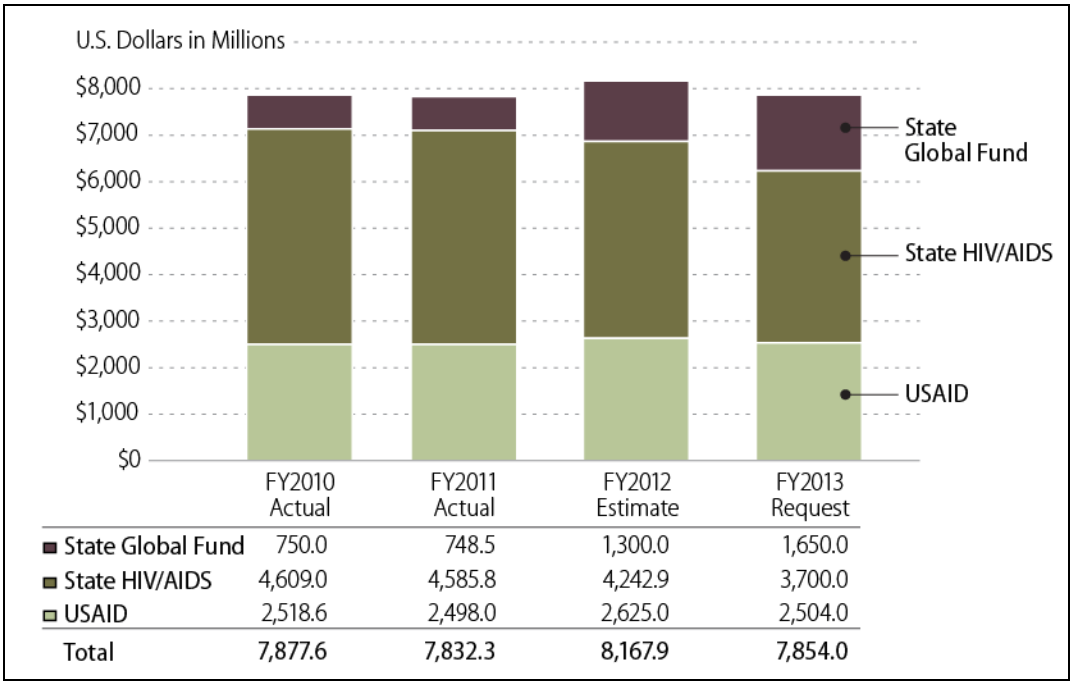
The increases included in the request are

- $530 million for USAID family planning and reproductive health, up 1.2% from FY2012; and
- $1.65 billion for the Global Fund, up 27% from FY2012.

[24] In FY2011, Congress also appropriated funds to HHS for the U.S. contribution to the Global Fund. In total, the FY2012 contribution to the Global Fund was $254 million more than FY2011 levels, including the HHS portion.

Figure 3. Global Health Spending, GHP Account, FY2010-FY2013

(in millions of current dollars)



	FY2010 Actual	FY2011 Actual	FY2012 Estimate	FY2013 Request
State Global Fund	750.0	748.5	1,300.0	1,650.0
State HIV/AIDS	4,609.0	4,585.8	4,242.9	3,700.0
USAID	2,518.6	2,498.0	2,625.0	2,504.0
Total	7,877.6	7,832.3	8,167.9	7,854.0

Sources: FY2012 Congressional Budget Justification for State-Foreign Operations.

Notes: Does not include spending on global health by USAID through other accounts like the Development Assistance or Economic Support Fund accounts.

The FY2013 budget request for CDC global health is $363 million, a slight increase from FY2012. When compared to FY2012 levels, the request includes steady funding or slight increases for most program areas. The largest increases occurred in two funding categories: global immunization (+9.4%) and NIH HIV/AIDS research (+6.7%).

While the FY2013 budget request would represent a shift in global health funding trends, the Administration argues that the decreases do not reflect changes in its commitment to global health, U.S. global health goals, or overall program implementation strategies. Instead, it contends that proposed reductions in global health funding reflect increased efficiencies brought about by better integration between programs, greater use of community health workers and nurses, increased country contributions to programs, cheaper shipping costs of medicines, and reduced per-person treatment costs. Scaling back funding for PEPFAR programs in some countries also represents an attempt to transfer costs to countries with growing capacity and domestic investment in the HIV/AIDS response, such as South Africa, Ethiopia, and Kenya. OGAC has also stated that funding is being reduced in countries where significant resources from other donors are available or where HIV prevalence is particularly low, including, most prominently, Ethiopia.[25] The Administration argues that despite reduced funding, it will still be

[25] Eric Goosby, *President's Budget Request Reflects Strong Commitment on Global AIDS*, Department of State, February 13, 2012, http://blog.aids.gov/2012/02/presidents-budget-request-reflects-strong-commitment-on-global-aids.html.

able to fulfill the GHI targets, including the President's recent pledge to support treatment for 6 million HIV-positive people worldwide by the end of 2013.[26]

Early action and debate within both the House and the Senate on FY2013 appropriations indicate that Congress may not support proposed reductions in funding for many global health programs. Certain program areas, however, will likely be the subject of ongoing congressional debate, including family planning and reproductive health as well as the U.S. contribution to the Global Fund.

Issues for the 112th Congress

The United States is among the world's largest donors for global health, particularly for efforts related to HIV/AIDS. Not only does the United States spend more than any other country on addressing the global HIV/AIDS pandemic, it also accounts for roughly 30% of all donor pledges to the Global Fund.[27]

The U.S. role in global health has been both applauded and criticized. Supporters have celebrated the attention the United States has brought to several global health issues, particularly through PEPFAR, PMI, and the NTD Program. At the same time, critics have opposed some of the ways in which these programs have been implemented. For example, some experts have criticized the United States' past use of parallel health systems created for U.S programs in lieu of relying on existing national systems, arguing that they have led to unnecessary duplication and have done little to support country ownership of global health programs, the functioning of national health systems, or broader responses to global health issues.

Regardless of opposing views of U.S. global health programs, there is consensus that the size of U.S. global health assistance affords the United States significant influence in how global health aid is carried out. This section analyzes some issues the second session of the 112th Congress might face as it debates global health programs and spending levels.

Developing a U.S. Global Health Strategy

The United States has not traditionally articulated any overarching global health strategy. Rather, U.S. global health programs, including the various presidential global health initiatives, have been developed separately as health emergencies have arisen or health issues have gained increasing attention. Likewise, while distinct agencies involved in global health activities have collaborated on an ad-hoc basis, they have historically had separate planning, implementing, and reporting systems.

