U.S. Global Health Assistance: FY2001-FY2016

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Summary

Congressional support for global health programs has remained strong for several years. U.S. global health funding rose from $1.7 billion in FY2001 to $9.3 billion in FY2015. These funds are managed by several U.S. agencies and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund)—a multilateral organization aimed at fighting the three diseases worldwide. Concern about infectious diseases, especially HIV/AIDS, tuberculosis, and malaria (HTAM), continues to drive budget growth. In FY2001, roughly 47% of the U.S. global health budget was aimed at these three diseases. By FY2015, roughly 70% of the U.S. global health budget was provided for fighting HTAM. The **Appendix** outlines U.S. funding for global health by agency and program. The 114th Congress may debate several pressing global health issues, including the folloring.

FY2016 Budget Request. The FY2016 budget request includes more than $9 billion for global health programs, roughly 2% less than in FY2015. The Administration proposes significant cuts through State-Foreign Operations for vulnerable children (-34%), global health security (-31%), tuberculosis (-19%), the Global Fund (-18%), neglected tropical diseases (-14%), and nutrition (-12%). The President is seeking a 5% increase for global health programs funded through the Labor-HHS appropriations. Some observers have questioned why the Administration has requested lower spending levels for programs aimed at advancing global health security and addressing infectious disease through State-Foreign Operations appropriations, while seeking an increase for similar programs through Labor-HHS Appropriations.

Coordinating Bilateral Health Programs. In his first term, President Obama announced the Global Health Initiative (GHI) to coordinate U.S. bilateral health programs. After having established interagency GHI task forces and developed interagency country health plans for 28 countries, the initiative appears to have stalled. The Administration has not nominated a GHI Coordinator and the interagency teams have largely disbanded. Some advocates assert that GHI was a good model and that global health programs need to be coordinated. Supporters of this idea assert that coordinated health programs are more cost-efficient, can have greater impact, and can advance country ownership. Detractors argue that this approach adds bureaucracy and could exacerbate interagency tensions. Concerns about disparate legislative oversight authorities have also been raised.

Strengthening Health Systems. The international community has coalesced around reducing maternal and mortality rates, as well as deaths caused infectious diseases. While these efforts have improved health outcomes in these areas, this approach has left many countries ill-prepared to address other health issues like disease outbreaks. The Ebola epidemic has prompted calls for investing in health systems to help countries withstand unanticipated health shocks, like disease outbreaks, but also to address looming health issues like noncommunicable disease. Opponents are concerned, however, that such an approach is difficult to measure and oversee.

The Growing Influence of Non-State Actors. Although the United States remains the largest donor for health assistance worldwide, some observers believe its influence is diminishing as non-state actors play a greater role. In 2013, for example, spending on global health by the Bill & Melinda Gates Foundation was higher than all countries in the Development Assistance Community except the United States. Some groups are also concerned that the United States is minimizing its ability to protect its priorities as it channels more funds to multilateral actors like the Global Fund and the GAVI Alliance. Others counter, however, that participation in these

organizations enables the United States to attract additional resources for global health programs and reduce redundancies. Supporters also point out that the United States plays a leading role in most multilateral health programs. For example, Ambassador Mark Dybul (the former PEPFAR Coordinator) is the Executive Director of the Global Fund, and U.S. officials sit on several influential Global Fund boards.

In addition to these issues, the 114th Congress may also discuss how to address other impending health challenges, such as rising noncommunicable disease prevalence, emerging diseases, and pandemic threats.

