



U.S. Global Health Assistance: Background and Issues for the 113th Congress

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June 21, 2013

Congressional Research Service

7-5700

www.crs.gov

R43115

Summary

Congressional support for global health programs has been increasing, particularly during the George W. Bush Administration. Combined global health funding from State-Foreign Operations, Labor-HHS and Defense appropriations rose from \$1.7 billion in FY2001 to \$8.9 billion in FY2012. The FY2013 Consolidated Appropriations Act (P.L. 113-6) includes approximately \$8.4 billion for global health programs funded through State-Foreign Operations appropriations, up from \$8.2 billion in FY2012. (FY2013 funding levels will likely change, however, due to sequestration.) These funds support global health programs implemented and managed by the U.S. Agency for International Development (USAID), State Department and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund)—a multilateral organization aimed at fighting HIV/AIDS, TB, and malaria worldwide. The act does not specify how much should be spent on global health programs through other appropriations.

Concern about infectious diseases, especially HIV/AIDS, has driven much of the budgetary increases. Excluding funding for the Global Fund, roughly 34% of the FY2001 U.S. global health budget was aimed at programs that address HIV/AIDS. By 2012, about 57% of U.S. global health spending was aimed at fighting HIV/AIDS worldwide, and the FY2014 budget request calls for nearly 54% of global health spending to be aimed at the disease.

In the 112th Congress, concerns about the strength of the U.S. economy and federal spending precipitated discussions about the role and efficacy of U.S. foreign aid, including global health programs. Critics began to push for U.S. global health programs to demonstrate impact and improve cost-efficiency. At the same time, supporters underscored the advances U.S. global health programs had made, the millions of lives saved in part with U.S. resources, and the promise of innovative health solutions. It is likely that this debate will continue in the 113th Congress. Other issues the 113th Congress may face include

- deliberating funding levels for U.S. global health programs;
- examining U.S. leadership of U.S. global health programs;
- maintaining global HIV/AIDS commitments;
- deliberating the reauthorization of the President's Emergency Plan for AIDS Relief (PEPFAR) in FY2013; and
- determining the appropriate mix of multilateral and bilateral spending for global HIV/AIDS, TB, and malaria programs.

These issues are summarized below.

Global Health Funding. Until FY2011, funding for global health had continuously increased. Since then, funding has fluctuated. In FY2011, funding fell slightly and then grew by 0.4% in FY2012. Sequestration requirements are prompting roughly 5% in budget cuts for global health funding in FY2013. In that fiscal year, Congress appropriated nearly \$8.5 billion for global health activities funded through State-Foreign Operations, some 8% more than the Administration requested. The FY2014 congressional budget justifications for Labor-HHS and Defense did not specify funding levels for their global health programs. Global health funding will likely be an important issue for the 113th Congress as it considers the FY2014 budget.

GHI Leadership. President Barack Obama created the Global Health Initiative (GHI) to improve the coordination and implementation of U.S. global health programs with the goal of deepening the impact of U.S. global health investments. In the *Quadrennial Diplomacy and Development Review*, the State Department announced plans to transfer the Office of the Global Health Coordinator from the Department of State to USAID if key milestones were met. In July 2012, the Administration announced that the GHI Office would close, but that the leadership structure for the initiative would be maintained with USAID, the Centers for Disease Control and Prevention (CDC), and the Office of the Global AIDS Coordinator (OGAC) at the State Department collaboratively planning related efforts. At the same time the GHI leadership announced the closing of the GHI Office, the State Department announced the establishment of the Office of Global Health Diplomacy. Some global health observers questioned the rationale for announcing these changes simultaneously.

Maintaining HIV/AIDS Commitments. The Lantos-Hyde Act of 2008 called for the Administration to develop “Partnership Frameworks” with countries that would outline gradual increases in country ownership of PEPFAR programs. As of May 7, 2013, 22 Partnership Frameworks have been signed. Some HIV/AIDS advocates are concerned that these agreements are being prematurely implemented and that countries will not be able to adequately maintain related activities, particularly in the areas of HIV/AIDS treatment. Interruptions in treatment can lead to drug resistance and death. Supporters, however, view these agreements as an important step toward encouraging country ownership and assert that spending reductions are occurring only in countries with a demonstrated capacity to replace the U.S. funds.

PEPFAR Reauthorization. The Lantos-Hyde Act (P.L. 110-293) authorizes appropriations to fight global HIV/AIDS, tuberculosis (TB), and malaria through the Office of the Global AIDS Coordinator (OGAC) and the President’s Malaria Initiative (PMI). This act expires at the end of FY2013. If Congress does not reauthorize the legislation, related programs could continue to be funded through annual appropriations, though some language demonstrating congressional intent would expire.

Multilateral and Bilateral Funding. Since the creation of the Global Fund, some debates about U.S. funding for global HIV/AIDS have pitted the Global Fund against PEPFAR. This framing is somewhat inaccurate because U.S. contributions to the Global Fund are part of the PEPFAR budget. Additionally, the Global Fund supports projects aimed at three diseases: HIV/AIDS, TB, and malaria. At the same time, the United States is a key partner of the Global Fund and provides support in a number of areas, including financing, board membership, and collaborative planning. Discussions comparing spending on bilateral HIV/AIDS programs and the Global Fund intensified following an announcement by the Obama Administration that it would seek \$4 billion for the Global Fund from FY2011 through FY2013. In FY2010, the Global Fund accounted for 14% of U.S. spending on global HIV/AIDS, TB, and malaria programs. In FY2012, 18% of U.S. funding for the three diseases was directed to the Global Fund. The President requests that in FY2014, 22% of U.S. spending on the three diseases be channeled through the Global Fund.

Although much of the discussions regarding the appropriate mix of multilateral and bilateral funding focus on HIV/AIDS spending, the issue has broader implications for global health programs. According to the World Health Organization (WHO), insufficient alignment of bilateral and multilateral programs is wasteful and inefficient.

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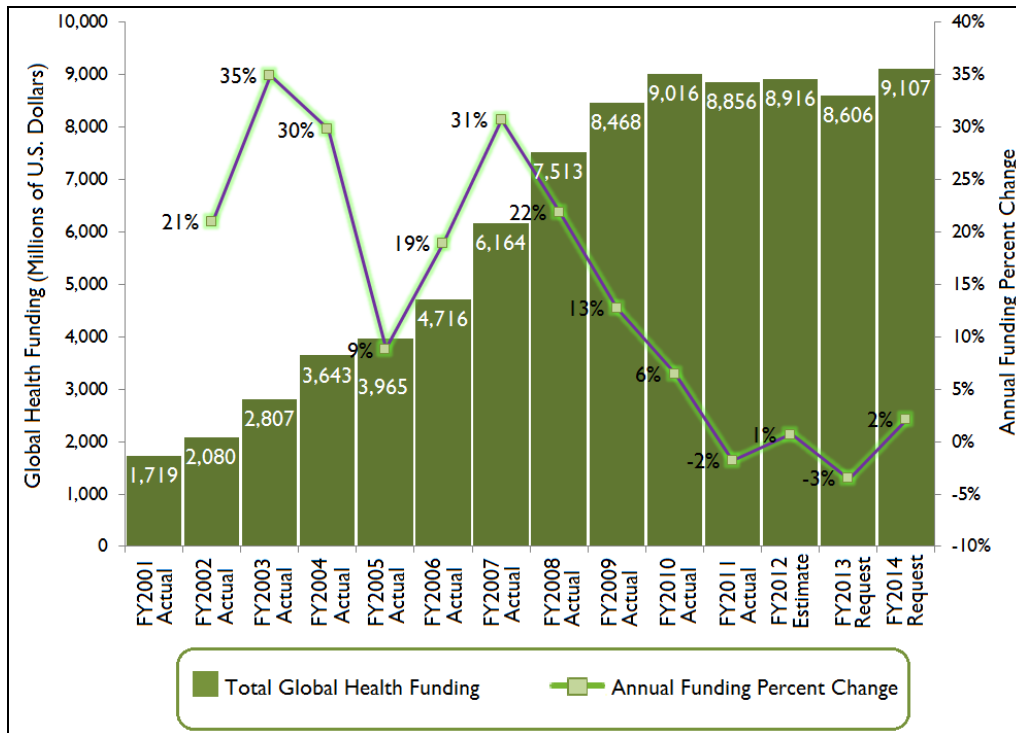
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Introduction

Congress has demonstrated interest in global health and has generally appropriated funds for global health in excess of presidential requests, particularly since FY2000. U.S. government funding for global health has grown from \$1.7 billion in FY2001 to \$8.9 billion in FY2012 (Figure 1). The Administration proposes spending more than \$9 billion on global health programs in FY2014.

Figure 1. U.S. Global Health Funding: FY2001-FY2014 Request

(current U.S. millions of dollars)



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

Note: Includes global health funding through three appropriations vehicles: State-Foreign Operations; Labor, HHS, and Education (Labor-HHS); and Defense. HIV/AIDS amounts include U.S. contributions to the Global Fund to Fight AIDS, Tuberculosis and Malaria.

U.S. support for global health has been motivated in large part by concern about emergent and reemerging infectious diseases. Following outbreaks of diseases like severe acute respiratory syndrome (SARS), HIV/AIDS, and pandemic influenza, several presidents have highlighted the threats they pose to economic development, stability, and security and launched a series of health initiatives to address them. In 1996, for example, President Bill Clinton issued a presidential decision directive that called infectious diseases a threat to domestic and international security and called for U.S. global health efforts to be coordinated with those aimed at counterterrorism.¹

¹ The White House, *Infectious Diseases*, Presidential Decision Directive NSTC-7, June 12, 1996.

President Clinton later requested \$100 million for the Leadership and Investment in Fighting an Epidemic (LIFE) Initiative in 1999 to expand U.S. global HIV/AIDS efforts.² President George W. Bush recognized the impact of infectious diseases on domestic and global security in his 2002 and 2006 national security strategy papers and created a number of initiatives aimed at them, including the President's Emergency Plan for AIDS Relief (PEPFAR) in 2004, the President's Malaria Initiative (PMI) in 2005 and the Neglected Tropical Diseases (NTD) Program in 2006.³

President Barack Obama also recognized the risk of infectious diseases and made several statements about how their spread across developing countries might impact U.S. security.⁴ Through the 2010 Quadrennial Diplomacy and Development Review (QDDR) and the 2010 National Security Strategy, the Obama Administration advocated for the coordination of health programs in other areas, such as security, diplomacy and development. Rather than create an initiative aimed at infectious diseases, President Obama sought to address them by affirming U.S. commitment to global health and refining how U.S. global health programs function. In 2009, President Obama announced the Global Health Initiative (GHI), a \$63 billion, six-year strategy aimed at improving the coordination and impact of U.S. global health initiatives (described fully in the section entitled, "The Global Health Initiative (GHI)").

Legislative and executive branch support for raising global health budgets have been largely aligned, though some debates have emerged on more finite issues, such as the type of HIV/AIDS interventions to support. Recurring debate has also centered on international family planning and reproductive health programs.⁵ During the 112th Congress, concerns about slow economic recovery began to erode support for maintaining higher global health spending levels. Some Members questioned levels of non-security foreign aid and argued for the reduction or elimination of development and health assistance. In total, foreign aid accounts for less than 1% of the federal budget. Some Members contended cuts to these programs could yield important savings, while others maintained such reductions would have little impact on the federal deficit, could imperil the lives of vulnerable populations reliant on U.S. assistance, and might erode progress achieved through increased investments. Examples of progress in global health aid include the following:

- **HIV/AIDS**—The number of people receiving HIV/AIDS treatments through PEPFAR has more than doubled from 1.7 million in 2008 to more than 5.1 million in 2012. Programs that prevent mother-to-child HIV transmission have protected 230,000 infants against HIV in 2012.⁶ New HIV infections fell by 24% from 2001 through 2011.⁷
- **Tuberculosis (TB)**—Between 1990 and 2011, TB mortality and prevalence rates decreased by 34% and 35%, respectively, in 28 USAID priority countries.⁸

² For more on the LIFE Initiative, see CRS Report RL33771, *Trends in U.S. Global AIDS Spending: FY2000-FY2008*.

³ For more on PMI and the NTD Program, see CRS Report R41644, *U.S. Response to the Global Threat of Malaria: Basic Facts* and CRS Report R41607, *Neglected Tropical Diseases: Background, Responses, and Issues for Congress*.