The Obama Administration has initiated the process of establishing a comprehensive U.S. global health strategy through the Global Health Initiative. GHI emphasizes a whole-of-government approach to global health, including through the development of interagency country strategy

[26] State Department, *Executive Budget Summary*, Function 150 and Other International programs, Fiscal Year 2013, pp. 74-80.

[27] For more information on the Global Fund, see CRS Report R41363, *The Global Fund to Fight AIDS, Tuberculosis, and Malaria: Issues for Congress and U.S. Contributions from FY2001 to FY2013* , by (name redacted) and (name redacted).

plans. In particular, the GHI strategy document states, "the GHI team is accountable for achieving the common performance goals articulated in the country-specific GHI results framework. Shared ownership of these goals across U.S. agencies should fuel creative 'systems thinking' and motivate efficient and effective collaboration at all levels."[28] The strategy also makes ambassadors the leaders in the field and the Secretary of State the overall head of GHI implementation.

Some have criticized the GHI approach to global health assistance. For example, critics argue that the process of GHI implementation has lacked transparency and that it remains unclear how GHI has altered the implementation of bilateral health programs, if at all. Likewise, while many believe interagency cooperation can reduce unnecessary program duplication and lead to more efficient services, other observers question whether the interagency approach is slowing implementation of GHI or making it difficult to conduct disease-specific activities.[29] Further, some argue that despite the Administration's attempt to articulate a U.S. global health strategy, it falls short of clarifying several long-standing issues with U.S. global health assistance, including

- ambiguous funding streams;
- distinct, disparate goals and objectives for health initiatives and agencies; and
- the vague role of each implementing agency as they relate to an overall strategy.

For example, some contend that while the Obama Administration emphasizes a whole-of-government global health strategy, GHI documents limit discussion to activities undertaken by USAID and the State Department, and select activities undertaken by CDC. The reports do not clearly explain what part, if any, other agencies might play. The role of the Department of Defense (DOD), for instance, expends a significant amount of resources on global health compared to some of the other agencies engaged in global health activities, yet GHI documents do not outline the relationship between DOD and the other implementing agencies nor do they explain how agencies like DOD will further the goals of GHI.[30] Also, the proposed timetable for transferring leadership from the Department of State to USAID leaves some uncertainty about who will ultimately be accountable for overseeing implementation of the GHI strategy and what USAID leadership of the initiative will mean operationally.

Congress might consider a number of options to support making a working global health strategy more clear and feasible, including measures to require annual reports or other mechanisms that

[28] *The United States Government Global Health Initiative: Strategy Document*, p. 12.

[29] See Todd Moss, *Too Big to Succeed? Why (W)Hole-of-Government Cannot Work for U.S. Development Policy*, Center for Global Development, October 5, 2010, http://blogs.cgdev.org/globaldevelopment/2010/10/too-big-to-succeed-why-whole-of-government-cannot-work-for-u-s-development-policy.php?utm_source=nl_weekly&utm_medium=email&utm_campaign=nl_weekly_10132010 and Nandini Oomman, *Secretary Clinton on the Global Health Initiative: More on the WHAT and the WHO, but Not the HOW*, Center for Global Development, Global Health Policy Blog, August 17, 2010, http://blogs.cgdev.org/globalhealth/2010/08/secretary-clinton-on-the-global-health-initiative-more-on-the-what-and-the-who-but-not-the-how.php.

[30] The Department of Defense supports a wide array of activities that improve global health, particularly following natural disasters and conflicts. The department also maintains laboratories in several countries that conduct research on tropical diseases. These facilities include the Global Emerging Infections System, the Walter Reed Army Institute of Research, Naval Medical Research Centers, and regional commands, including U.S. Africa Command. For more information on these activities, see U.S. Army Medical Research and Materiel Command, *USAMRMC Product Portfolio*, June 2007.

- explain the role of each implementing agency, including the agency lead;
- explain how integrated services will be supported given the different funding streams to distinct organizations and program areas as well as existing disease-specific reporting requirements;
- clarify funding for global health activities undertaken by agencies other than USAID, CDC, and the State Department;
- detail metrics used across agencies to monitor and evaluate progress in making annual progress in GHI targets;
- illustrate annual progress in achieving GHI targets and spending by each agency;
- delineate U.S. spending and activities in related multilateral organizations including the Global Fund and UNAIDS; and
- describe the role of the recipient government in program design, implementation and evaluation, particularly as articulated in any signed bilateral frameworks or agreements.

At the same time, field staff from implementing agencies have indicated that reporting requirements can be excessive and burdensome and may limit time spent on program implementation and quality assurance. Congress may consider reviewing reporting requirements, including mandatory annual reporting on the impact of U.S. assistance on efforts to control HIV/AIDS, TB, and malaria as well as other reports, and combining them where possible to ensure that they aid rather than detract from program effectiveness.

Congressional debate on foreign aid reform may impact U.S. health assistance and encourage the Administration to develop a more clear global health strategy. The 112th Congress has mostly limited discussions about GHI to specific global health programs, rather than questioning whether GHI is the appropriate strategy to advance U.S. global health policy. Similarly, Congress has not yet enacted legislation authorizing or otherwise directing how GHI should be carried out, if at all, as it has for most other presidential health initiatives.

Funding the Global Health Initiative

Some analysts have expressed concern over the possibility that Congress may not provide enough funds to meet the Administration's blueprint for GHI, which initially called for the United States to spend $63 billion on global health from FY2009 through FY2014. In the first four fiscal years of GHI, Congress provided $34.9 billion, an average of $8.7 billion annually, for global health programs under the initiative.[31] Should Congress decide to meet the GHI $63 billion target, annual appropriations would need to reach, on average, $14 billion in FY2013 and FY2014.