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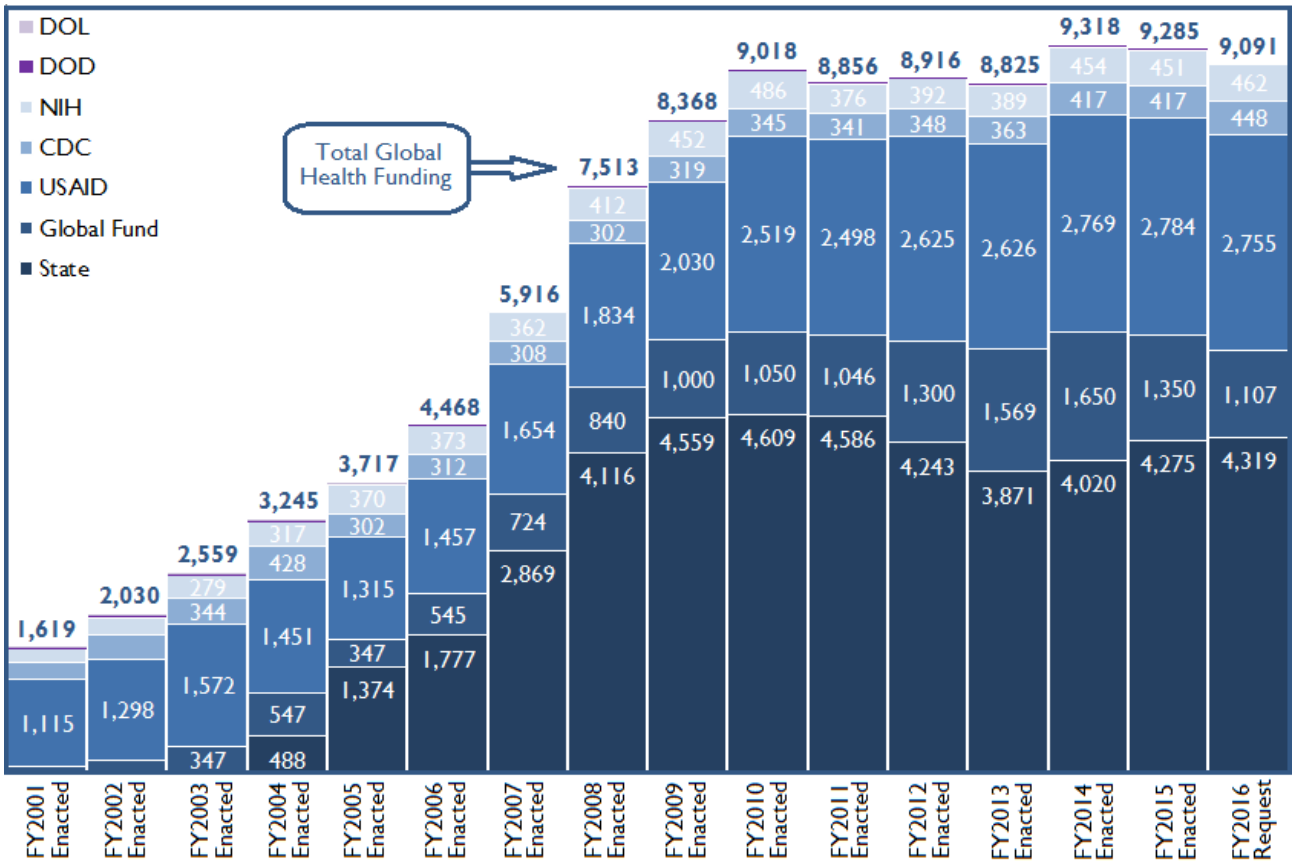
Introduction

Congress has demonstrated sustained interest in global health with annual appropriations increasingly significantly throughout the Bush Administration and averaging nearly $9 billion during the Obama Administration. U.S. government funding for global health has grown from $1.6 billion in FY2001 to $9.3 billion in FY2015 (**Figure 1**). 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 such diseases pose to economic development, stability, and security and launched a series of health initiatives to address them.

Figure 1. Global Health Funding: FY2001-FY2016 (request)

(current U.S. $ millions)



Source: Created by CRS from correspondence with the Office of Management and Budget (OMB) and the Office of the Global AIDS Coordinator (OGAC), appropriations legislation, and budgetary requests.

Acronyms: Department of Labor (DOL), Department of Defense (DOD), National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDC), U.S. Agency for International Development (USAID), Department of State (State).

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] 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] Prompted in part by the West Africa Ebola epidemic, the 114th Congress has begun deliberating how to address concerns about weak health systems while preserving congressional priorities for key global health programs like PEPFAR. The Ebola epidemic revealed not only the threat that weak health systems in developing countries pose to the world, but also elucidated gaps in international frameworks for responding to global health crises. Consensus is emerging that health system strengthening is important for protecting advancements in global health and for bolstering international security, though debate abounds regarding the appropriate approach for achieving this goal and the role the United States might play in such efforts, especially in relation to other U.S. global health assistance priorities.

Advancements in Global Health

In 2000, the international community established the Millennium Development Goals (MDGs) a global commitment to advance economic development and reduce suffering worldwide by 2015. The MDGs focus on eight key areas, three of which focus on health issues (**Figure 2**). Each MDG includes a set of targets that are used to measure progress in attaining the goals. Although none of the health-related targets were met, global efforts have resulted in health improvements worldwide. The section below summarizes these advancements.

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

[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, *U.S. International Family Planning Programs: Issues for Congress*.

Maternal and Child Health

Figure 2. United Nations Millennium Development Goals

Source: United Nations webpage on the MDGs at http://www.un.org/millenniumgoals

Intensified efforts to improve healthcare during pregnancy and childbirth has resulted in a 45% reduction in maternal deaths from 1990, when 523,000 women died from complications in pregnancy and childbirth.[6] Nonetheless, in every day of 2013, on average almost 800 women died from complications in pregnancy and childbirth, amounting to 289,000 deaths. Roughly one-third of these deaths occurred in Nigeria and India. Human resource constraints continue to complicate efforts to reduce maternal mortality. In many developing countries, especially in sub-Saharan Africa, pregnant women deliver their babies without the assistance of trained health practitioners who can help to avert deaths caused by hemorrhage. The World Health Organization (WHO) estimates that 27% of all maternal deaths are caused by severe bleeding. Pre-existing conditions like HIV/AIDS and malaria are also key contributors to maternal mortality, accounting for roughly 28% of maternal deaths.