⁴ See for example, White House, "Statement by the President on Global Health Initiative," press release, May 5, 2009.

⁵ See CRS Report R41360, *Abortion and Family Planning-Related Provisions in U.S. Foreign Assistance Law and Policy* and CRS Report RL33250, *International Family Planning Programs: Issues for Congress*.

⁶ PEPFAR, *Working Together for an AIDS-Free Generation: World AIDS Day Results*, March 14, 2013.

⁷ WHO, *Millennium Development Goals*, Fact Sheet, Number 290, November 2012.

⁸ Personal correspondence with USAID, March 29, 2013.

- **Malaria**—From 2006 through 2011, more than 59 million insecticide-treated nets (ITNs) and 11 million malaria treatments were procured with PMI support. Malarial deaths declined by roughly 33% from 985,000 in 2000 to 655,000 in 2010. Children younger than five years account for the vast majority of malarial deaths. In 12 of the original 15 PMI countries, child mortality rates have declined in the range of 16% (Malawi) and 50% (Rwanda).⁹
- **Maternal and Child Health**—USAID and the Centers for Disease Control and Prevention (CDC) have been key contributors to improved global coverage of vaccines, from 73% in 2000 to 85% in 2010. The World Health Organization (WHO) estimates that the U.S.-backed Global Alliance for Vaccines and Immunization (GAVI)¹⁰ supported the immunization of more than 325 million children by the end of 2011, thereby preventing more than 5 million deaths from vaccine-preventable diseases annually.¹¹ Since 1990, deaths among children under five have dropped by 42.5% from nearly 12 million annually to 6.9 million in 2011; maternal deaths decreased by 47% from 1990 to 2010.¹²
- **Family Planning and Reproductive Health**—USAID considers child spacing and access to voluntary contraception as important strategies for reducing child and maternal mortality and averting abortions. Use of modern contraception in 27 countries reportedly increased from 10% in 1965 to 37% in 2011.¹³

Debates about U.S. global health funding levels will likely continue in the 113th Congress and may intensify as Members seek to reduce overall spending.

Appropriations for U.S. Global Health Programs

Congress funds most global health assistance through three appropriations bills: State-Foreign Operations and Related Programs (State-Foreign Operations); Labor, Health and Human Services, and Education (Labor-HHS); and Department of Defense (**Figure 2**). These bills are used to fund global health efforts implemented by USAID, CDC, and the Department of Defense (DOD), including PEPFAR programs that are coordinated by the Department of State and implemented by several U.S. agencies (**Figure 3**). Through PEPFAR, the United States contributes to multilateral efforts to combat HIV/AIDS, TB, and malaria, including the Global Fund and the Joint United Nations Program on HIV/AIDS (UNAIDS).

⁹ USAID, *The President's Malaria Initiative, Sixth Annual Report to Congress*, April 2012, pp. 5 and 9.

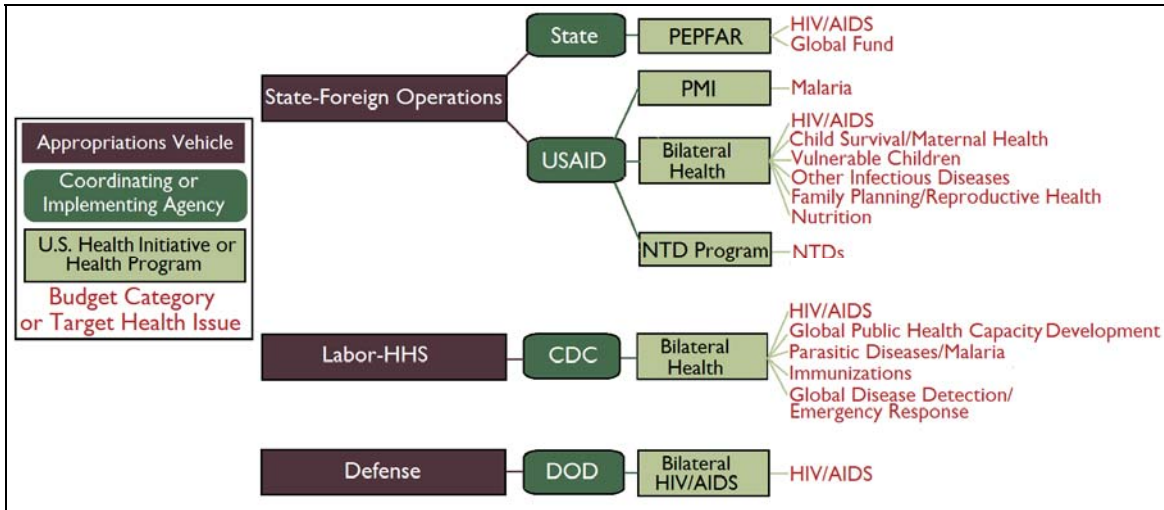
¹⁰ GAVI Alliance is a public-private partnership focused on increasing access to immunization for children around the world.

¹¹ GAVI Alliance, *GAVI Alliance Progress Report*, 2011, p. 7.

¹² WHO, *Millennium Development Goals*, Fact Sheet, Number 290, November 2012.

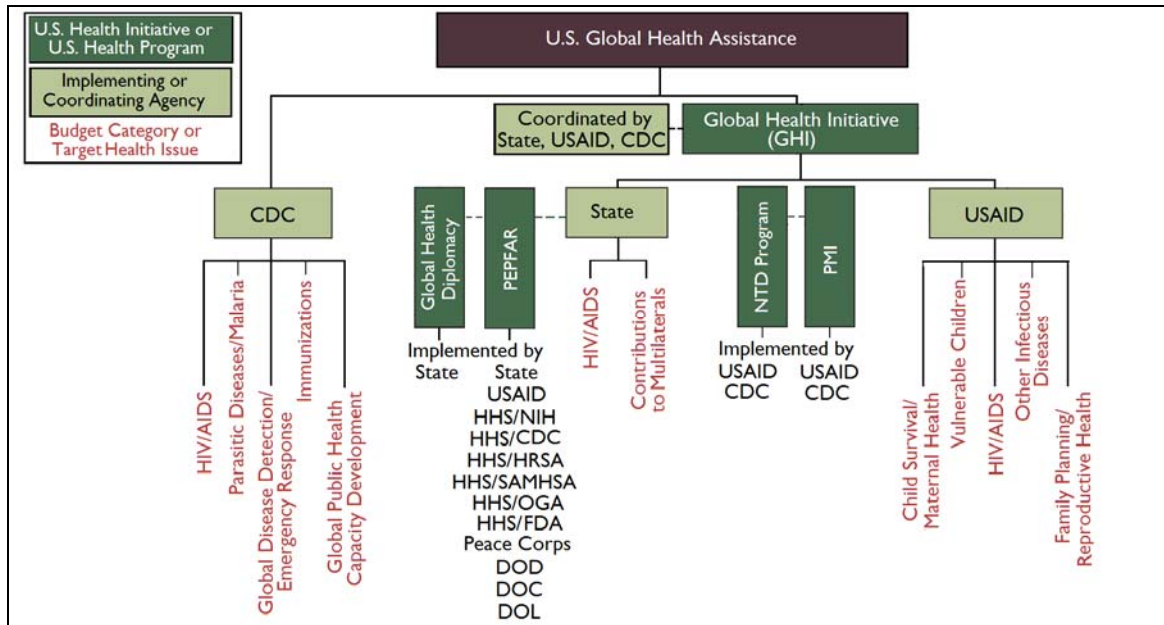
¹³ *Ibid.*, p. 72 and USAID webpage on family planning.

Figure 2. U.S. Global Health Assistance: Appropriation Vehicles



Source: Created by CRS from appropriations legislation.

Figure 3. U.S. Global Health Assistance: Implementing Agencies and Initiatives



Source: Created by CRS from appropriations legislation.

Notes: Appropriations for HIV/AIDS programs implemented by CDC, State and USAID are part of PEPFAR.

Acronyms not previously described: Department of Commerce (DOC), Department of Labor (DOL), Department of State (State), Food and Drug Administration (FDA), Health Resources and Services Administration (HRSA), National Institutes of Health (NIH) Office of Global Health Affairs, Substance Abuse and Mental Health Services Administration (SAMHSA).

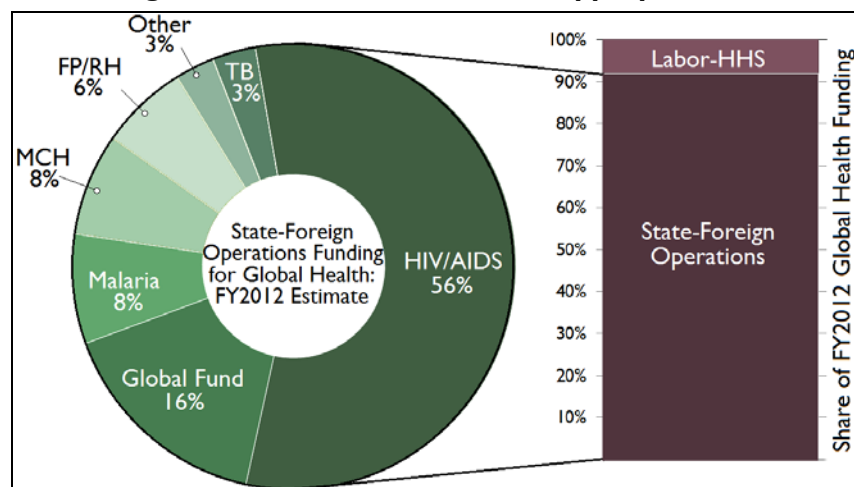
Reports about U.S. spending on global health can vary because there is no single “global health” appropriation. Some groups count funding for development issues that impact health, like water and sanitation, towards U.S. global health spending. This report focuses on activities that receive a specific amount for global health through State-Foreign Operations appropriations and Labor-

HHS appropriations, and for global HIV/AIDS through Department of Defense appropriations. Specific activities supported through these three appropriations vehicles are discussed below.

State-Foreign Operations Appropriations

The majority of U.S. global health programs are funded through the Global Health Programs Account in the State-Foreign Operations appropriations (**Figure 4**). Most of the funds are used for fighting HIV/AIDS, TB and malaria through bilateral programs and the Global Fund. A table outlining global health funding through State-Foreign Operations is included in **Appendix C**.

Figure 4. FY2012 Global Health Appropriations



Source: Created by CRS from appropriations legislation and data received from OMB.

Labor-HHS Appropriations

Through Labor-HHS appropriations, Congress funds global health programs implemented by CDC and provides resources to support international HIV/AIDS research conducted by the National Institutes of Health (NIH). Congress appropriates specific amounts for various global health programs implemented by CDC, though the appropriations language does not cover the breadth of global health activities managed by CDC. At the same time, appropriations language does not specify a particular amount for global HIV/AIDS research grants funded through NIH, though the Administration typically includes these amounts in reports on PEPFAR funding. A table outlining global health spending through Labor-HHS is included in **Appendix C**.

Defense Appropriations

Congress appropriates funds to DOD in support of its PEPFAR-related work through Defense appropriations. On average, Congress provides between \$8 million and \$10 million annually for these purposes. At the same time, DOD receives additional resources from the State Department as an implementing partner of PEPFAR. A table outlining U.S. funding for global HIV/AIDS programs, including those implemented by DOD, is included in **Appendix C**.

Implementing Agencies and Departments

This section briefly describes global health activities implemented or coordinated by each agency or department with appropriations, as described above. This discussion is limited to those agencies and departments for which Congress provides specific funding: USAID, State, CDC, and DOD.

U.S. Agency for International Development¹⁴

USAID groups its global health activities into three areas: saving mothers and children, creating an AIDS-Free generation, and fighting other infectious diseases. A summary of these efforts is described below.

- **Saving Mothers and Children.** USAID seeks to save the lives of women and children by reducing morbidity and mortality from common diseases and undernutrition; supporting vulnerable children and orphans; increasing access to family planning; and raising awareness about reproductive health. Under this category, Congress designates a specific amount for the following health areas:
 - maternal and child health,
 - malaria,
 - nutrition,
 - family planning and reproductive health, and
 - social services (vulnerable children).
- **Creating an AIDS-Free Generation.** USAID aims to combat HIV/AIDS by supporting voluntary counseling and testing, awareness campaigns, and the supply of antiretroviral medicines, among other activities.
- **Fighting Other Infectious Diseases.** USAID works to address a number of infectious diseases and resultant outbreaks. Congress appropriates a specific amount for: TB, pandemic influenza and other emerging threats, and NTDs.