Congressional debate over funding levels for global health programs is tied to broader, longstanding discussions over the value, design, and funding levels of foreign aid programs in general. These debates are related to concern over aid effectiveness and reform of USAID, as well

[31] This includes $8.3 billion in FY2009, $8.9 billion in FY2010, $8.8 billion in FY2011, and $8.8 billion in FY2012. These amounts include spending by USAID and the Department of State through the GHP Account; CDC, NIH, and DOD spending on HIV/AIDS and malaria; and U.S. contributions to the Global Fund.

as the U.S. federal budget deficit and efforts to reduce government spending. Some Members have long-questioned the impact of U.S. global health investments, have called attention to corruption practices by various recipient governments receiving global health assistance, and have encouraged greater commitment to global health issues by these states.[32] Some Members of Congress have also argued that investing significant resources in global health represents "misplaced priorities" in a difficult fiscal environment.[33]

USAID is reportedly responding to concerns over aid effectiveness. For example, in 2011, USAID Administrator Rajiv Shah created a new suspension and debarment task force, led by Deputy Administrator Don Steinberg, to monitor, investigate and respond to suspicious activity.[34] In the same year, USAID released a new evaluation policy that supports increasing independent evaluation of ongoing projects with results being released within three months of completion.[35] In February 2012, President Obama signed an executive order establishing the President's Global Development Council, to be administered by USAID. According to the White House, the Global Development Council will inform and provide advice to the President and other U.S. officials on U.S. global development policies and practices and solicit input on current and emerging issues in the field.[36]

The debate about U.S. global health spending levels is complex and, some argue, distinct from the general debate over foreign aid levels because many U.S. global health programs offer immediate life-saving interventions. Likewise, some advocates argue that given advances in global health research and development, increased funding is critical for scaling up the use of new—and potentially very successful—tools to prevent and treat diseases, including HIV/AIDS and malaria. Finally, some global health experts contend that a decline or leveling off of global health spending could threaten U.S. efforts to develop multi-year agreements with governments that call for recipient countries to increasingly assume responsibility over the programs (see "Enhancing Country Ownership").

Maintaining HIV/AIDS Commitments

Despite the Administration's intention to bolster health system strengthening activities and increase investments in other global health areas, tackling HIV/AIDS remains a priority of the Obama Administration. On World AIDS Day in December 2011, President Obama announced that the United States was committed to supporting treatment of 6 million people by the end of 2013.[37] This announcement came soon after the summer 2011 release of new findings from an HIV prevention trial, which indicated that early initiation of HIV treatment, called anti-retroviral

[32] Shannon Kowalski, *The Human Cost of Misplaced Priorities*, Open Society Foundation, Blog, April 5, 2010, http://blog.soros.org/2010/04/the-human-cost-of-misplaced-priorities/.

[33] Letter from House Committee on Foreign Affairs, to Representative Paul Ryan and Representative Van Hollen, March 17, 2011.

[34] U.S. Congress, Senate Committee on Foreign Relations, *Statement by Dr. Rajiv Shah, USAID Administrator*, Hearing on International Development Policy Priorities in the FY 2012 Budget, 112th Cong., 1st sess., April 13, 2011.

[35] Ibid. Also see, USAID, *Evaluation Policy*, January 19, 2011, http://www.usaid.gov/evaluation/USAID_EVALUATION_POLICY.pdf?020911.

[36] The White House, "Fact Sheet: The President's Global Development Council," press release, February 9, 2012, http://www.whitehouse.gov/the-press-office/2012/02/09/fact-sheet-president-s-global-development-council.

[37] The White House, "Remarks by the President on World AIDS Day," press release, December 1, 2011, http://www.whitehouse.gov/photos-and-video/video/2011/12/01/president-obama-world-aids-day#transcript.

therapy (ART), in discordant couples[38] reduced HIV transmission by 96%, by lowering the viral loads of infected people and therefore reducing the possibility of transmission.[39] The finding has been hailed by many as a "game-changer" in the fight against global HIV/AIDS and has increased calls for U.S. support of HIV treatment around the world.[40]

Given the recent scientific advances and the Administration's new treatment target, some HIV/AIDS experts have expressed concern over declining funding for bilateral HIV/AIDS programs. Advocates argue that cuts to U.S. programs could squander the promise of newly available prevention and treatment tools and could directly or indirectly contribute to additional HIV/AIDS-related deaths. [41]

Most developing countries are heavily reliant on donors to fund their national HIV/AIDS plans. UNAIDS estimates that 90% of HIV/AIDS spending in low-income countries is financed by external donors.[42] The United States government provides more funding for global HIV/AIDS assistance than any other country. One report estimates, for example, that U.S. spending on global HIV/AIDS programs amounted to 54.2% of all government donor spending in 2010.[43] Some groups, particularly the Global Fund, have come to depend upon U.S. government contributions both to finance their programs and to attract additional funding. In November 2011, the Global Fund announced that it would be canceling the 11th round of funding due to inadequate financial resources. The announcement has led advocates to express concern over sustaining progress made in the fight against global HIV/AIDS and has highlighted the importance of the United States' role as a donor.

Some analysts are especially concerned about U.S. capacity to maintain life-long HIV/AIDS treatment programs.[44] This issue is particularly sensitive since taking people off of medicine would inevitably have fatal consequences. Critics question whether the United States should seek to augment the number of patients receiving treatment in view of the fact that HIV-positive people need to be treated for a lifetime and the U.S. HIV/AIDS budget is not expected to increase. Likewise, while many of the costs associated with HIV treatment have declined over

[38] An HIV-serodiscordant couple is one in which one partner is HIV-positive and the other HIV-negative.

[39] National Institutes of Health, National Institute of Allergy and Infectious Diseases, "Treating HIV-infected people with antiretrovirals protects partners from infection: Findings result from NIH-funded international study," press release, May 12, 2011, http://www.niaid.nih.gov/news/newsreleases/2011/Pages/HPTN052.aspx.

[40] "HIV Treatment as Prevention: Breakthrough of the Year, 2011," *Science Magazine*, Special Issues 2011, http://www.sciencemag.org/site/special/btoy2011/.

[41] See, for example, amfAR, the Foundation for AIDS Research, Averting Deaths, Lowering Costs and Beginning to End the HIV/AIDS Epidemic: The Investment Case for Maintaining PEPFAR Funding in FY13, April 2012, http://www.amfar.org/uploadedFiles/_amfar.org/In_The_Community/Publications/Pepfar-Investment-April-2012.pdf and Gabe Joselow, "MSF Alarmed Over Plans to Cut US AIDS Program," Voice of America, April 10, 2012.

[42] Michel Sidibé, Executive Director of UNAIDS, "Partners in Treatment," Remarks at United Nations Industrial Development Organization (UNIDO) Industrial Development Board (IDB) 38th Session, November 24, 2010, http://www.unaids.org/en/media/unaids/contentassets/documents/speech/2010/20101124_SP_Sidibe_ViennaTreatment_en.pdf.