International efforts to improve child health have roughly cut the number of child deaths in half from 12.7 million in 1990 to 6.3 million in 2013.[7] WHO estimates that more than half of the 1,700 child deaths that occurred in each day of 2013 could have been avoided through low-cost interventions, such as medicines to treat pneumonia, diarrhea, and malaria, as well as tools that prevent the transmission of malaria and HIV/AIDS from mother to child.[8] Other factors, like inadequate access to nutritious food, also impact child health. WHO estimates that undernutrition contributes to roughly 45% of all child deaths.[9] The risk of a child dying is at its highest within the first month of life, when 44% of all child deaths occur. Children in sub-Saharan Africa are more than 15 times more likely to die before reaching age five than their counterparts in developed countries.

HIV/AIDS

In 2012, roughly 2.3 million people worldwide contracted HIV, a 33% reduction in new infections compared to 2001. Some 70% of new HIV cases occurred in sub-Saharan Africa. While the number of new cases is declining, the number of people living with HIV is rising. In 2012, more than 35 million people were living with HIV globally. Expanded access to anti-

[6] Unless otherwise indicated, all statistics in this paragraph are from WHO, "Saving Mothers' Lives," infographic, 2014.

[7] United Nations Children's Fund (UNICEF), *The State of the World's Children*, 2015.

[8] WHO, "Children: reducing mortality," Fact sheet number 178, September 2014.

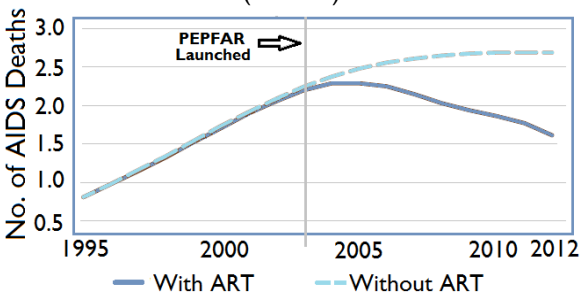
[9] Ibid.

retroviral treatments has decreased the number of people dying from AIDS-related causes. In 2012, 1.6 million people died from HIV/AIDS, down from the peak of 2.3 million in 2005.

The United States has contributed substantially to improving global access to ART through PEPFAR and its support for the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund). In 2012, WHO estimated that 9.7 million people in low- and middle-income countries were receiving ART.[10] By the end of September 30, 2014, PEPFAR was supporting the provision of ART to roughly 7.7 million people.[11]

Figure 3. AIDS Deaths Worldwide: 1995-2012

(millions)



Source: Adapted by CRS from the Joint United Nations Program on AIDS (UNAIDS), *2013 Global Report*, 2013.

Other Infectious Diseases

In recent years, a succession of new and reemerging infectious diseases have caused outbreaks and pandemics that have affected thousands of people worldwide: Severe Acute Respiratory Syndrome (SARS, 2003), Avian Influenza H5N1 (2005), Pandemic Influenza H1N1 (2009), Middle East Respiratory Syndrome coronavirus (MERS-CoV, 2013), and the ongoing Ebola outbreak in West Africa. The incapacity of the Guinea, Liberia, and Sierra Leone to contain and end the ongoing Ebola epidemic has revealed the threat that weak health systems pose to the world. The United States plays a leading role in the Global Health Security Agenda, a multilateral effort to improve the capacity of countries worldwide to detect, prevent, and respond to diseases with pandemic potential.

At the same time that the world faces threats from new diseases, long-standing diseases like tuberculosis (TB) continue to pose a threat to global health security. Among infectious diseases, TB is the second most common cause of death worldwide. Multi-drug resistant (MDR)-TB is of growing concern, as it is more expensive and difficult to treat. Less than half of all MDR-TB patients survive. WHO asserts that global funding for addressing MDR-TB is insufficient and weaknesses in health systems complicate efforts to treat the disease and prevent its further spread.