Centers for Disease Control and Prevention¹⁵

Through Labor-HHS appropriations, Congress specifies support for the following CDC global health activities:

- **HIV/AIDS.** CDC works with Ministries of Health (MOHs) and global partners to increase access to integrated HIV/AIDS care and treatment services; strengthen and expand high-quality laboratory services; conduct research; and support resource-constrained countries develop sustainable public health systems.

¹⁴ For background on USAID's global health programs, see CRS Report RS22913, *USAID Global Health Programs: FY2001-FY2012 Request*; and <http://www.usaid.gov/what-we-do/global-health>.

¹⁵ For background on CDC's global health programs, see CRS Report R40239, *Centers for Disease Control and Prevention Global Health Programs: FY2001-FY2012 Request*; and <http://www.cdc.gov/globalhealth/index.html>.

- **Parasitic Diseases and Malaria.** CDC aims to reduce death and illness associated with parasitic diseases, including malaria, by capacity building and enhancing surveillance, monitoring and evaluation, vector control, case management, and diagnostic testing. CDC also identifies best practices for parasitic disease programs and conducts epidemiological and laboratory research for the development of new tools and strategies.
- **Global Disease Detection (GDD) and Emergency Response.** Through GDD, CDC builds capacity to monitor, detect, and assess disease threats and responds to requests from other U.S. agencies, United Nations agencies, and non-governmental organizations for support in humanitarian assistance activities.
- **Global Immunization.** CDC works to advance several global immunization initiatives aimed at preventable diseases, including polio, measles, rubella, and meningitis; accelerate the introduction of new vaccines; and strengthen immunization systems in priority countries through technical assistance, monitoring and evaluation, social mobilization and vaccine management.
- **Global Public Health Capacity Development.** CDC help MOHs develop Field Epidemiology Training Programs (FETPs) that strengthen health systems by enhancing laboratory management, applied research, communications, program evaluation, program management, and disease detection and response.

Department of State

Through OGAC, the State Department leads PEPFAR and oversees all U.S. spending on global HIV/AIDS, including those appropriated to other agencies and multilateral groups like the Global Fund and UNAIDS. In July 2012, the Administration announced an expansion of the State Department's engagement in global health with the launch of the Office of Global Health Diplomacy (OGHD).¹⁶ The office seeks to “guide diplomatic efforts to advance the United States’ global health mission” and provide “diplomatic support in implementing the Global Health Initiative’s principles and goals.”¹⁷ The Global AIDS Coordinator also leads OGHD. The key objectives of the OGHD are to

- provide ambassadors with expertise, support and tools to help them effectively work with country officials on global health issues;
- elevate the role of ambassadors in their efforts to pursue diplomatic strategies and partnerships within countries to advance health;
- support ambassadors to build political will among partner countries to improve health and strengthen health systems;
- strengthen the sustainability of health programs by helping partner countries meet the health care needs of their own people and achieve country ownership; and
- foster shared responsibility and coordination among donor nations, multilateral institutions, civil society, the private sector, faith-based organizations, foundations, and community members.

¹⁶ GHI, “Global Health Initiative Next Steps - A Joint Message,” press release, July 3, 2012.

¹⁷ Department of State, “Strengthening Global Health by Elevating Diplomacy,” blog post, December 14, 2012.

Following the announcement of the OGH, some observers questioned whether the Administration was quietly abandoning GHI. For more on this issue, see section on “Coordinating GHI.”

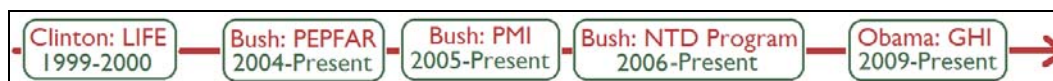
Department of Defense

DOD carries out a wide range of health activities abroad, including infectious disease research, health assistance following natural disasters and other emergencies, and training of foreign health workers and officials.¹⁸ The only global health activity for which Congress provides a specific appropriation, however, is DOD’s HIV/AIDS Prevention Program (DHAAP). Congress has never appropriated more than \$10 million to DOD for its global HIV/AIDS work, though it receives transfers from the Department of State as an implementing agency of PEPFAR. These funds are used to support research, care, treatment and prevention programs.¹⁹ **Table C-4** in **Appendix C** outlines annual funding for DHAAP.

U.S. Government Global Health Initiatives

As previously discussed, Presidents Clinton and Bush created global health initiatives to address infectious diseases (**Figure 5**). During the Bush Administration, consensus emerged that these initiatives, particularly PEPFAR, needed to be better integrated with other public health activities to improve efficiency and sustainability. President Obama maintained support for the Bush Era health initiatives but attempted to address these concerns with the launch of the GHI. The section below describes these global health initiatives.

Figure 5. Timeline of U.S. Government Global Health Initiatives



Source: Created by CRS.

President’s Emergency Plan for AIDS Relief (PEPFAR)²⁰

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. Later that year, Congress enacted the Leadership Act (P.L. 108-25), which authorized \$15 billion to be spent from FY2004-FY2008 on bilateral and multilateral HIV/AIDS, TB and malaria programs and authorized the creation of OGAC to oversee all U.S. spending on global HIV/AIDS. OGAC distributes the majority of the funds it receives from Congress for global HIV/AIDS programs to

¹⁸ For more information on these efforts, see CRS Report RL34639, *The Department of Defense Role in Foreign Assistance: Background, Major Issues, and Options for Congress*; and Kaiser Family Foundation, *The U.S. Department of Defense and Global Health*, September 2012.

¹⁹ For more on DOD’s HIV/AIDS research, see <http://www.hivresearch.org/research.php> and for DHAAP, see <http://www.med.navy.mil/sites/nhr/dhapp/Pages/default.aspx>.

²⁰ For more information on PEPFAR, see CRS Report R42776, *The President’s Emergency Plan for AIDS Relief (PEPFAR): Funding Issues After a Decade of Implementation, FY2004-FY2013*.

multilateral groups like the Global Fund, as well as federal agencies and departments. In 2008, Congress enacted the Lantos-Hyde Act (P.L. 110-293), which authorized the appropriation of \$48 billion for global HIV/AIDS, TB, and malaria efforts from FY2009-FY2013.

President's Malaria Initiative (PMI)²¹

In June 2005, President Bush announced PMI to expand and coordinate U.S. global malaria efforts. PMI was originally established as a five-year, \$1.2 billion effort to halve the number of malaria-related deaths in 15 sub-Saharan African countries 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).²² The Obama Administration expanded the goals of PMI to halving the burden of malaria among 70% of at-risk populations in Africa by 2014 and added the Democratic Republic of Congo, Guinea, Nigeria, and Zimbabwe as partner countries.

The Lantos-Hyde Act authorized the establishment of the U.S. Malaria Coordinator at USAID. The Malaria Coordinator oversees implementation efforts of USAID and CDC and is advised by an Interagency Advisory Group that includes representatives from USAID, HHS, State, DOD, the National Security Council (NSC), and the Office of Management and Budget (OMB).

Neglected Tropical Disease (NTD) Program²³

The NTD Program started in 2006, following FY2006 appropriations language that directed USAID to make available at least \$15 million for fighting seven NTDs.²⁴ It is managed by USAID and jointly implemented by USAID and CDC. When the program was launched, the Bush Administration sought to support the provision of 160 million NTD treatments for 40 million people in 15 countries. In 2008, President Bush reaffirmed his commitment to tackling NTDs and proposed spending \$350 million from FY2008 through FY2013 on expanding the program 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 NTDs among 70% of the affected population in target countries.

The Global Health Initiative (GHI)

In May 2009, President Obama announced GHI to expand the impact of U.S. government health programs. GHI aims to improve the coordination and integration of U.S. bilateral global health programs, which were described above, and emphasizes the application of results-based funding. Other important goals of GHI include the following:

²¹ For more information on PMI, see CRS Report R41644, *U.S. Response to the Global Threat of Malaria: Basic Facts*, and CRS Report R41802, *The Global Challenge of HIV/AIDS, Tuberculosis, and Malaria*.

²² The original 15 PMI countries were Angola, Benin, Ethiopia, Ghana, Kenya, Liberia, Madagascar, Malawi, Mali, Mozambique, Rwanda, Senegal, Tanzania, Uganda and Zambia.

²³ For more information on the NTD Program, see CRS Report R42931, *Progress in Combating Neglected Tropical Diseases (NTDs): U.S. and Global Efforts from FY2006 to FY2013*.

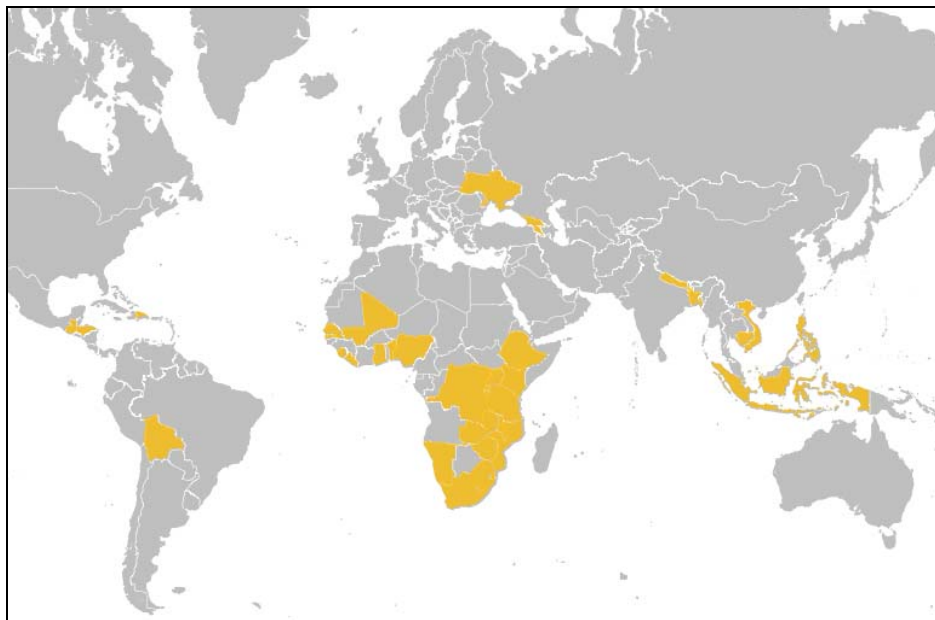
²⁴ Section 593, P.L. 109-102, FY2006 Foreign Operations Appropriations. The seven NTDs specified in the legislation are: three soil-transmitted helminthes, schistosomiasis, lymphatic filariasis, trachoma, and onchocerciasis.

- increasing the impact of U.S. global health investments;
- advancing country ownership of health aid;
- strengthening health systems;
- investing in women and girls; and
- enhancing program monitoring and evaluation and research and innovation.²⁵

GHI encompasses global health activities implemented by USAID and carried out through PEPFAR and PMI. The initiative aims to advance sustainable improvements in global health in three areas: protecting communities from infectious diseases, saving the lives of mothers and children and creating an AIDS-free generation. In each of these areas, the Administration has set goals and measurable indicators. For a description of these, see **Figure A-1** in **Appendix A**.

Through GHI, the U.S. government is developing “country strategies” that outline U.S. support for national health plans. The purpose of the strategies is to align the goals of GHI and partner countries, coordinate U.S. global health efforts, and enhance the efficiency and sustainability of these efforts. The strategies are developed in the U.S. missions by representatives of each implementing agency and have reportedly been completed for approximately 40 countries.²⁶ As of June 18, 2013, GHI has published 35 of these (**Figure 6**).

Figure 6. GHI Country Strategies: A Map



Source: GHI website, <http://www.ghi.gov/country/index.htm>, accessed on June 18, 2013.

Notes: The country strategies have been published for Armenia, Bangladesh, Benin, Bolivia, Burundi, Cambodia, Democratic Republic of Congo, Dominican Republic, Ethiopia, Georgia, Ghana, Guatemala, Honduras, Indonesia, Kenya, Lesotho, Liberia, Malawi, Mali, Mozambique, Namibia, Nepal, Nigeria, Philippines, Rwanda, Senegal, Sierra Leone, South Africa, Swaziland, Tanzania, Uganda, Ukraine, Vietnam, Zambia, and Zimbabwe.