[43] Jennifer Kates et al., *Financing the Response to AIDS in Low-and Middle-Income Countries: International Assistance from Donor Governments in 2010*, Kaiser Family Foundation, August 2011, http://www.kff.org/hivaids/upload/7347-07.pdf.

[44] Mead Over, *Prevention Failure: The Ballooning Entitlement Burden of U.S. Global AIDS Treatment Spending and What to Do About It*, Working Paper 144, April 2008, http://www.cgdev.org/files/15973_file_Presidential_AIDS_Policy_FINAL.pdf; and Neil Patel, *Emergency to Efficiency*, Harvard Political Review Online, December 5, 2010, http://hpronline.org/americas-foreign-policy/emergency-to-efficiency/#.

time,[45] a growing proportion of patients may require more expensive second- and third-line treatments following the failure of first-line treatments.[46] Finally, the recent findings about ART's preventative benefits raise new questions related to the appropriate distribution of limited—or decreasing—funding for global HIV/AIDS, including how funds should be divided between ART as treatment, ART as prevention, and other non-treatment-based forms of prevention. Congress might consider the following questions:

- Given decreasing funding for bilateral HIV/AIDS programs, how will the United States meet its goals related to HIV treatment?
- If HIV/AIDS spending decreases, will U.S. support for other HIV interventions like care and prevention be diverted for treatment?
- How long should U.S. investments in HIV/AIDS be expected, and when might the recipient governments assume ownership over PEFPAR programs since PEPFAR budgets typically exceed the entire health budgets of recipient countries?
- How might other U.S. global health priorities be affected by the long-term costs of AIDS treatment?

Investing in New Areas

The majority of U.S. global health funding is provided for HIV/AIDS activities. In FY2012, for example, roughly 57% of U.S. global health spending through the Global Health Programs (GHP) account was for bilateral HIV/AIDS efforts. Including contributions to the Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund), global HIV/AIDS spending accounted for more than 72% of GHP funding in FY2012. A significant proportion of congressional hearings and legislation aimed at improving global health have also focused on HIV/AIDS and how other issues are affected by the disease.

In the past few years, however, Members of Congress and the Administration have supported increased funding for health areas other than HIV/AIDS, with some arguing that extending funding to programs tackling other health challenges can better maximize the health impact of U.S. assistance. Despite this support, given the U.S. commitment to individuals already receiving life-saving medicine under PEPFAR programs, some experts argue that reducing or leveling off global health funding might limit the United States' ability to invest in more recently identified global health priority areas.

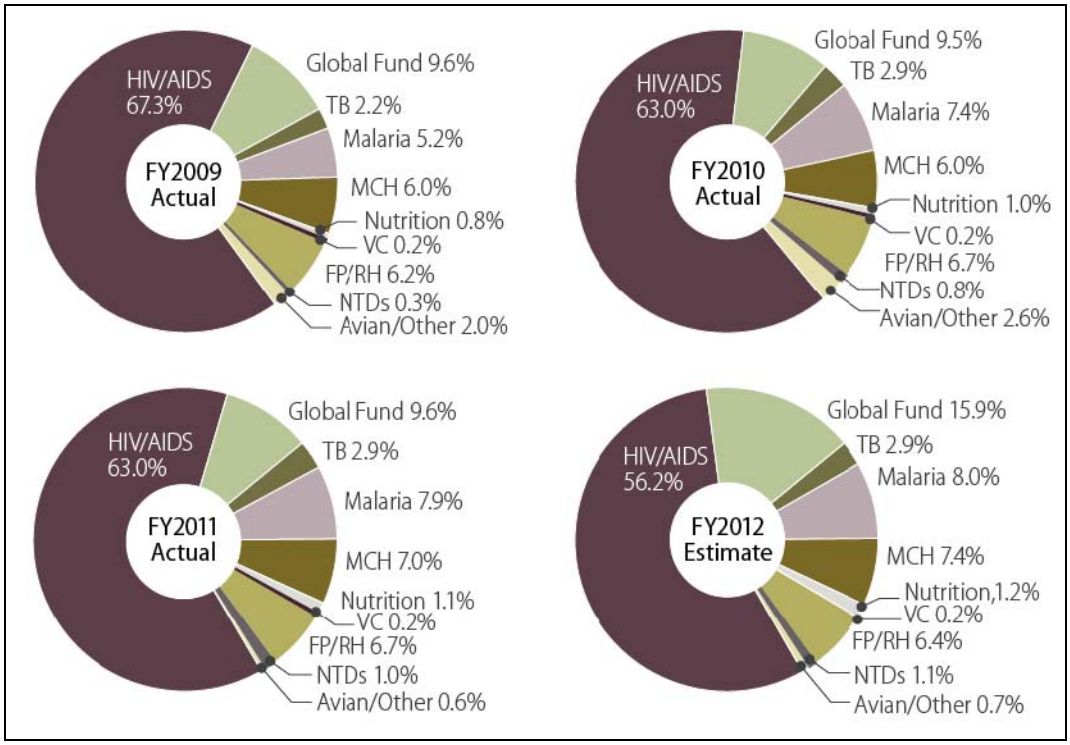
From FY2009 to FY2012, for example, spending by USAID on malaria, maternal and child health, and neglected tropical diseases saw significant increases (**Figure 4**). While spending in these areas rose, the change in share of resources spent on these health challenges has been less pronounced, due to increases in spending on other health challenges through the GHP account.

[45] Office of the Global AIDS Coordinator, State Department, *Report on Costs of Treatment in the President's Emergency Plan for AIDS Relief*, February 2012, http://www.pepfar.gov/documents/organization/188493.pdf.

[46] After some time, HIV may become resistant to the initial drug regimen. After that, doctors prescribe stronger medicine, known as second-line treatment, which is usually more expensive.

Figure 4. GHP Global Health Spending, by Program Area, FY2009-FY2012

(in millions of current dollars and percentages)



Source: Created by CRS from http://www.foreignassistance.gov and appropriations legislation.

Notes: Includes supplemental appropriations.

Abbreviations: Maternal and Child Health (MCH), Vulnerable Children (VC), Tuberculosis (TB), Family Planning and Reproductive Health (FP/RH), Neglected Tropical Diseases (NTDs), and Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund).

While debating FY2013 global health funding, Congress may face difficult questions related to allocation of finite resources and trade-offs between longstanding health programs, such as PEPFAR, and more recently identified global health priorities, such as those outlined above.