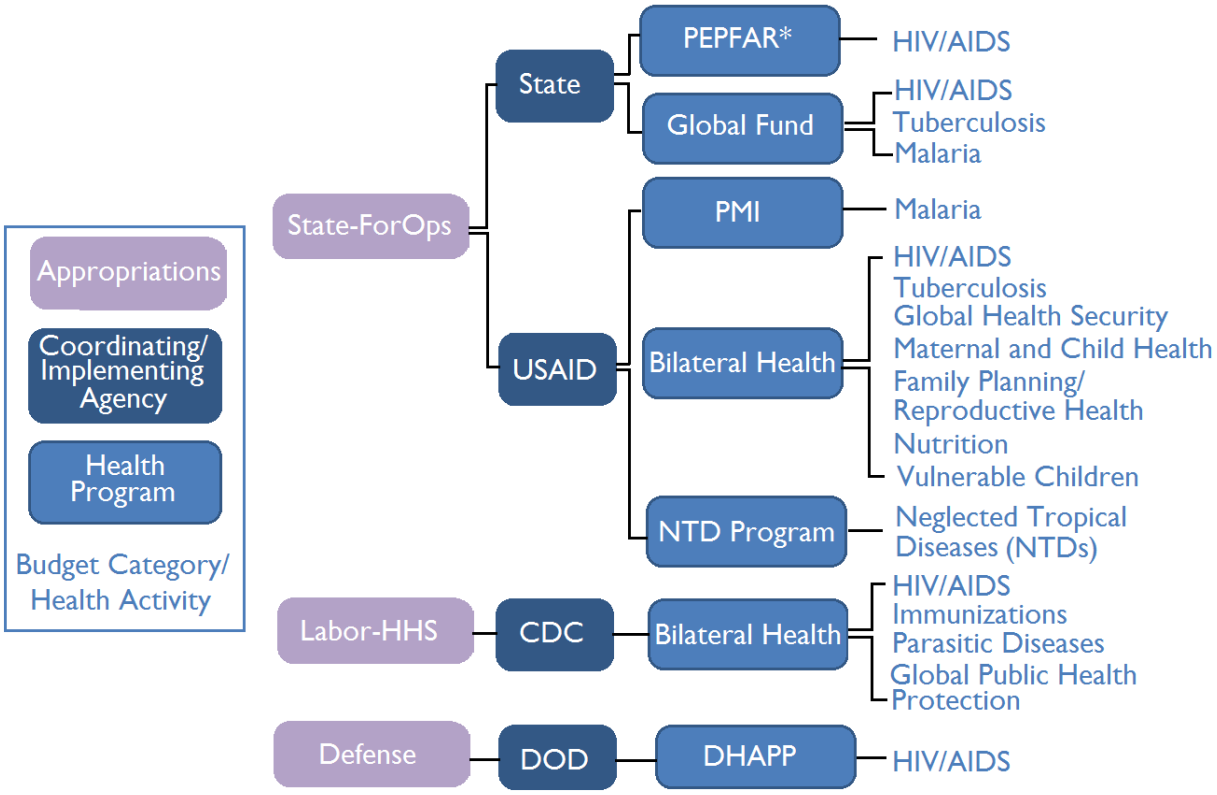
Appropriations for U.S. Global Health Programs

Congress funds most global health assistance through three appropriations bills: State-Foreign Operations and Related Programs (State-ForOps); Labor, Health and Human Services, and Education (Labor-HHS); and Department of Defense (DOD) (**Figure 4**). These bills are used to fund global health efforts implemented by USAID, CDC, and the Department of Defense, including PEPFAR programs that are coordinated by the Department of State and implemented by several U.S. agencies. Through PEPFAR, the United States contributes to multilateral efforts to combat HIV/AIDS, TB, and malaria (HATM), including the Global Fund and the Joint United Nations Program on HIV/AIDS (UNAIDS).

[10] WHO, *World Health Statistics Report*, 201.

[11] OGAC, *"World AIDS Day 2014 Update: PEPFAR Latest Results*," Fact Sheet, 2014.

Figure 4. U.S. Global Health Assistance: Appropriation Vehicles



Source: Created by CRS from appropriations legislation.

Notes: *PEPFAR is implemented by each of the departments and agencies listed within the figure.

Acronyms: Department of State (State), Foreign Operations (ForOps), Department of Labor (Labor), Department of Health and Human Services (HHS), U.S. Agency for International Development (USAID), Department of State (State), U.S. Centers for Disease Control and Prevention (CDC), U.S. Department of Defense (DOD), President's Emergency Plan for AIDS Relief (PEPFAR), President's Malaria Initiative (PMI), DOD HIV/AIDS Prevention Program (DHAPP).