²⁵ For more information on these goals, see GHI, *United States Government Global Health Initiative Strategy*, 2011.

²⁶ Personal communication with OGAC, April 1, 2013.

Coordinating GHI

From 2011 to mid-2012, GHI was coordinated by an executive director at the Department of State who reported to the Secretary of State and the GHI Operations Committee. The committee, which oversees and manages GHI, is chaired by the USAID Administrator, the Global AIDS Coordinator, and the Director of CDC. The Administration considered transferring leadership of GHI from the State Department to USAID by late FY2012 on the condition that USAID met a set of benchmarks related to management capacity, as outlined in the Quadrennial Diplomacy and Development Review (QDDR).²⁷

In July 2012, the co-coordinators of GHI—Ambassador Goosby (State/OGAC), Lois Quam (State/GHI), Administrator Rajiv Shah (USAID) and Director Thomas Frieden (CDC)—announced a collective recommendation to end the QDDR benchmark process, close the GHI office, and establish an Office of Global Health Diplomacy (GHD) at the Department of State to guide diplomatic efforts for advancing the U.S. global health mission.²⁸ The press release underscored, however, that GHI would continue to be the central focus and guiding strategy of U.S. global health programs.

Several observers debated the implications of the statement, particularly whether the Administration was quietly abandoning GHI. Some interpreted the announcement as a signal that the Administration was using the new GHD office to indirectly resolve arguments in Washington about who should ultimately lead U.S. global health efforts.²⁹ The Administration maintains, however, that the GHD office is not taking over the coordinating function that the GHI office played.³⁰ Further, the Administration maintains a website for GHI and continues to cite it as the guiding mechanism for U.S. global health work.

Funding GHI

When launching GHI, President Obama proposed spending \$63 billion on global health from FY2009 through FY2014. The President announced that \$51 billion of those funds would be aimed at HIV/AIDS and TB programs and the rest on global health programs implemented by USAID. From FY2009-FY2012, GHI funding reached \$34.3 billion. The FY2013 Consolidated Appropriations act provided an additional \$5.7 billion for State-managed HIV/AIDS programs, including \$1.65 billion for the Global Fund. The act also included nearly \$2.8 billion for global health programs implemented by USAID, though it did not specify for which programs. **Figure 7** estimates the additional funds needed to meet the GHI funding goals. This figure will likely change, however, as FY2013 funding levels for global health spending under sequestration has not yet been released.

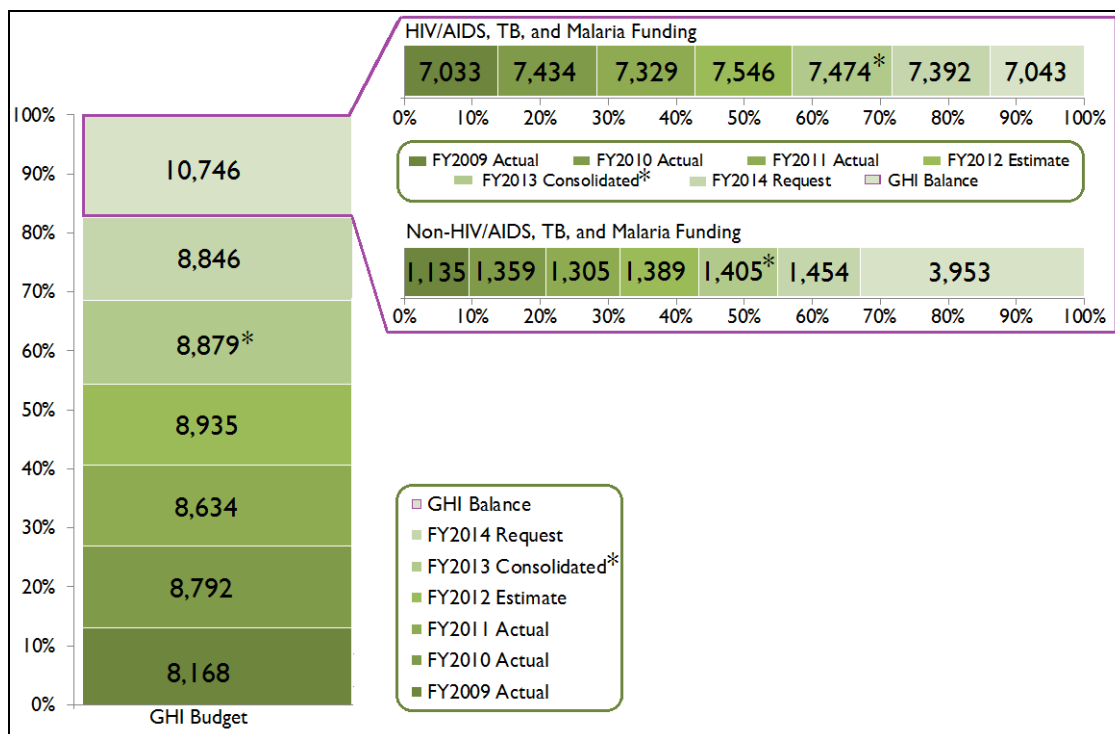
²⁷ For a list of the benchmarks, see Appendix 2 in State Department, *Quadrennial Diplomacy and Development Review*, 2010, pp. 217-219.

²⁸ GHI, “Global Health Initiative Next Steps - A Joint Message,” press release, July 3, 2012. For more information on this office, see the “Department of State” section.

²⁹ Amanda Glassman, “The Office of Global Health Diplomacy: A Christmas Miracle or Lump of Coal?” December 17, 2012.

³⁰ Personal communication with OGAC, April 1, 2013.

Figure 7. GHI Funding: FY2009-FY2014
(current U.S. millions and percentage of GHI budget goal)



Source: Created by CRS from appropriations legislation and data received from OMB.

Notes: *FY2013 HIV/AIDS, TB, and malaria total was calculated by adding the \$4.1 billion for State-HIV/AIDS and \$1.65 for the Global Fund, as specified in the FY2013 Consolidated Appropriations act with FY2012 estimates for related programs. These include \$350 million for USAID HIV/AIDS programs, \$650 million for USAID malaria programs, \$236 million for USAID TB programs, \$117.8 million for CDC HIV/AIDS programs, \$9.4 million for CDC malaria programs, and 8.0 million for DOD HIV/AIDS programs. The \$388.9 million FY2013 request is used for NIH international HIV/AIDS research, as the Administration's request is generally met and Congress does not provide an amount for this program. Instead, NIH draws the funds from the budget for the Office of HIV/AIDS Research. Due to sequestration, however, these figures will likely change.

HIV/AIDS, TB and Malaria Programs. From FY2009-FY2012, the United States spent \$34.3 billion on global HIV/AIDS, TB and malaria programs. The FY2013 Consolidated Appropriations act appropriated \$5.7 billion for State-managed HIV/AIDS programs, including \$1.65 billion for the Global Fund. Assuming that other HIV/AIDS, TB and malaria-related efforts are funded at FY2012 levels in FY2013 and that the President's FY2014 budget for the diseases is met, funding for fighting these three diseases would be roughly \$7 billion—or—about 15% less than sought by the Administration, though this amount may change following sequestration.

Non-HIV/AIDS, TB and Malaria Programs. From FY2009-FY2012, the United States spent nearly \$5.2 billion on non-HIV/AIDS, TB and malaria programs. The FY2013 Consolidated Appropriations act appropriated almost \$2.8 billion for global health programs implemented by USAID. Assuming that USAID's HIV/AIDS, TB and malaria programs would be funded at FY2012 levels for FY2013 and that the President's FY2014 budget for other health programs is met, funding for programs not associated with these three diseases would be about \$5.2 billion—or some 32%—less than sought by the Administration, though this amount may change following sequestration.

Prioritizing Non-HIV/AIDS Programs Through GHI

One goal of GHI is to improve the health of women and children, particularly through investments in maternal and child health, family planning and reproductive health and nutrition. The President also seeks to increase support for fighting other infectious diseases like NTDs. Congress has supported these ideas and increased funding in these areas. From FY2009 through FY2012, funding for maternal and child health grew by 22% and rose by 15% for family planning and reproductive health. During the same time period funding for nutrition grew by 73% and more than doubled for NTDs.

Nutrition. The Obama Administration has taken several steps to emphasize the importance of improving nutrition worldwide. In September 2010, former Secretary of State Hillary Clinton launched the 1,000 Days Campaign, a global effort to promote targeted action and investment in improving the nutritional status of pregnant women and children within their first two years of life.³¹ In addition, USAID Administrator Rajiv Shah serves as the U.S. representative to the United Nations Scaling Up Nutrition (SUN) Movement, which aims to improve nutrition worldwide.³² A group of Nobel Laureate economic experts ranked efforts to address undernutrition as the most cost-effective investment in foreign aid. The economists concluded that each dollar spent on reducing chronic undernutrition could yield a \$30 benefit.³³

The Administration addresses nutrition through a variety of programs. For example, nutrition is a link between the Global Health Initiative and the Feed the Future (FtF) Initiative. Focus countries for FtF are largely aligned around GHI countries with the highest burden of undernutrition. USAID also uses resources through accounts like the Development Assistance account and McGovern-Dole International Food for Education to improve nutrition worldwide, though funding levels for nutrition activities within these accounts are not set by Congress. USAID is reportedly working on a strategic framework that would improve means for tracking nutrition funding and outcomes across all programs, especially global health, food security and food aid.

Other Infectious Diseases. President Obama has advocated increasing funding for programs to combat other infectious diseases. Congressional support for this idea preceded the GHI. From FY2000-FY2012 funding grew for TB by 45% and malaria by 70%. From FY2006-FY2012, funding rose by 256% for NTDs. Despite these increases, TB and NTD programs continued to account for less than 3% and 2% of the GHI budget respectively due to the large portion of the budget aimed at the HIV/AIDS and the Global Fund (**Figure 8**).

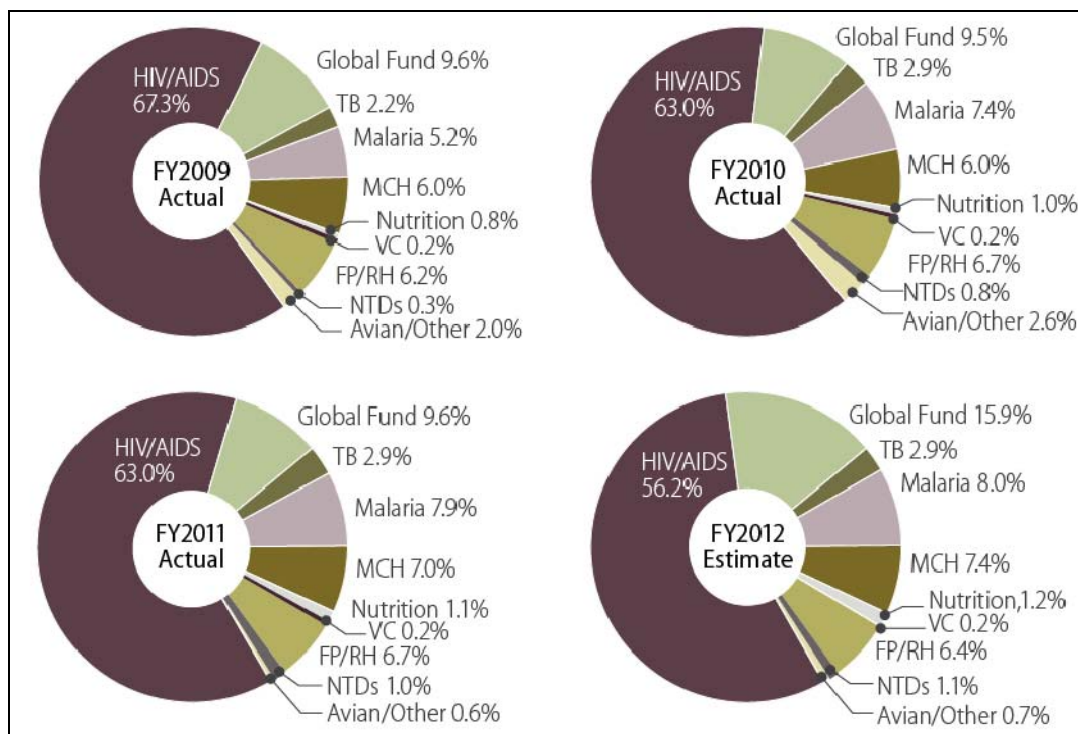
³¹ Hillary Clinton, “1,000 Days: Change a Life, Change the Future,” remarks, New York City, September 21, 2010.