Enhancing Country Ownership

Several actions by the Obama Administration indicate an enhanced emphasis on country ownership of global health programs. Country ownership refers to strengthening the capacity of countries—including governments and civil society—to develop and manage their own health programs, particularly in the areas of developing health plans, forecasting monetary and infrastructural needs, ensuring that financing mechanisms can sufficiently manage and monitor fiduciary transactions, refining regulatory and procurement processes, and developing executive skills like writing grant proposals and making presentations.[47] Advocates of country ownership assert that it makes assistance more effective and allows for an easier transition of program responsibility from foreign donors to recipient country governments and other stakeholders. The

[47] Personal communication with USAID, February 16, 2011.

level of ownership that can be achieved varies widely, as countries have different degrees of capacity and health needs.

Country ownership has been highlighted as a key goal of GHI and USAID Administrator Shah has made public statements endorsing the concept.[48] OGAC advocates using "Partnership Frameworks" in PEPFAR programs to support country capacity and leadership.[49] Partnership Frameworks describe the expected role of both the U.S. and recipient governments and outline how increased country ownership will be attained. In Nigeria, for example, the government commits to funding half of the national HIV/AIDS program by the end of the framework's five-year implementation.[50]

The State Department's Quadrennial Diplomacy and Development Review identifies a number of steps that the United States expects to take to enhance country ownership, including

- providing 20% of U.S. funds to partner country governments, local organizations, and local businesses;
- more than doubling direct grants to local nonprofit organizations so that they account for 6% of program funds;
- partnering with at least 1,000 local organizations, more than double the current number;
- granting local private businesses at least 4% of U.S. foreign assistance;
- supporting local supply chains; and
- transitioning the leadership of HIV/AIDS treatment programs from external organizations to national governments and indigenous organizations.[51]

Despite the fact that the Obama Administration has emphasized that increased country ownership does not necessarily mean reduced U.S. investments, some observers have expressed concern over the possible consequences of long-term decreases in U.S. global health spending, as recipient countries are expected to play a progressively predominant role. For example, if recipient countries are unable or unwilling to fill funding gaps due to declining U.S. support for global health programs, some argue that HIV infection and mortality rates could climb. Furthermore, some health experts are concerned that if HIV/AIDS infection and mortality rates begin to rise, other bilateral health efforts might become less effective as vulnerable populations succumb more quickly to diseases like malaria or TB;[52] and advancements in other sectors, like agriculture, could be threatened as people become too weak to engage in income-generating activities. In addition, countries might employ a variety of strategies to cope with stagnant or

[48] John Donnelly, *Shah: 'We Want Real Outcomes Health,'*Aspen Global Health and Development, September 15, 2010, http://www.ministerial-leadership.org/blog/shah-we-want-real-outcomes-health.

[49] See the PEPFAR website on Partnership Frameworks at http://www.pepfar.gov/frameworks/.

[50] Ambassador Eric Goosby advocated the application of the Partnership Framework in his statement for U.S. Congress, House Committee on Foreign Affairs, *PEPFAR: From Emergency to Sustainability and Advances Against HIV/AIDS*, 111th Cong., September 29, 2010, http://internationalrelations.house.gov/111/goo092910.pdf.

[51] U.S. Department of State and USAID, *Leading Through Civilian Power: The First Quadrennial Diplomacy and Development Review*, p. 99.

[52] Roll Back Malaria, for example, estimates that it will cost $5 billion annually between 2011 and 2020 to sustain the gains made in tackling malaria worldwide. See Roll Back Malaria, "World Malaria Day 2010," press release, April 25, 2010, http://www.rbm.who.int/worldmalariaday/keyfigures.html.

decreased global health spending levels, such as reducing spending on other health problems, particularly those that disproportionately affect vulnerable groups, like neglected tropical diseases. Observes have also questioned the ability of many resource-poor countries to assume increased logistical, or technical control over global health programs. Finally, some have also expressed concern that the United States will be unable to hold countries sufficiently accountable while shifting control to host governments and other local actors.

Balancing Bilateral and Multilateral Assistance

The United States is a leading contributor to several multilateral health organizations, including the Global Fund, UNAIDS, the World Health Organization (WHO), the International AIDS Vaccine Initiative (IAVI), and the GAVI Alliance, among others. Despite this support, the vast majority of U.S. global health assistance is channeled through bilateral programs. Over the last decade, Congress has frequently debated the appropriate balance between bilateral and multilateral assistance.

The Obama Administration has indicated its intention to strengthen support for multilateral partners through sustained financial contributions, increased technical assistance to multilateral projects in the field, and improved coordination of health activities, as appropriate. The Administration has taken several actions that indicate heightened support for global health activities supported by multilateral organizations, including the following:

- **Multi-year pledge to the Global Fund:** The United States has historically set its annual pledge levels for the Global Fund through annual appropriations. At an October 2010 donor's conference, the United States made its first multi-year pledge to the Global Fund: a three-year, $4 billion commitment.
- **FY2013 Budget Request:** While the FY2013 budget request includes an overall decreased amount of funding for global health programs, it includes funding increases for the Global Fund (+27%) and GAVI Alliance[53] (+11.5%) from FY2012 levels.
- **Restored funding for the United Nations Population Fund (UNFPA):** Over the past three decades, Congresses have debated whether the United States should support UNFPA. Deliberations centered on whether UNFPA funds were diverted to support China's coercive family planning programs and policies. Since taking office, President Obama has requested continued funding for UNFPA in FY2013, including an 11.4% increase over the FY2012 funding level.

Identifying the appropriate degree of support for multilateral organizations has been a key issue in past Congresses, and some analysts expect it to remain an important point of debate during the 112th Congress. Proponents of strong bilateral funding argue that direct U.S. global health spending carries a number of advantages, including the ability to

- strategically direct where and how aid is used;
- more easily monitor and evaluate use of aid and program impact; and

[53] The GAVI alliance is a public-private partnership focused on increasing access to immunization for children around the world.

- more rapidly adjust how funds are spent.

On the other hand, supporters of higher multilateral spending argue U.S. participation in multilateral responses to global health offers distinct advantages, including the ability to

- pool and leverage limited resources in the face of global challenges such as global health;
- capitalize on efficiencies in global health programming;
- coordinate assistance with a range of donors; and
- provide aid that better aligns with the priorities of the recipient countries.