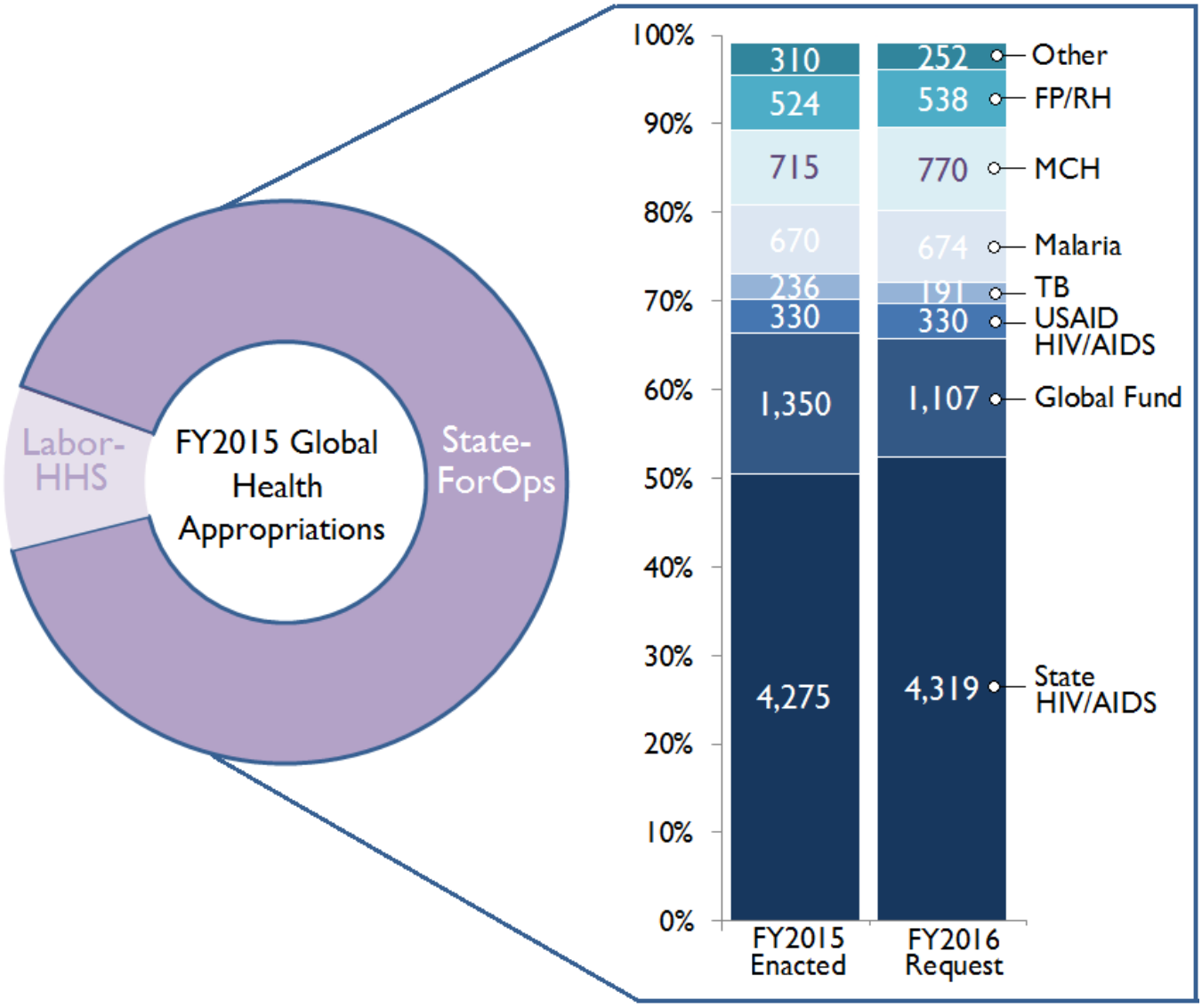
State-Foreign Operations Appropriations

The majority of appropriations for global health programs are provided through the Global Health Programs Account (GHP) in State-Foreign Operations appropriations (**Figure 5**). More than 80% of the funds are used for fighting HATM through bilateral programs and the Global Fund. A table outlining global health funding through State-Foreign Operations is included in **Appendix**.

Labor-HHS Appropriations

Through Labor-HHS appropriations, Congress funds global health programs implemented by CDC and global HIV/AIDS research conducted by the National Institutes of Health (NIH). Labor-HHS appropriations do not specify an amount for NIH global HIV/AIDS research, 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**.

Figure 5. Global Health Funding by Appropriation Vehicle: FY2015 and FY2016



Source: Created by CRS from appropriations legislation and budget requests.

Notes: The FY2015 global health donut Includes appropriations for the Department of Defense. The "other" row includes funding for nutrition, vulnerable children, neglected tropical diseases, and pandemic influenza programs.

Acronyms: family planning and reproductive health (FP/RH), maternal and child health (MCH), tuberculosis (TB), U.S. Agency for International Development (USAID), Department of State (State), Department of Health and Human Services (HHS), Foreign Operations (ForOps).

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**.

Implementing Agencies and Departments

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

U.S. Agency for International Development[12]

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 vaccine-preventable deaths, malaria, and undernutrition; supporting vulnerable children and orphans; and increasing access to family planning.
- **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 Prevention[13]

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.
- **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 Immunization.** CDC works to advance several global immunization initiatives aimed at preventable diseases, including polio, measles, rubella, and

[12] 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.

[13] 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.

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. Through the Global Disease Detection (GDD) program, CDC builds capacity to monitor, detect, and assess disease threats and responds to requests from other U.S. agencies, United Nations agencies, and nongovernmental organizations for support in humanitarian assistance activities.

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).[14] 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."[15] 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.

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.[16] The only global health activity for which Congress provides a specific

[14] GHI, "Global Health Initiative Next Steps - A Joint Message," press release, July 3, 2012.

[15] Department of State, "Strengthening Global Health by Elevating Diplomacy," blog post, December 14, 2012.

[16] 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.

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 DOD 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.[17] **Table A-3** in the **Appendix** outlines annual funding for DHAAP.

Presidential Health Initiatives

As previously discussed, Presidents Clinton and Bush created global health initiatives to address infectious diseases (**Figure 6**). 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 6. Timeline of Presidential Health Initiatives

Source: Created by CRS.

President's Emergency Plan for AIDS Relief (PEPFAR)[18]

In January 2003, President Bush announced PEPFAR, a government-wide initiative to combat global HIV/AIDS. 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 bilateral HIV/AIDS programs and multilateral efforts, like those carried out by the Global Fund.

In 2008, Congress enacted the Lantos-Hyde Act (P.L. 110-293), which amended the Leadership Act to authorize the appropriation of $48 billion for global HIV/AIDS, TB, and malaria efforts from FY2009-FY2013. In November 2013, Congress enacted P.L. 113-56, the PEPFAR Stewardship and Oversight Act. [19] The act did not extend the multi-year funding authority. There is some debate about how this might impact the program. This issue is discussed further in the Issues for Congress section.