³² For more information on the SUN Movement, see <http://scalingupnutrition.org/>.

³³ John Hoddinott et al., *Copenhagen Consensus 2012 Challenge Paper*, March 30, 2012, p. 4. A related report on nutrition concluded that the cost-benefit ratios ranged between \$23.8 and \$138.6. *Ibid.*, p. 37. Nutrition advocates commonly use this statistic to assert that each dollar invested could yield up to a \$139 return.

Figure 8. GHI Global Health Spending, by Program Area, FY2009-FY2012

(in millions of current U.S. dollars and percentages)



Source: Created by CRS from appropriations legislation and data received from OMB.

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

Non-Communicable Diseases. The majority of U.S. global health resources are aimed at fighting infectious diseases. Nonetheless, non-communicable diseases (NCDs) are a growing problem in middle-income and developing countries. More than 36 million people died from NCDs worldwide in 2008, primarily from cardiovascular diseases (CVDs), which accounted for 48% of NCD deaths. Some 21% of NCD deaths were attributable to cancers, while 12% were associated with chronic respiratory diseases and 3% with diabetes.³⁴ A combination of factors contribute to the rising prevalence of NCDs in low- and middle-income countries, including increasing use of tobacco and illicit drugs, declining levels of physical activity, and changing diets. Limited capacity in low- and middle-income countries to address NCDs, which are mostly preventable, have resulted in higher mortality rates from NCDs than among more affluent countries. In 2008, for example, more than 80% of all NCD deaths occurred among people younger than 60 years in low- and middle-income countries (**Appendix B**).

FY2014 Funding

The Administration has requested \$9.1 billion to fund global health programs in FY2014, roughly 2% more than FY2012 levels (**Table 1**). Notable increases include a 57% boost for the Global

³⁴ WHO, *Noncommunicable Diseases Country Profiles 2011*, 2011, p.5.

Fund and 13% jump in funding for CDC’s global health programs. State-managed bilateral HIV/AIDS programs were the only efforts for which the Administration requested a reduction from FY2012 levels (-10.5%). When compared against the FY2013 Consolidated Appropriations Act, the FY2014 budget request for State-managed global HIV/AIDS efforts was 1.2% lower and the request for the Global Fund was the same.

Table 1. U.S. Government Global Health Funding: FY2011-FY2014 Request
(current U.S. \$ millions)

	FY2011 Enacted	FY2012 Estimate	FY2013 Request	FY2013 CR^a	FY2014 Request	FY2012 Estimate -FY2014 Request	FY2013 CR- FY2014 Request
State Global HIV/AIDS	4,585.8	4,492.9	3,700.0	4,070.5	4,020.0	-10.5%	-1.2%
State Global Fund	748.5	1,300.0	1,650.0	1,650.0	1,650.0	57.1%	0.0%
USAID Global Health	2,498.0	2,625.0	2,504.0	2,641.1	2,645.0	0.8%	0.1%
State-Foreign Operations	7,832.3	8,417.9	7,854.0	8,361.6	8,315.0	1.8%	-0.6%
CDC Global Health	340.1	347.6	362.9	n/s ^b	393.0	13.1%	n/s ^a
NIH Global AIDS Research	375.7	392.4	388.9	392.0	399.1	1.7%	1.8%
HHS Global Fund ^c	297.3	0.0	0.0	0.0	0.0	0.0%	n/s ^a
Labor-HHS	1,013.1	740.0	751.8	n/s^b	792.1	7.0%	n/s^a
DOD Global HIV/AIDS ^d	10.0	8.0	0.0	n/s ^a	n/s	n/s	n/s ^a
Total	8,855.4	9,165.9	8,605.8	n/s^a	9,107.1	2.1%	n/s^a

Source: Compiled by CRS from congressional budget justifications, appropriations legislation, and personal communication with OMB.

Notes: Includes global health funding provided through State-Foreign Operations, Labor-HHS, and Defense appropriations.

- a. The FY2013 Consolidated Appropriations act did not specify (n/s) an amount for these programs barring efforts to sum U.S. global health funding (n/a). The amounts listed in this column will likely change due to sequestration.
- b. The FY2014 congressional budget justification did not provide a budget amount for FY2013.
- c. FY2011 was the last fiscal year in which Congress appropriated funds for a U.S. contribution to the Global Fund through Labor-HHS. This category is not applicable (n/a) for all other fiscal years.
- d. The Administration does not typically request funds for DOD global HIV/AIDS programs. Efforts to compare FY2012 funding against FY2013 budgetary requests are not applicable (n/a).

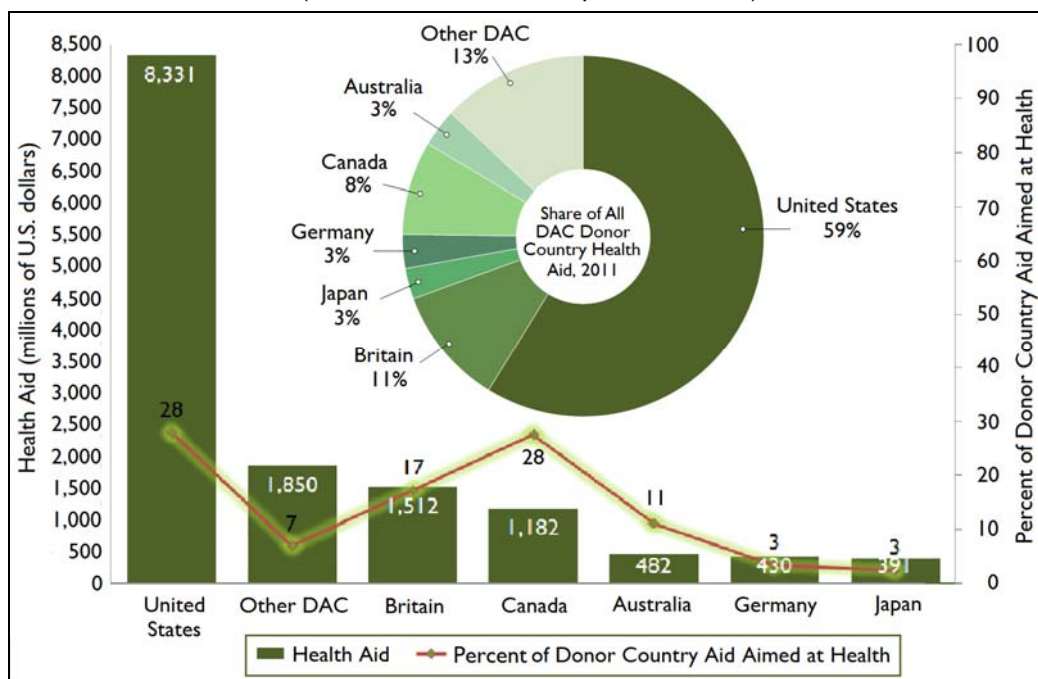
The Administration maintains the proposed budget reductions for some global health activities, particularly HIV/AIDS, reflect increased efficiencies brought about by better integration between programs, greater use of community health workers and nurses, and lower treatment costs. Scaling back funding for bilateral HIV/AIDS programs in some countries, such as South Africa, Kenya, Ethiopia, and also represent efforts to encourage program ownership among countries with growing capacity to manage national HIV/AIDS programs through higher domestic

investments, greater availability of resources from other donors, and reductions in HIV prevalence.³⁵ Despite global HIV/AIDS budget cuts, the Administration projects fulfilling related GHI targets, particularly the target that calls for supporting the provision of HIV/AIDS treatments for 6 million HIV-positive people worldwide by the end of 2013.³⁶

Global Health Spending by Other Stakeholders

The United States provides more official development assistance (ODA) for health than any other country in the Development Assistance Committee (DAC).³⁷ In 2011, U.S. spending on global health accounted for more than half of all health aid provided by DAC members (Figure 9). At the same time, the United States apportions more of its foreign aid to improving global health than most other donor countries. As illustrated in Figure 9, Canada is the only other donor that apportions 28% of its ODA to health aid.

Figure 9. Official Development Assistance for Health, by Country, 2011
(current U.S. millions and percent of total)



Source: Created by CRS from the Organization for Economic Cooperation and Development (OECD) website on statistics at <http://www.oecd.org/statistics/>, accessed on February 5, 2012.

Notes: Data in this figure reflects reported spending by DAC members. The data does not include funding from other sources, including European Union institutions, the World Bank or private donors like the Gates Foundation. Health aid levels in this figure include the OECD aid categories of health and population.

³⁵ Eric Goosby, *President's Budget Request Reflects Strong Commitment on Global AIDS*, Department of State, February 13, 2012.

³⁶ State Department, *Executive Budget Summary*, Function 150 and Other International programs, FY2013, pp. 74-80.

³⁷ DAC is an organization of 24 countries that focus on development. DAC members are part of the OECD, a group of 34 countries committed to international development.

Due to varying data collection practices, as described in the section on “Defining U.S. Global Health Assistance and GHI,” total amounts reported by OECD on global health aid may differ from national estimates. The Administration reports, for example, that the United States spent \$8.85 billion on global health aid in FY2011, while the OECD reports the United States spent \$8.33 billion in 2011.

In 2011, ODA for health by other DAC countries include Greece (\$3 million), Portugal (\$17 million), Finland (\$20 million), New Zealand (\$20 million), Luxembourg (\$41 million), Switzerland (\$67 million), Austria (\$74 million), Italy (\$91 million), Ireland (\$96 million), Denmark (\$142 million), Netherlands (\$154 million), Korea (\$162 million), France (\$179 million), Sweden (\$182 million), Norway (\$183 million), Spain (\$200 million), Belgium (\$211 million).

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 2011, for example, spending on global health by the Bill & Melinda Gates Foundation was higher than all DAC countries except the United States. Specifically, the OECD reported that in 2011, the Gates Foundation spent some \$2.4 billion on global health, roughly \$553 million more than Britain, the second largest DAC donor.³⁸

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. influence in this realm in particular.³⁹ The growth of actors in the global health sector raises several questions:

- How might U.S. influence be affected by the growing number of global health actors, particularly in the area of country ownership?
- How might the United States effectively engage with non-state actors to avoid duplication of resources and improve the sustainability of its investments?
- How might the United States maintain its accountability and transparency standards while reducing reporting burdens?

Issues for the 113th Congress

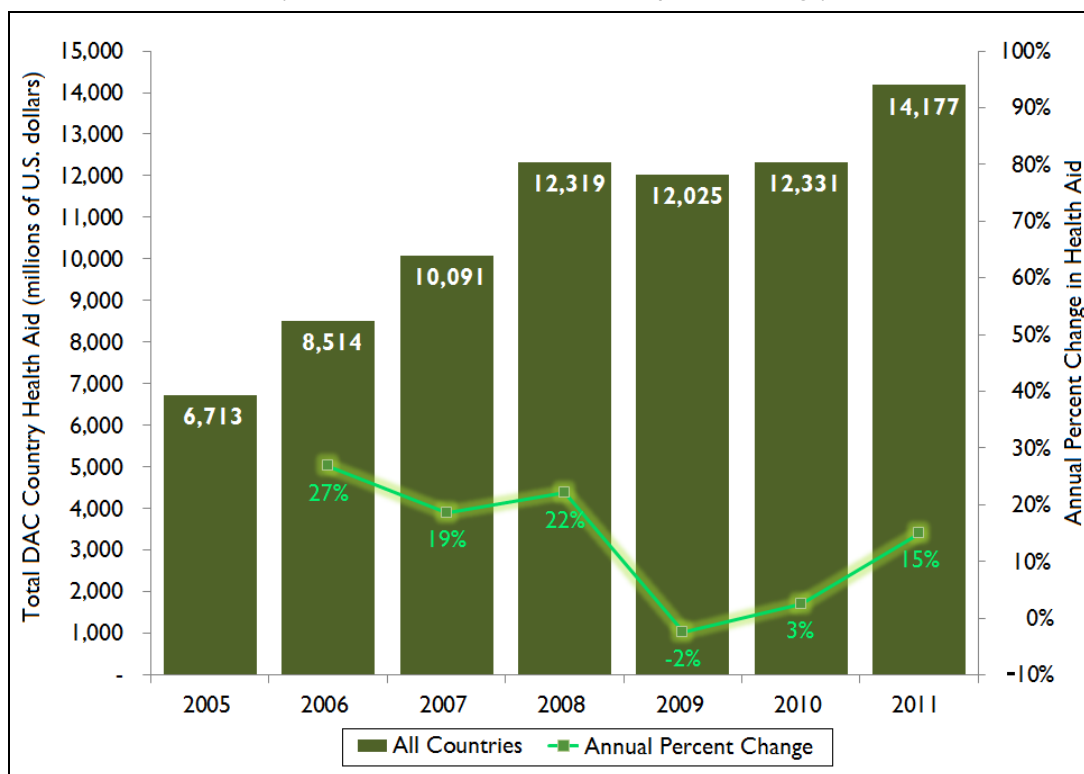
The U.S. role in global health has been both applauded and criticized. Supporters have celebrated the attention the United States has brought to global health, as well as advancements U.S. programs have helped to make in improving global health. In real terms, donor countries have increased ODA for health since the launch of U.S. global health initiatives like PEPFAR, PMI, and the NTD Program (**Figure 10**). At the same time, some critics have disapproved of the establishment of U.S. health programs that parallel, rather than operate within, national health services, particularly for global HIV/AIDS programs. Critics contended the U.S. programs

³⁸ OECD online database at <http://stats.oecd.org/>.