Some observers would like the debate about bilateral and multilateral funding to include a discussion of how the United States and other donors finance health aid, and how increased U.S. engagement with multilateral donors might facilitate more effective programs. In particular, a growing number of analysts are urging bilateral and multilateral donors to better align their programs. According to a report by WHO, 20% to 40% of health spending is wasted through inefficiency.[54] The report identified several areas in which donors could eliminate waste—namely through aligning financial, reporting, and monitoring practices—and asserted that recipient governments could have more staff and time to extend health coverage if donors harmonized the auditing, monitoring, and evaluation of their programs.

While U.S. agencies are increasingly cooperating and coordinating with multilateral partners, the 112th Congress might consider calling on the Obama Administration to bolster its support for better aligning U.S. global health aid with support provided by multilateral donors, particularly in the areas of pooled procurement, supply chain networks, and reporting practices. In addition, Congress might consider U.S. ratification of the *International Health Partnership Compact*, an international agreement that calls for the international community to work together to improve the efficiency of health aid. The compact specifically calls on

- **international organizations and bilateral donors** to use national health plans as the basis for funding and planning health aid, ensure efforts to address particular diseases are funded and implemented as part of a broader effort to improve health systems, and be accountable for health aid by annually evaluating, monitoring, and reporting on results;
- **governments** to use national health plans to guide development of health systems, work with all stakeholders (including civil society and international organizations) and ensure that budgets reflect common vision for the health sector, tackle misappropriation of funds, strengthen health and financial management systems, and be accountable to the citizenry and funders through reports on results; and
- **other donors** to use their resources to advance coordinated multilateral approaches to strengthening health systems, continue to invest in learning and evaluation mechanisms to identify best practices, and be accountable and hold

[54] World Health Organization (WHO), *Health Systems Financing: The Path to Universal Coverage*, World Health Report, 2010, p. vi, http://whqlibdoc.who.int/whr/2010/9789241564021_eng.pdf.

organizations receiving support accountable for measuring impact and directing funding to proven successes.

As of early 2012, 52 countries, multilateral organizations and other donors have signed the International Health Partnership Compact. While the Bush[55] and Obama[56] Administrations have indicated support for the agreement, the United States has not yet ratified it.

Global Health Spending by Other Stakeholders

According to the Organization for Economic Cooperation and Development (OECD), the United States provides more official development assistance (ODA) for health than any other country in the Development Assistance Committee (DAC). In 2010, the United States expended roughly $7.4 billion in ODA for health sector activities, which accounted for more than half (59.9%) of all health sector assistance provided by DAC members (**Figure 5**).[57] At the same time, when measured as a portion of GDP, the United States gives less health aid than several European donors. Global financial constraints have put pressure on development assistance worldwide, and, as a result, global health funding from a number of donors has begun to level off.

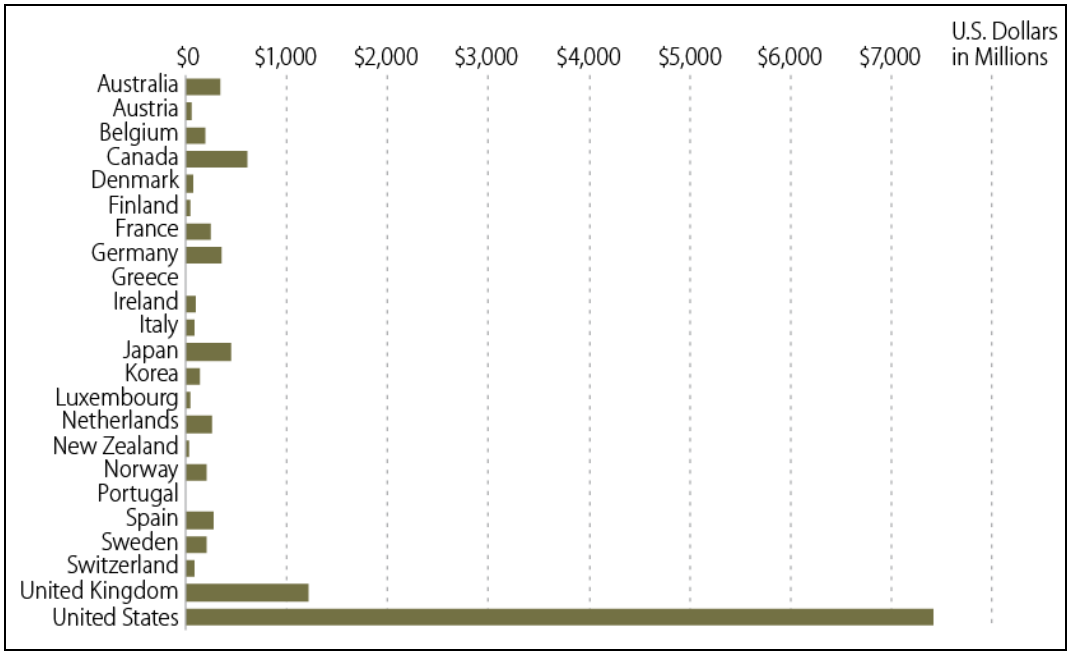
[55] See Joint letter from USAID and the Office of the Global AIDS Coordinator to the Right Honorable Douglas Alexander, Secretary of State for Britain Department for International Development (DFID), September 23, 2008, http://www.internationalhealthpartnership.net/pdf/USAID_IHP.pdf.

[56] The Obama Administration acknowledged the agreement in its first report on the Global Health Initiative. See USAID, *The United States Government Global Health Initiative Strategy*, March 1, 2011, p. 8, http://www.usaid.gov/ghi/documents/GHI_Strategy.pdf.

[57] OECD online database at http://stats.oecd.org/Index.aspx?DatasetCode=ODA_SECTOR.

Figure 5. Official Development Assistance for Health, 2010

(in millions of current dollars)



Source: Compiled by CRS from OECD online database at http://stats.oecd.org/Index.aspx?DatasetCode=ODA_SECTOR.

Notes: The OECD considers ODA for health to include assistance to hospitals and clinics, including specialized institutions such as those for tuberculosis and maternal and child care; other medical and dental services, including disease and epidemic control, vaccination programs, nursing, provision of drugs, and health demonstration; public health administration and medical insurance programs; and reproductive health and family planning.