[17] 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/nhrc/dhapp/Pages/default.aspx.

[18] 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*.

[19] For more information on the PEPFAR Stewardship and Oversight Act, see CRS Report R43232, *The President's Emergency Plan for AIDS Relief (PEPFAR), U.S. Global HIV/AIDS, Tuberculosis, and Malaria Programs: A Description of Permanent and Expiring Authorities.*

President's Malaria Initiative (PMI)[20]

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 preventive treatment for pregnant women (IPTp). [21] 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 Leadership Act, as amended 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) Program[22]

The NTD Program started in 2006, following FY2006 appropriations language that directed USAID to make available at least $15 million for fighting seven NTDs.[23] 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)

Early in his Administration, President Obama announced the Global Health Initiative (GHI) to strengthen health systems, improve the coordination and integration of U.S. bilateral global health programs, and expand results-based funding. Other stated goals of GHI were to:

- increase the impact of U.S. global health investments;
- advance country ownership of health aid; and
- enhance program monitoring and evaluation and research and innovation.

[20] 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*.

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

[22] 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 FY2015*.

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

As part of GHI, officials from USAID, Department of State and HHS jointly planned how U.S. global health aid would be spent and aligned this strategy with the national health plans of 28 priority recipient countries. Despite having developed country health plans, some question whether GHI continues to be carried out, as the prior coordinating mechanism for the initiative has lapsed and a new GHI Coordinator has not been identified.

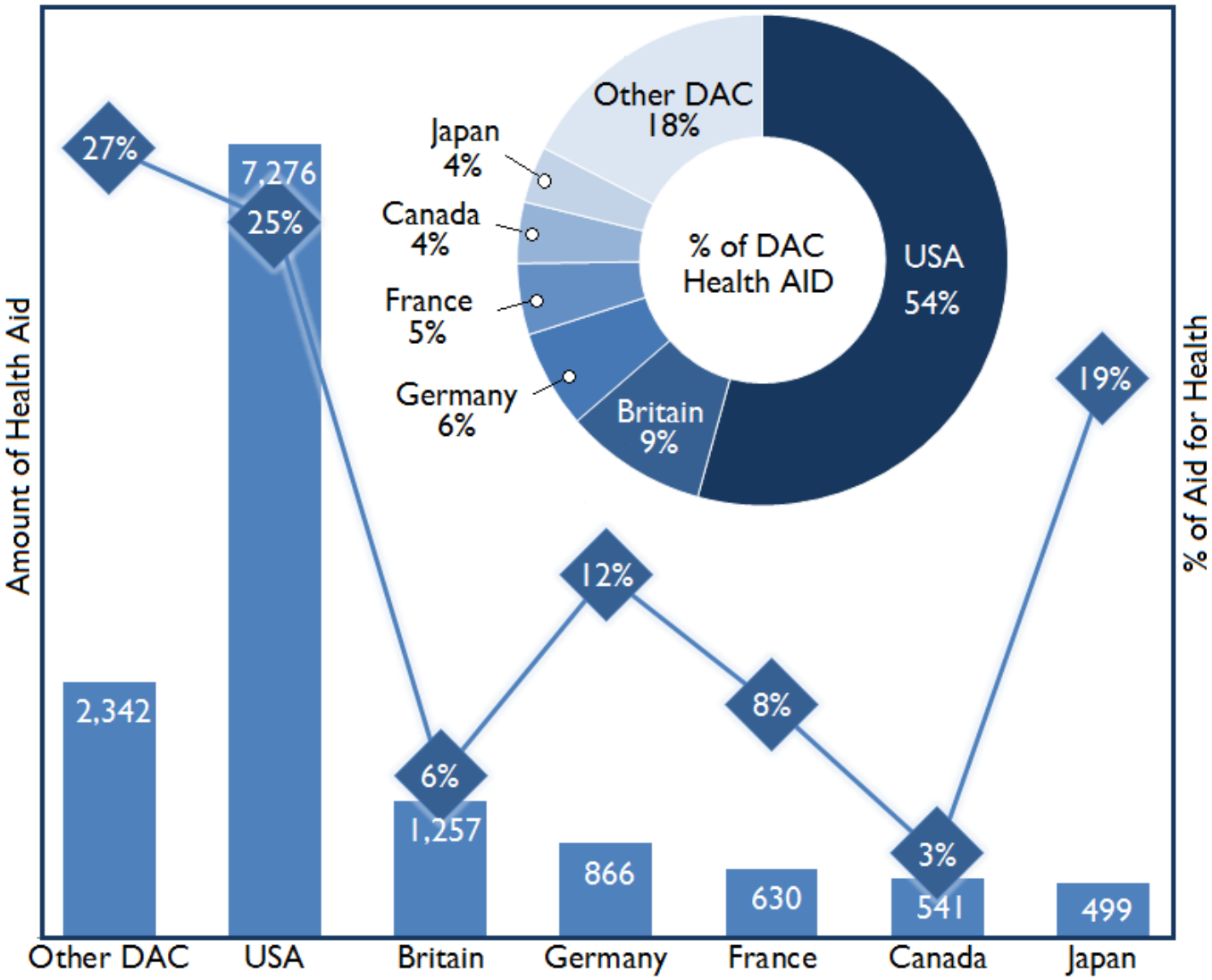
Global Health Spending by Other Stakeholders

The United States provides more official development assistance (ODA) for health than any other country in the Development Assistance Committee (DAC).[24] In 2013, U.S. spending on global health accounted for more than half of all health aid provided by DAC members (**Figure 7**). 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 7**, Canada is the only other donor that apportions 28% of its ODA to health aid.