³⁹ 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.

unnecessarily duplicated national health efforts of host countries and hampered country ownership of health programs. This section discusses these issues as well as some other pressing global health policy issues facing the 113th Congress.

Figure 10. Official Development Assistance for Health, FY2005-FY2011
(current U.S. \$ millions and annual percent change)



Source: Created by CRS from the Organization for Economic Cooperation and Development (OECD) website on statistics at <http://www.oecd.org/statistics/>, accessed on February 5, 2012.

Notes: Data in this figure reflects spending by DAC members and does not include funding from other sources, including European Union institutions, the World Bank or private donors like the Gates Foundation.

Health aid levels include the OECD aid categories of health and population.

Defining U.S. Global Health Assistance and GHI

When President Obama announced the Global Health Initiative, some expressed hope that questions about what programs should be counted towards U.S. global health spending would be resolved. Some believe these questions remain and that some confusion persists about what activities are included under GHI. For example, official documents on GHI spending only cover global health activities funded through PEPFAR and the Global Health Programs account in State-Foreign Operations, even though other agencies and departments outside of State, USAID and CDC play a role in GHI. The Department of Defense, for instance, expends a significant amount of resources on global health,⁴⁰ yet GHI documents do not outline the relationship

⁴⁰ The Department of Defense supports a wide array of activities that improve global health, especially responses to natural disasters and conflicts. The department also maintains laboratories in several countries that conduct research on (continued...)

between DOD and the other implementing agencies nor do they explain how agencies like DOD will further the goals of GHI.

Questions also remain about the coordination of global health programs between Washington and the field and whether several long-standing issues with U.S. global health assistance have been addressed, including

- a lack of consensus on what programs to count towards U.S. global health spending;
- an unclear role for each implementing agency in improving global health, particularly through GHI; and
- ambiguous leadership of U.S. global health efforts.

By any calculation, funding for global health has grown considerably since FY2000, particularly through FY2008. Congress has used appropriations and authorizing legislation to direct how those budgetary increases are to be applied and to detail the roles and responsibilities for key global health positions. The Leadership Act, for example, authorized the creation of the Global AIDS Coordinator while the Lantos-Hyde Act authorized the establishment of the Malaria Coordinator. The legislation spelled out the roles of the coordinators, the oversight authority of the positions and the priority areas to be addressed in carrying out related programs.

Congress has not separately authorized GHI. Legislation authorizing the establishment of a Global Health Coordinator could clarify some of the questions regarding GHI, as discussed above. Congress has also not yet considered legislation to authorize the Global Health Diplomacy Office. Authorizing legislation might also be considered as an option for clarifying the role of the GHD office, as well as resolving some of the questions listed in previous sections about the oversight authorities of the office.

Funding GHI

Debates about U.S. global health spending levels are complex and, some argue, distinct from general debates over foreign aid levels because many U.S. global health programs offer immediate life-saving interventions. Several global health advocates argue that U.S. support for global health is critical for scaling up the use of new—and potentially very successful—tools to prevent and treat diseases, including HIV/AIDS and malaria. A number of observers 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. At the same time, some Members have questioned the impact of U.S. global health investments, criticized corrupt practices by various governments receiving global health assistance, and called for greater commitment to health by recipient countries.⁴¹

(...continued)

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.

⁴¹ Shannon Kowalski, *The Human Cost of Misplaced Priorities*, Open Society Foundation, Blog, April 5, 2010.

The Administration is reportedly taking steps to address concerns about aid effectiveness and corruption. In 2011, USAID Administrator Rajiv Shah created a suspension and debarment task force to monitor, investigate and respond to suspicious activity.⁴² In the same year, USAID released a new evaluation policy that seeks to increase independent evaluation of ongoing projects with results being released within three months of completing the evaluation.⁴³ 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 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.⁴⁴

Maintaining HIV/AIDS Commitments

On World AIDS Day in December 2011, President Obama announced that the United States was committed to supporting treatments for 6 million HIV-positive people by the end of 2013.⁴⁵ This announcement followed the May 2011 release of findings, which indicated that early initiation of HIV treatment in discordant couples⁴⁶ reduced HIV transmission by 96%. The NIH-funded research found that HIV transmission rates declined precipitously following consistent and proper use of HIV medication due to dramatic reductions in viral loads.⁴⁷ The finding was hailed by many as a “game-changer” and led several HIV/AIDS experts to argue that HIV/AIDS could be eliminated as a public health problem.⁴⁸ The announcement also led to calls for maintaining U.S. support of HIV treatment around the world.

The United States spends more than any other country on fighting HIV/AIDS worldwide, accounting for 59% of all donor government spending in 2011.⁴⁹ Additionally, the United States remains a key donor for multilateral programs, like the Global Fund, accounting for roughly 1/3 of all country donors. Most developing countries are heavily reliant on donors to fund their national HIV/AIDS plans.⁵⁰ In Kenya, for example, donors provided more than 80% of the resources needed to support its \$709 million HIV/AIDS budget in 2011.⁵¹

The Lantos-Hyde Act called for the creation of partnership frameworks that would outline plans for increasing country ownership and funding of national HIV/AIDS plans.⁵² The U.S.-South Africa Partnership Framework Implementation Plan, for example, envisions reducing PEPFAR

⁴² 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.

⁴³ Ibid. Also see, USAID, *Evaluation Policy*, January 19, 2011.

⁴⁴ The White House, “Fact Sheet: The President’s Global Development Council,” press release, February 9, 2012.

⁴⁵ The White House, “Remarks by the President on World AIDS Day,” press release, December 1, 2011.

⁴⁶ HIV-serodiscordant couples have one partner who is HIV-positive and another who is HIV-negative.

⁴⁷ NIH, 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.

⁴⁸ “HIV Treatment as Prevention: Breakthrough of the Year, 2011,” *Science Magazine*, Special Issues 2011.

⁴⁹ Jennifer Kates et al., *Financing the Response to AIDS in Low-and Middle-Income Countries: International Assistance from Donor Governments in 2011*, Kaiser Family Foundation, July 2012, p. 2.

⁵⁰ 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.

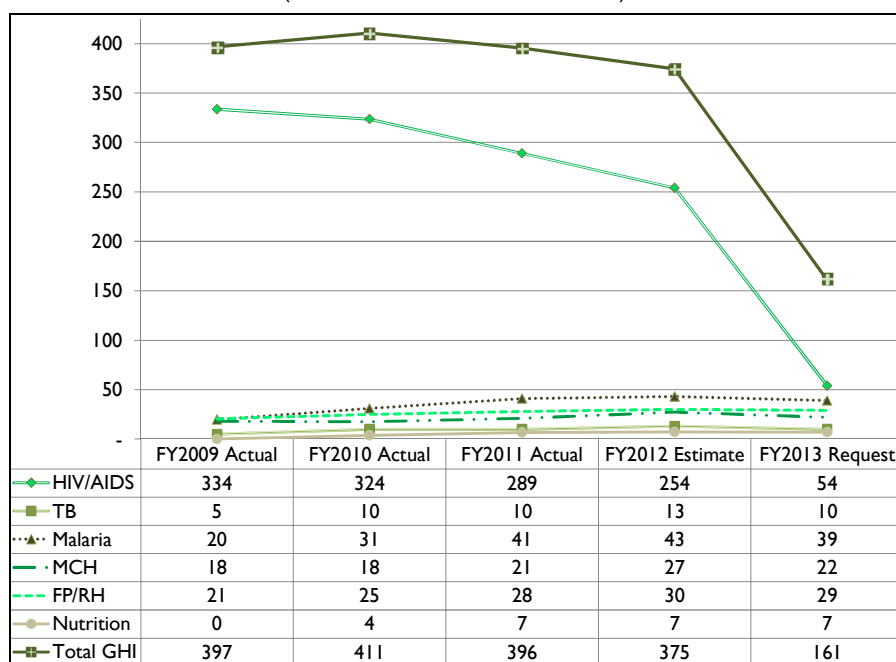
⁵¹ UNAIDS, *Together We Will End AIDS*, 2012, p. 109.

⁵² P.L. 110-293, Section 301. Also see the PEPFAR website on Partnership Frameworks.

aid from the FY2012 level of roughly \$484 million to \$250 million by FY2017.⁵³ Similarly, the government of Nigeria, commits to funding half of its national HIV/AIDS program by the end of the framework’s five-year implementation.⁵⁴

Most global health experts agree that country ownership of global health programs is important. Some observers are concerned, however, that the United States is hastily drafting partnership frameworks with countries that are not prepared to assume control over national HIV/AIDS programs.⁵⁵ The FY2013 budget request, for example, called for a 57% reduction in global health spending for Ethiopia from FY2012 levels. The biggest cut would come from PEPFAR programs, which the Administration proposes decreasing by roughly 80% from \$254 million in FY2012 to \$54 million in FY2013 (Figure 11).

Figure 11. GHI Spending in Ethiopia, FY2009-FY2013
(millions of U.S. current dollars)



Source: Created by CRS from <http://www.foreignassistance.gov>.

Notes: FY2009-FY2011 actual, FY2012 estimate, FY2013 request. Congress had not yet specified funds for nutrition programs in FY2009.

There is some uncertainty about what impact spending cuts may have on national HIV/AIDS plans.⁵⁶ In January 2013, for example, global health experts expressed alarm about proposals to

⁵³ Department of State, *Partnership Framework Implementation Plan in Support of South Africa’s National HIV, STI & TB Response, 2012/13 - 2016/2017*, August 2012, p. 33, <http://www.pepfar.gov/documents/organization/196651.pdf>.

⁵⁴ 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.

⁵⁵ Deirdre Shesgreen, “What Should Country Ownership Really Mean as PEPFAR Moves into Next Phase?” *Center for Global Health Policy*, May 20, 2010.