Despite decreases in funding from donor governments, the global health funding system is becoming increasingly complicated as a variety of new actors become involved. The private sector and private foundations are playing a growing role in addressing global health. In 2009, for example, spending on global health by the Bill & Melinda Gates Foundation was higher than all DAC countries except the United States. Specifically, OECD reported that in 2009, the Gates Foundation spent $1.8 billion on global health, some $800 million more than Britain.[58] Likewise, in 2011, after the Global Fund's decision to cancel its 11th funding round, the Gates Foundation announced it would contribute $750 million to the Fund. An ever-growing array of disease-specific partnerships, like the Stop Malaria Partnership, are also emerging, many of which rely on complex funding and implementation structures that include national, multilateral, private, nongovernmental, and academic partners.

GHI Strategy documents released by the Obama Administration and legislation introduced by the 112th Congress appear to welcome broader engagement in global health, particularly public-private partnerships. There is some debate, however, among global health analysts about how the burgeoning number of players might impact global health effectiveness in general and U.S.

[58] OECD online database at http://stats.oecd.org/Index.aspx?DatasetCode=ODA_SECTOR.

influence in this realm in particular.[59] The growth of actors in the global health sector raises several questions:

- How will U.S. influence be affected by the increasing number of global health actors?
- What role should non-state actors play in shaping global health policies?
- Will there ultimately be more convergence or more divergence in the implementation of global health activities?
- Will private donors adhere to international standards and norms?

Conclusion

Global health has been a central issue in congressional debates over foreign assistance programs and funding levels. Some expect that global health reform will be an area of ongoing congressional concern, both as a way to potentially reduce spending and to improve the effectiveness of aid. The Global Health Initiative suggests a new direction for global health programming, but it remains to be seen whether Congress will support the Administration's requests for funds to achieve the goals laid out in GHI. In determining funding levels for global health programs, Congress may consider the extent to which the United States should invest in new global health areas, ways that the United States can encourage country ownership of global health programs, the appropriate balance of funding between bilateral and multilateral programs, and the role that the United States should play in global health, particularly in relation to other donors.

Along with debating issues related to U.S. global health assistance, Congress may also wish to consider its own role in determining how U.S. global health programs are implemented. Congress has exercised growing involvement in shaping global health programs through funding distribution guidelines, spending directives and limitations, and priority-area recommendations. Global health analysts have debated whether Congress's elevated role has helped or hindered the efficacy of global health programs. For example, some argue that congressional spending directives have limited the ability of country teams to tailor programs to in-country needs. Others argue that congressional mandates and recommendations serve to protect critical areas in need of support and can facilitate the implementation of a cohesive global health strategy across agencies. Possible passage of legislation by the 112th Congress related to GHI may require Congress to reflect on how it can best support an effective and efficient response to global health needs.

[59] See for example, Nicole A. Szlezák et al., "The Global Health System: Actors, Norms, and Expectations in Transition," *PLoS Medicine*, vol. 7, no. 1 (January 5, 2010), p. e1000183; Robert Black et al., "Accelerating the Health Impact of the Gates Foundation," *The Lancet*, vol. 373, no. 9675 (May 9, 2009), pp. 1584-1585; Kirstin Matthews and Vivian Ho, "The Grand Impact of the Gates Foundation," *European Molecular Biology Organization*, vol. 9, no. 5 (2008), pp. 409-412; David Stuckler, Sanjay Basu, and Martin McKee, "Global Health Philanthropy and Institutional Relationships: How Should Conflicts of Interest Be Addressed?," *PLoS Medicine*, vol. 8, no. 4 (April 12, 2011), p. e1001020.

Appendix. U.S. Global Health Spending by Agency

Table A-1. Spending Counted under the Global Health Initiative, FY2009-2013

(in millions of current dollars)

Agency/Program	FY2009 Actual	FY2010 Actual	FY2011 Actual	FY2012 Estimate	FY2013 Request
USAID					
MCH	440.1	474.0	548.9	605.6	578.0
Nutrition	54.9	75.0	89.8	95.0	90.0
VC	15.0	15.0	15.0	17.5	13.0
HIV/AIDS	350.0	350.0	349.3	350.0	330.0
Tuberculosis	162.5	225.0	224.6	236.0	224.0
Malaria	382.5	585.0	618.8	650.0	619.0
NTDs	25.0	65.0	76.8	89.0	67.0
Avian Influenza/Other	145.0	201.0	47.9	58.0	53.0
FP/RH	455.0	528.6	527.0	523.9	530.0
Global Fund	100.0	0.0	0.0	0.0	0.0
USAID Total	***2,130.0***	***2,518.6***	***2,498.0***	***2,625.0***	***2,504.0***
State Department					
HIV/AIDS	4,559.0	4,609.0	4,585.8	4,242.9	3,700.0
Global Fund	600.0	750.0	748.5	1,300.0	1,650.0
State Total	***5,159.0***	***5,359.0***	***5,334.3***	***5,542.9***	***5,350.0***
OTHER GHI					
CDC HIV/AIDS	118.9	119.0	118.7	117.1	117.2
CDC Malaria	9.4	9.4	9.2	9.2	9.4
NIH HIV/AIDS	451.7	485.6	375.7	364.5	388.9
NIH Malaria	121.0	112.0	145.0	147.0	147.0
HHS Global Fund	300.0	300.0	297.3	0.0	0.0
DOD HIV/AIDS	8.0	10.0	10.0	8.0	0.0
DOD Malaria	30.6	26.4	27.4	0.0	0.0
OTHER Total[a]	***1,039.6***	***1,062.4***	***983.3***	***645.8***	***662.5***
GHI TOTAL	**8,328.6**	**8,940.0**	**8.815.6**	**8,813.7**	**8,516.5**

Source: Appropriations legislations, congressional budget justifications, and personal communication with the Office of Management and Budget (OMB).

Abbreviations: Maternal and Child Health (MCH), Vulnerable Children (VC), Family Planning and Reproductive Health (FP/RH), and Neglected Tropical Diseases (NTDs).

a. This includes funds targeting avian and pandemic influenza and other public health threats, as well funds received in supplemental appropriations.