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

Figure 7. Official Development Assistance for Health by Donor Country, 2013

(current U.S. $ millions and percentages)



Source: Created by CRS from the Organization for Economic Cooperation and Development (OECD) website on statistics at http://www.oecd.org/statistics/, accessed on March 30, 2015.

Notes: Data in this figure reflects reported spending by DAC countries. 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.

The 2013 amount for the United States excludes a $1.56 billion U.S. contribution to the Global Fund.

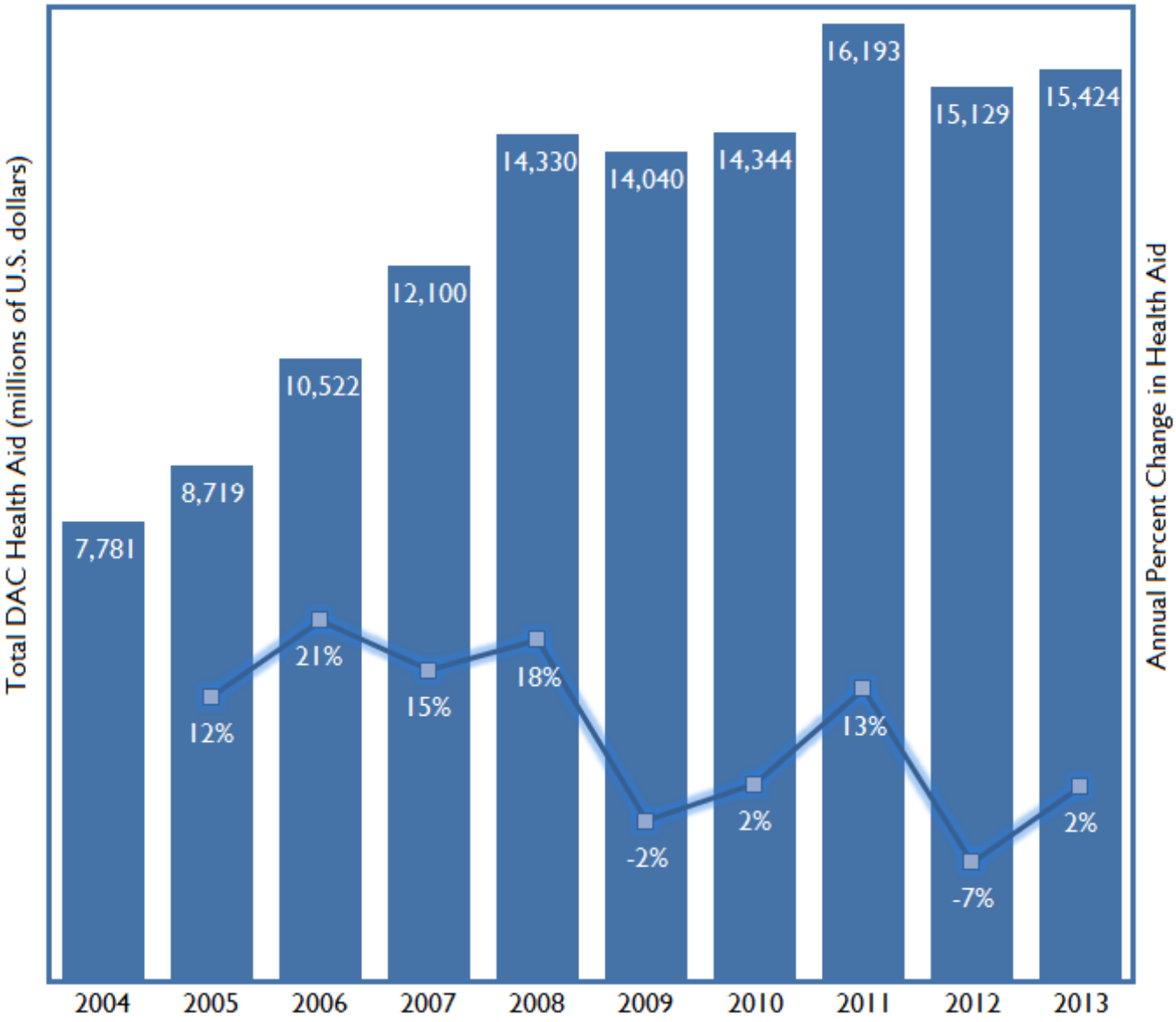
In 2013, ODA for health by other DAC countries include Norway ($386 million), Australia ($371 million), Korea ($331 million), Sweden ($289 million), Netherlands ($211 million), Switzerland ($155 million), Belgium ($153 million), Ireland ($94 million), Italy ($72 million), Spain ($58 million), Austria ($51 million), Luxembourg ($50 million), Denmark ($47 million), New Zealand ($25 million), Finland ($24 million), Portugal ($17 million), Iceland ($3 million), Czech Republic ($2 million), Poland ($1 million), and Slovenia ($1 million).