⁵⁶ Amanda Glassman, “Ethiopia’s AIDS Spending Cliff,” *Center for Global Development*, September 11, 2012.

drastically reduce PEPFAR funds in Ethiopia. An Ethiopian official reportedly indicated, however, that the government had been expecting the budget cuts and that it will reduce funding for “softer programmatic activities;” employ innovative strategies; and mobilize internal resources to replace the lost funds.⁵⁷

Opponents to sharp budget cuts point to reports and press accounts from South Africa of stock outs, staff shortages, and poor service at several district and national health centers due to poor management of resources.⁵⁸ HIV/AIDS advocates are concerned that by shifting HIV/AIDS service to local health centers, patients may not be able to access their medicines in a timely fashion (raising the risk of drug resistance) or may avoid the centers altogether due to the poor conditions.⁵⁹

Reductions of U.S. global HIV/AIDS budgets are distressing for those concerned about taking advantage of recent scientific developments and about maintaining funding for HIV/AIDS treatment programs. This issue is sensitive, since people without medicine will inevitably die. The Administration maintains that reductions in operating costs and increased efficiencies will enable the United States to reach its treatment goals while reducing spending.⁶⁰ There is some concern that abrupt reductions in global HIV/AIDS funding will imperil the gains made over the last decade from unprecedented spending levels. Other observers question whether the United States should vow to continuously increase the number of patients receiving treatment considering HIV-positive people need to be treated for a lifetime.⁶¹

Extending PEPFAR Authorization Legislation

Funds to carry out PEPFAR have been authorized under two successive authorization acts: the Leadership Act of 2003 (P.L. 108-25) and the Lantos-Hyde Act of 2008 (P.L. 110-293). The acts authorized the appropriation of \$15 billion and \$48 billion, respectively, for fighting HIV/AIDS, TB, and malaria. Authorization for funds to carry out PEPFAR is set to expire at the end of FY2013. The U.S. Congress has become more divided over issues related to foreign aid in general since Lantos-Hyde was enacted. It is uncertain whether these issues will be sufficiently resolved as to enable reauthorization in the 113th Congress. If Congress does not enact a second reauthorization, PEPFAR activities could continue to be funded through annual appropriations, but Congress might consider whether its priorities could be sufficiently delineated through appropriations alone.

⁵⁷ United Nations Office for the Coordination of Humanitarian Affairs, “Ethiopia: Concerns Over HIV/AIDS Funding Cuts,” *IRIN News*, January 9, 2013.

⁵⁸ Doctors Without Borders, *Emergency Intervention at Mthatha Depot: The Hidden Cost of Inaction*, January 2013.

⁵⁹ Mishack Mahlangu, “HIV Patients Stranded As PEPFAR Funds Dry Up,” *Health Systems Trust*, January 29, 2013; Doctors Without Borders et al., *Emergency Intervention at Mthatha Depot*, January 2013.

⁶⁰ Eric Goosby, “President’s Budget Request Reflects Strong Commitment on Global AIDS,” *blog.aids.gov*, February 13, 2012.

⁶¹ 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; and Neil Patel, *Emergency to Efficiency*, Harvard Political Review Online, December 5, 2010.

Balancing Bilateral and Multilateral Activities

The appropriate balance between bilateral and multilateral assistance is a frequent point of contention among U.S. policymakers. This debate has intensified in recent years as the Obama Administration has taken several steps to heighten support for multilateral organizations, particularly the Global Fund. The United States is a leading contributor to several other multilateral health organizations, including UNAIDS, WHO, the International AIDS Vaccine Initiative (IAVI), and the GAVI Alliance, among others. Nonetheless, discussions about the appropriate mix of multilateral and bilateral funding have primarily focused on U.S. support for the Global Fund.

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
- more rapidly adjust how funds are spent.

On the other hand, some observers maintain U.S. participation in multilateral responses to global health offers distinct advantages, including the ability to

- pool and leverage limited resources, which can capitalize on efficiencies,
- coordinate assistance with a range of donors, and
- provide aid that better aligns with the priorities of the recipient countries.

The debate about the appropriate funding levels for bilateral and multilateral funding can distract from another important issue: alignment of bilateral and multilateral programs. According to a report by WHO, 20% to 40% of health spending is wasted through inefficiency.⁶² The report identified several areas in which donors could eliminate waste, namely through aligning financial, reporting, and monitoring practices. By harmonizing the auditing, monitoring, and evaluation of bilateral and multilateral programs, WHO asserted, health staff could use some of the time spent on compiling reports to addressing other health issues.

Supporters of donor harmonization call on the Obama Administration to sign the *International Health Partnership Compact*, an international agreement drafted by the International Health Partnership (IHP+) that calls for the international community to work together to improve the efficiency of health aid.⁶³ 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;

⁶² WHO, *Health Systems Financing: The Path to Universal Coverage*, World Health Report, 2010, p. vi.

⁶³ See the IHP+ website at <http://www.internationalhealthpartnership.net/en/>.

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

As of May 2013, 58 countries, multilateral organizations, and other donors have signed the International Health Partnership Compact.⁶⁴ While the Obama Administration has indicated support for the agreement,⁶⁵ the United States has not signed it.

Conclusion

Global health has been a central issue in congressional debates over foreign assistance programs and funding levels. Some expect that global health will be an area of ongoing congressional interest, both as a way to potentially reduce overall spending and to improve the effectiveness of aid. In determining funding levels for global health programs, Congress may consider

- ways that the United States can encourage country ownership of global health programs;
- the appropriate balance of funding between bilateral and multilateral programs;
- the role that the United States plays in global health, particularly in relation to other donors; and
- the extent to which the United States can invest in new global health areas.

The rising global prevalence of non-communicable diseases can threaten U.S. efforts to transfer ownership of U.S. global health programs to recipient countries. Many middle-income countries like South Africa face dual epidemics of diseases associated with growing prosperity (diabetes) and persistent poverty (vaccine preventable deaths). In the absence of higher spending levels, bolstering health systems will likely gain greater importance in U.S. global health programs. Such efforts could help countries formulate sustainable plans to address these mostly preventable diseases while addressing infectious diseases that have threatened poor countries for decades.

Along with debating issues related to U.S. global health assistance, Congress may also consider its own role in U.S. global health aid. Congress has exercised growing involvement in shaping global health programs by authorizing the creation of key global health positions, enacting legislation that included spending directives and described congressional priorities. Global health analysts have debated whether Congress's elevated role has helped or hindered the efficacy of

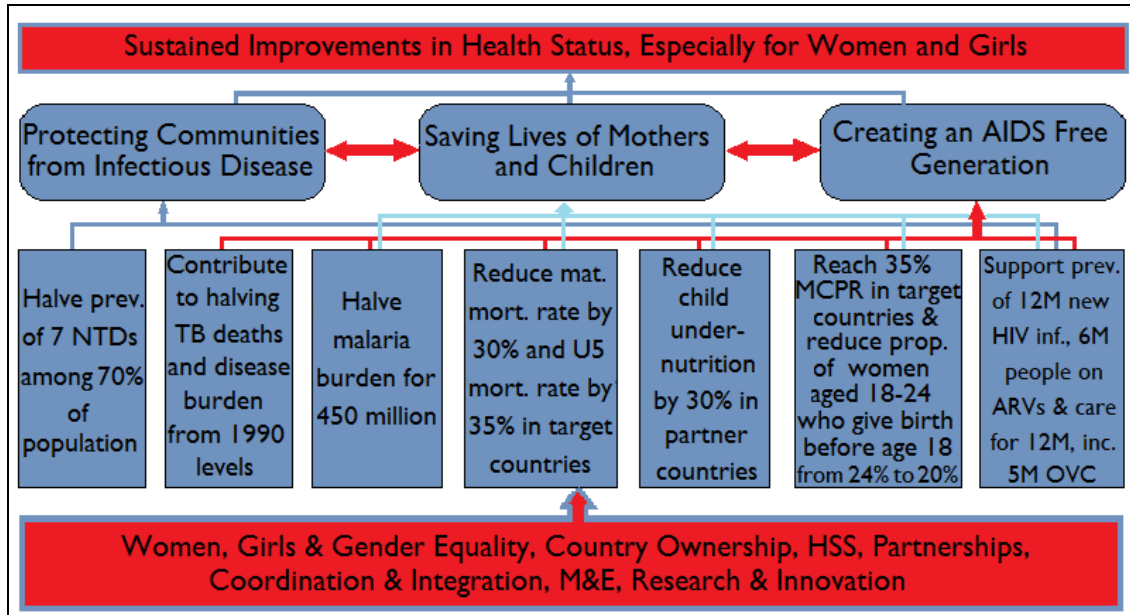
⁶⁴ See <http://www.internationalhealthpartnership.net/>.

⁶⁵ See USAID, *The United States Government Global Health Initiative Strategy*, March 1, 2011, p. 8.

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 have protected critical areas in need of support and facilitated the implementation of a cohesive global health strategy across agencies.

Appendix A. GHI Framework

Figure A-1. GHI Framework

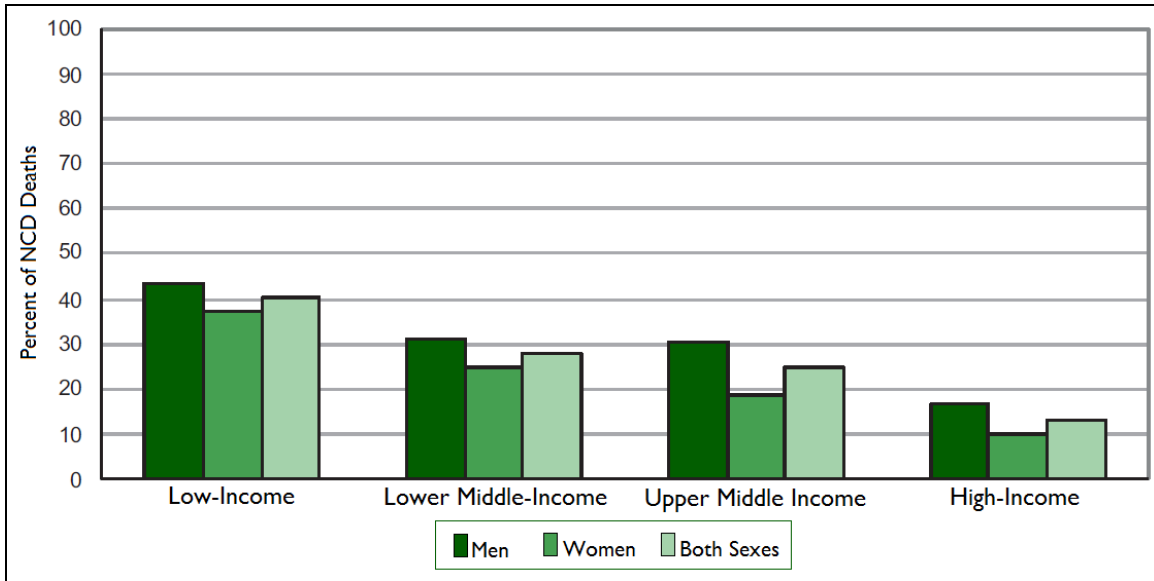


Source: Reproduced by CRS from GHI website, <http://www.ghi.gov/about/goals/index.htm>, accessed on January 9, 2013.

Abbreviations and Acronyms: anti-retroviral treatments (ARVs), health system strengthening (HSS), maternal (mat.), million (M), modern contraceptive prevalence rate (MCPR), monitoring and evaluation (ME), mortality (mort.), neglected tropical diseases (NTDs), proportion (prop.), tuberculosis (TB).

Appendix B. Non-Communicable Disease (NCD) Deaths Among People Under 60 Years, by Country Income-Group

Figure B-1. Global NCD Mortality Among People Under 60 Years



Source: WHO, *Noncommunicable Diseases Country Profiles 2011*, 2011, p. 5.

Appendix C. U.S. Global Health Funding, FY2001-FY2014

Table C-1. U.S. Global Health Spending, by Agency, FY2001-FY2014
(current U.S. \$ millions)

Agency/Department	FY2001 Actual	FY2002 Actual	FY2003 Actual	FY2004 Actual	FY2005 Actual	FY2006 Actual	FY2007 Actual
State HIV/AIDS	0.0	0.0	0.0	488.1	1,373.9	1,777.1	2,869.0
USAID Global Health	1,115.1	1,297.5	1,572.0	1,451.4	1,314.6	1,456.9	1,653.9
Global Fund	100.0	50.0	248.4	397.6	248.0	445.5	625.0
State-Foreign Operations	1,215.1	1,347.5	1,820.4	2,337.1	2,936.5	3,679.5	5,147.9
CDC Global Health	224.1	315.5	344.0	427.9	302.1	311.7	307.6
NIH Global AIDS Research	160.1	218.2	278.5	317.2	369.5	373.0	361.7
Global Fund	0	125.0	99.0	149.0	99.2	99.0	99.0
DOL HIV/AIDS	10.0	10.0	9.9	2.0	0.0	0.0	0.0
Labor-HHS Appropriations	390.8	665.3	728.0	903.9	772.7	783.7	768.3
DOD HIV/AIDS	10.0	14.0	7.0	4.3	7.5	5.2	0.0
Total Global Health	1,715.9	2,076.8	2,803.8	3,642.9	3,964.7	4,715.9	6,163.7
Agency/Department	FY2008 Actual	FY2009 Actual	FY2010 Actual	FY2011 Actual	FY2012 Estimate	FY2013 Consolidated ^a	FY2014 Request
State HIV/AIDS	4,116.4	4,559.0	4,609.0	4,585.8	4,242.9	4,070.5	4,020.0
USAID Global Health	1,834.2	2,030.0	2,518.6	2,498.0	2,625.0	2,641.1	2,645.0
Global Fund	545.5	700.0	750.0	748.5	1,300.0	1,650.0	1,650.0
State-Foreign Operations	6,496.1	7,289.0	7,877.6	7,832.3	8,417.9	8,361.6	8,315.0
CDC Global Health	302.3	319.1	334.8	330.2	347.6	not specified ^a	393.0
NIH Global AIDS Research	411.7	451.7	485.6	375.7	392.4	392.0	399.1
Global Fund	294.8	300.0	300.0	297.3	0.0	0.0	0.0
DOL HIV/AIDS	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Labor-HHS Appropriations	1,008.8	1,060.5	1,132.3	1,013.1	740.0	not specified ^a	792.1
DOD HIV/AIDS	8.0	8.0	8.0	10.0	8.0	not specified ^a	0.0
Total Global Health	7,512.9	8,457.5	9,017.9	8,855.4	9,165.9	not specified ^a	9,107.1

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

Notes: This table does not include funding for the UN Children's Fund (UNICEF), which was appropriated to the Child Survival and Health account prior to FY2004.