Table A-2. State-Foreign Ops Global Health Spending, GHP Account, FY2001-2013

(in millions of current dollars)

Agency/Program	FY2001 Actual	FY2002 Actual	FY2003 Actual	FY2004 Actual	FY2005 Actual	FY2006 Actual	FY2007 Actual
MCH	295.3	315.0	411.9	328.1	347.5	369.6	392.6
Nutrition	n/a	n/a	n/a	n/a	n/a	n/a	n/a
VC	14.9	25.0	26.8	27.8	24.5	12.6	6.5
HIV/AIDS	305.0	395.0	587.7	513.5	347.2	346.5	325.0
TB	50.0	60.0	64.2	74.7	79.4	81.8	80.8
Malaria	55.0	65.0	64,6	79.6	79.4	98.9	248.0
NTDs	n/a	n/a	n/a	n/a	n/a	14.8	14.9
Pandemic Influenza/Other	18.7	35.0	25.8	29.6	39.8	139.2	189.6
FP/RH	376.2	402.5	391.0	398.1	396.8	393.5	396.5
USAID Global Fund	100.0	50.0	248.4	397.6	248.0	247.5	247.5
USAID Total	***1,215.1***	***1,347.5***	***1,820.4***	***1,849.0***	**1,562.6**	***1,704.4***	***1,901.4***
State HIV/AIDS	n/a	n/a	n/a	488.1	1,373.9	1,777.1	2,869.0
State Global Fund	n/a	n/a	n/a	n/a	n/a	198.0	377.5
State Total	***0.0***	***0.0***	***0.0***	***488.1***	**1,373.9**	***1,975.1***	***3,246.5***
GHP Total	**1,215.1**	**1,347.5**	**1,820.4**	**2,337.1**	**2,936.5**	**3,679.5**	**5,147.9**

Agency/Program	FY2008 Actual	FY2009 Actual	FY2010 Actual	FY2011 Actual	FY2012 Estimate	FY2013 Request
MCH	449.0	440.1	474.0	548.9	605.6	578.0
Nutrition	n/a	54.9	75.0	89.8	95.0	90.0
VC	14.9	15.0	15.0	15.0	17.5	13.0
HIV/AIDS	347.2	350.0	350.0	349.3	350.0	330.0
TB	148.0	162.5	225.0	224.6	236.0	224.0
Malaria	347.2	382.5	585.0	618.8	650.0	619.0
NTDs	14.9	25.0	65.0	76.8	89.0	67.0
Pandemic Influenza/Other	115.0	145.0	201.0	47.9	58.0	53.0
FP/RH	398.0	455.0	528.6	527.0	523.9	530.0
USAID Global Fund	0.0	100.0	0.0	0.0	0.0	0.0
USAID Total	***1,834.2***	***2,130.0***	***2,518.6***	***2,498.0***	***2,625.0***	***2,504.0***
State HIV/AIDS	4,116.4	4,559.0	4,609.0	4,585.8	4,242.9	3,700.0
State Global Fund	545.5	600.0	750.0	748.5	1,300.0	1,650.0
State Total	***4,661.9***	***5,159.0***	***5,359.0***	***5,334.3***	***5,542.9***	***5,350.0***
GHP TOTAL	**6,496.1**	**7,289.0**	**7,877.6**	**7,832.3**	**8,167.9**	**7,854.0**

Source: Appropriations legislation, congressional budget justifications, and personal communication with OMB.

Notes: Totals in FY2001-2003 include funds appropriated to multiple accounts in an effort to allow accurate comparisons with later years. This table does not include funding for Education programs or the U.S. contribution to the UN Children's Fund (UNICEF), which were appropriated to the Child Survival and Health account prior to FY2004. It does include funding for Family Planning and Reproductive Health programs, which were previously appropriated to the Development Assistance account. Until FY2010, nutrition funding was included as part of maternal and child health funding.

Table A-3. Labor, HHS Global Health Spending: FY2001-2013

(in millions of current dollars)

HHS Program	FY2001 Actual	FY2002 Actual	FY2003 Actual	FY2004 Actual	FY2005 Actual	FY2006 Actual	FY2007 Actual
HIV/AIDS	104.5	168.7	182.6	266.9	123.8	122.6	121.0
Immunizations	106.6	133.8	148.8	137.8	144.4	144.3	142.4
Polio	*91.2*	*107.4*	*106.4*	*96.8*	*101.2*	*101.1*	*99.8*
Other Global/Measles	*15.4*	*26.4*	*42.4*	*41.0*	*43.2*	*43.2*	*42.6*
Malaria	9.6	9.6	9.2	9.2	9.1	9.0	8.9
Global Disease Detection	0.0	0.0	0.0	11.6	21.4	32.4	32.0
Other Global Health	0.0	0.0	0.0	2.4	3.4	3.4	3.3
CDC Total	**220.7**	**312.1**	**340.6**	**427.8**	**302.0**	**311.7**	**307.6**
NIH Global AIDS Research	160.1	218.2	278.5	317.2	369.5	373.0	361.7
NIH Global Malaria Research	62.0	74.0	72.0	88.6	103.8	98.0	111.8
HHS Global Fund	0.0	125.0	99.0	149.0	99.2	99.0	99.0
DOL	10.0	10.0	9.9	9.9	2.0	0.0	0.0
Labor, HHS, Education Total	**452.8**	**739.3**	**800.0**	**992.5**	**876.5**	**881.7**	**880.1**

HHS Program	FY2008 Actual	FY2009 Actual	FY2010 Actual	FY2011 Actual	FY2012 Estimate	FY2013 Request
Global AIDS Program (GAP)	118.9	118.9	119.0	118.7	117.1	117.2
Immunizations	139.8	143.3	153.7	150.8	160.3	175.4
Polio	*98.0*	*101.5*	*101.8*	*101.6*	*111.3*	*126.4*
Other Global/Measles	*41.8*	*41.8*	*51.9*	*49.3*	*49.0*	*49.1*
Malaria	8.7	9.4	9.4	9.2	9.2	9.4
Global Disease Detection	31.4	33.7	44.2	41.9	41.6	41.7
Other Global Health	3.5	3.5	20.4	19.5	19.4	19.3
CDC Total	**302.3**	**308.8**	**346.7**	**340.1**	**347.6**	**363.0**
NIH Global AIDS Research	411.7	451.7	485.6	375.7	364.7	388.9
NIH Global Malaria Research	132.5	121.0	112.0	145.0	147.0	147.0
HHS Global Fund	294.8	300.0	300.0	297.3	0.0	0.0
DOL	0.0	0.0	0.0	0.0	0.0	0.0
Labor, HHS, Education Total	**1141.3**	**1181.5**	**1244.3**	**1158.1**	**859.3**	**898.9**

Source: Appropriations legislation, congressional budget justifications, and personal communication with OMB.

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