Figures in FY2001-2008 include funds appropriated to multiple accounts within State-Foreign Operations. Figures in FY2009-FY2013 only include appropriations to the Global Health Programs Account.

a. The FY2013 Consolidated Act did not specify an amount.

Table C-2. State-Foreign Operations Appropriations, FY2001-2014

(current U.S. \$ millions)

Agency/Program	FY2001 Actual ^a	FY2002 Actual ^a	FY2003 Actual ^a	FY2004 Actual ^a	FY2005 Actual ^a	FY2006 Actual ^a	FY2007 Actual ^a
HIV/AIDS	305.0	395.0	587.7	513.5	347.2	346.5	325.0
Tuberculosis	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
USAID Global Fund	100.0	50.0	248.4	397.6	248.0	247.5	247.5
Maternal/Child Health	295.3	315.0	411.9	328.1	347.5	369.6	392.6
Nutrition ^c	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Vulnerable Children	14.9	25.0	26.8	27.8	24.5	12.6	6.5
Family Planning/Reproductive Health	376.2	402.5	391.0	398.1	396.8	393.5	396.5
Neglected Tropical Diseases ^d	n/a	n/a	n/a	n/a	n/a	14.8	14.9
Pandemic Flu/Other	18.7	35.0	25.8	29.6	39.8	139.2	189.6
USAID Total	1,215.1	1,347.5	1,820.4	1,849.0	1,562.6	1,704.4	1,901.4
State Department HIV/AIDS ^e	n/a	n/a	n/a	488.1	1,373.9	1,777.1	2,869.0
State Department Global Fund ^f	n/a	n/a	n/a	n/a	n/a	198.0	377.5
State Department Total	0.0	0.0	0.0	488.1	1,373.9	1,975.1	3,246.5
State-Foreign Operations 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 ^a	FY2009 Actual ^b	FY2010 Actual ^b	FY2011 Actual ^b	FY2012 Estimate ^b	FY2013 Consolidated	FY2014 Request
HIV/AIDS	347.2	350.0	350.0	349.3	350.0		330.0
Tuberculosis	148.0	162.5	225.0	224.6	236.0		191.0
Malaria	347.2	382.5	585.0	618.8	650.0		670.0
USAID Global Fund	0.0	100.0	0.0	0.0	0.0		0.0
Maternal/Child Health	449.0	440.1	474.0	548.9	605.6	not specified ^g	680.0
Nutrition ^c	n/a	54.9	75.0	89.8	95.0		95.0
Vulnerable Children	14.9	15.0	15.0	15.0	17.5		13.0
Family Planning/Reproductive Health	398.0	455.0	528.6	527.0	523.9		534.0
Neglected Tropical Diseases ^d	14.9	25.0	65.0	76.8	89.0		85.0
Pandemic Flu/Other	115.0	145.0	201.0	47.9	58.0		47.0
USAID Total	1,834.2	2,130.0	2,518.6	2,498.0	2,625.0	2,641.1	2,645.0
State Department HIV/AIDS ^e	4,116.4	4,559.0	4,609.0	4,585.8	4,492.9	4,070.5	4,020.0
State Department Global Fund ^f	545.5	600.0	750.0	748.5	1,300.0	1,650.0	1,650.0
State Department Total	4,661.9	5,159.0	5,359.0	5,334.3	5,792.9	5,720.5	5,670.0
State-Foreign Operations Total	6,496.1	7,289.0	7,877.6	7,832.3	8,417.9	8,361.6	8,315.0

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

Notes: This table does not include funding for the UN Children’s Fund (UNICEF), which was appropriated to the Child Survival and Health account prior to FY2004.

- a. Figures in FY2001-2008 include funds appropriated to multiple accounts within State-Foreign Operations.
- b. Figures in FY2009-FY2013 only include appropriations to the Global Health Programs Account.
- c. After the announcement of GHI in 2009, Congress began to appropriate funds for nutrition programs. Until then, nutrition funds were included in appropriations for maternal and child health programs.
- d. USAID received its first appropriation for neglected tropical diseases per language in the FY2006 State Foreign Operations appropriations that directed USAID to make available at least \$15 million for fighting seven NTDs.
- e. The Department of State received its first appropriation for managing PEPFAR funds through FY2004 State Foreign Operations appropriations.
- f. Congress provided funds to the State Department for a contribution to the Global Fund for the first time in FY2006 through the FY2006 State Foreign Operations appropriations.
- g. The FY2013 Consolidated Act did not specify an amount.

Table C-3. Labor, HHS Appropriations, FY2001-2014

(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
<i>Polio</i>	91.2	107.4	106.4	96.8	101.2	101.1	99.8
<i>Other Global/Measles</i>	15.4	26.4	42.4	41.0	43.2	43.2	42.6
Parasitic Disease/Malaria	n/a	n/a	n/a	n/a	n/a	n/a	n/a
<i>Malaria</i>	13.0	13.0	12.6	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
FE(L)TP/SMDP	n/a	n/a	n/a	2.4	3.4	3.4	3.3
CDC Total	224.1	315.5	344.0	427.9	302.1	311.7	307.6
NIH Global AIDS Research	160.1	218.2	278.5	317.2	369.5	373.0	361.7
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	394.2	668.7	731.4	904.0	772.8	783.7	768.3
HHS Program	FY2008 Actual	FY2009 Actual	FY2010 Actual	FY2011 Actual	FY2012 Estimate	FY2013 Consolidated	FY2014 Request
Global AIDS Program (GAP)	118.9	118.9	119.0	118.7	117.1		131.9
Immunizations	139.8	143.3	153.7	150.9	160.3		183.0
<i>Polio</i>	98.0	101.5	101.8	101.6	111.3		131.0
<i>Other Global/Measles</i>	41.8	41.8	51.9	49.3	49.0		52.0
Parasitic Disease/Malaria ^a	n/a	n/a	19.8	19.9	19.4		22.2
<i>Malaria</i>	8.7	9.4	9.4	9.4	9.4	not specified ^b	10.7
Global Disease Detection	31.4	33.7	44.2	41.9	41.6		45.6
FE(L)TP/SMDP	3.5	13.8	8.5	9.3	9.2		10.3
CDC Total	302.3	319.1	345.2	340.7	347.6		393.0
NIH Global AIDS Research	411.7	451.7	485.6	375.7	392.4		399.1
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	1,008.8	1,070.8	1,130.8	1,013.7	740.0	not specified ^b	792.1

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

Acronyms: not applicable (n/a), not specified (n/s), Field Epidemiology Laboratory Training Program (FELTP)/Sustainable Management Development Program (SMDP).

- a. The FY2012 Congressional Budget Justification proposed creating a new funding category, Parasitic Diseases/Malaria, that combined funding for programs aimed at addressing parasitic diseases (like neglected tropical diseases) with those aimed at combating malaria. Since FY2010, CDC operating plans have reported spending in this fashion.
- b. The FY2013 Consolidated Act did not specify an amount.

Table C-4. PEPFAR, FY2001-FY2014

(current U.S. \$ millions)

Agency/Department	FY2001 Actual	FY2002 Actual	FY2003 Actual	FY2004 Actual	FY2005 Actual	FY2006 Actual	FY2007 Actual
State HIV/AIDS ^a	0.0	0.0	0.0	488.1	1,373.9	1,975.1	3,246.5
<i>State Global Fund^b</i>	<i>0.0</i>	<i>0.0</i>	<i>0.0</i>	<i>0.0</i>	<i>0.0</i>	<i>198.0</i>	<i>377.5</i>
USAID Global HIV/AIDS	405.0	445.0	836.1	911.1	595.2	594.0	572.5
<i>USAID Global Fund</i>	<i>100.0</i>	<i>50.0</i>	<i>248.4</i>	<i>397.6</i>	<i>248.0</i>	<i>247.5</i>	<i>247.5</i>
State-Foreign Operations	405.0	445.0	836.1	1,399.2	1,969.1	2,569.1	3,819.0
CDC Global HIV/AIDS	104.5	168.7	182.6	266.9	123.8	122.6	121.0
NIH Global AIDS Research	160.1	218.2	278.5	317.2	369.5	373.0	361.7
HHS Global Fund	0.0	125.0	99.0	149.0	99.2	99.0	99.0
DOL Global HIV/AIDS	10.0	10.0	9.9	9.9	2.0	0.0	0.0
Labor-HHS Appropriations	274.6	521.9	570.0	743.3	594.5	594.6	581.7
DOD Global HIV/AIDS	10.0	14.0	7.0	4.3	7.5	5.2	0.0
Total PEPFAR	689.6	980.9	1,413.1	2,146.5	2,571.1	3,168.9	4,400.7
Total Global Fund	100.0	175.0	347.4	546.6	347.2	544.5	724.0
Agency/Department	FY2008 Actual	FY2009 Actual	FY2010 Actual	FY2011 Actual	FY2012 Estimate	FY2013 Consolidated	FY2014 Request
State HIV/AIDS ^a	4,661.9	5,159.0	5,359.0	5,334.3	5,542.9	4,070.5	4,020.0
<i>State Global Fund^b</i>	<i>545.5</i>	<i>600.0</i>	<i>750.0</i>	<i>748.5</i>	<i>1,300.0</i>	<i>1,650.0</i>	<i>1,650.0</i>
USAID Global HIV/AIDS	347.2	450.0	350.0	349.3	350.0	not specified ^c	330.0
<i>USAID Global Fund</i>	<i>0.0</i>	<i>100.0</i>	<i>0.0</i>	<i>0.0</i>	<i>0.0</i>	<i>0.0</i>	<i>0.0</i>
State-Foreign Operations	5,009.1	5,609.0	5,709.0	5,683.6	5,892.9	not specified^c	6,000.0
CDC Global HIV/AIDS	118.9	118.9	119.0	118.7	117.1	not specified ^c	131.9
NIH Global AIDS Research	411.7	451.7	485.6	375.7	364.7	392.0	399.1
HHS Global Fund	294.8	300.0	300.0	297.3	0.0	0.0	0.0
DOL Global HIV/AIDS	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Labor-HHS Appropriations	825.4	870.6	904.6	791.7	481.6	not specified^c	531.0
DOD Global HIV/AIDS	8.0	8.0	10.0	10.0	8.0	not specified ^c	0.0
Total PEPFAR	5,842.5	6,487.6	6,623.6	6,485.3	6,382.5	not specified^c	6,531.0
Total Global Fund	840.3	1,000.0	1,050.0	1,045.8	1,300.0	1,650.0	1,650.0

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

Notes: Rows that are indented and italicized are included within totals of the preceding rows.

- a. The Department of State received its first appropriation for managing PEPFAR funds through FY2004 State Foreign Operations appropriations.
- b. Congress provided funds to the State Department for a contribution to the Global Fund for the first time in FY2006 through the FY2006 State Foreign Operations appropriations.
- c. The FY2013 Consolidated Appropriations Act did not specify an amount.

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