Funding for global health assistance has grown over the past decade (**Figure 8**). Between 2004 and 2014, DAC countries and other donors nearly doubled their support for global health aid. Development assistance for health grew most robustly from 2004 through 2008 and vacillated

thereafter. Nonetheless, donor support for global health has remained firm and has been primarily aimed at addressing key ailments like HIV/AIDS.

Figure 8. Official Development Assistance for Health, FY2005-FY2013

(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 March 23, 2015.

Issues for the 114th Congress

In 1978, at the International Conference on Primary Health Care, health experts drafted the Alma-Ata Declaration, an international commitment to ensure "an acceptable level of health for all the

people of the world by the year 2000."[25] Member countries of the World Health Organization endorsed the Declaration the following year at the 32nd World Health Assembly. The Declaration was ground-breaking as it was the first time that the international community agreed to focus on primary health and it prioritized specific health issues. In 2000, the United Nations General Assembly adopted the Millennium Development Goals, which included a set of targets for achieving specific health outcomes by 2015, including reducing child mortality by two-thirds, reducing maternal mortality by three-quarters and having halted the spread of HIV.[26] As discussed earlier, progress has been made in some areas, but key health challenges remain. The United Nations General Assembly has agreed to reconvene in September 2015 and adopt Sustainable Development Goals aimed at addressing residual health and development issues.[27] While donors remain committed to improving access to quality primary health, some groups are drawing attention to other issues, such as global health security and health system strengthening.

Since the Alma-Ata Declaration was signed, health experts have debated the merits of focusing on select health issues. Detractors argued that "selective primary health care" was a "narrow technocentric approach that diverted attention away from basic health and socioeconomic development and did not address the social causes of diseases."[28] Supporters of the selective primary health care approach asserted that it "created the right balance between scarcity and choice."[29] The merits of this process continue to be debated and such discussions have intensified in the 114th Congress. Opponents have argued that disease-specific programs exacerbate resource constraints in the public sector by establishing parallel bureaucracies and undermine local government capacity by drawing limited local resources to donor-funded health programs. Supporters have asserted that vertical programs facilitate the measurement and evaluation of health programs, accelerate progress on addressing select health challenges by encouraging collaborative approaches, and enhance oversight capacity. This debate has continued in the global health community and remains a key issue facing the 114th Congress. This section explores the health system debate as well as other pressing global health issues.

FY2016 Budget

The FY2016 budget request includes more than $9 billion for global health programs, roughly 2% less than the FY2015 funding level (**Table 1**). The bulk of the reduction is comprised of a cut to the Global Fund (-18%) through the State-Foreign Operations appropriations, though the Administration also requests significant cuts for tuberculosis (-19%), nutrition (-12%), vulnerable children (-34%), neglected tropical diseases (-14%), and global health security (-31%). In light of the global impact of the West Africa Ebola epidemic, some observers question why the Administration is requesting reduced funding for USAID programs aimed at advancing global health security and addressing infectious diseases like TB. For detailed information on the State-Foreign Operations appropriations budget request and prior funding levels, see **Table A-2**.

[25] For more information on the Declaration of Alma-Ata, see http://www.who.int/.

[26] For more information on the MDGs, see http://www.un.org/millenniumgoals.

[27] For more information on the SDGs, see https://sustainabledevelopment.un.org.

[28] Cueto, Marcos, "The ORIGINS of Primary Health Care and Selective Primary Health Care," *American Journal of Public Health*, (November 2004), Issue 94, Number 11, pp. 1864-1874.

[29] Ibid.

In contrast to the State-Foreign Operations appropriations, the President is seeking a 5% increase for global health programs funded through the Labor-HHS appropriations. The bulk of the budgetary increase is for intensifying global health security efforts through the Global Public Health Protection program and to advance the Global Health Security Agenda. These efforts will be complemented by the establishment of National Public Health Institutes (NPHI) in 10 partner countries. The FY2015 Consolidated Appropriations (P.L. 113-235) provided $597 million for the establishment of NPHI as part of a $1.2 billion appropriation for CDC-managed international responses to the Ebola epidemic. For additional information on the Labor-HSS appropriations, see **Table A-3**.

Table 1. Global Health Funding by Agency, FY2013-FY2016 Request

(current U.S. $ millions)

	FY2013 Enacted	FY2014 Enacted	FY2015 Enacted[a]	FY2016 Request	FY2015-FY2016 ($)	FY2015-FY2016 (%)
State-GHP	3,870.8	4,020.0	4,275.0	4,319.0	+44.0	+1%
USAID-GHP	2,626.0	2,769.5	2,784.0[b]	2,755.0	-29.0	-1%
Global Fund	1,569.0	1,650.0	1,350.0	1,107.0	-243.0	-18%
State-ForOps Total	***8,065.8***	***8,439.5***	***8,409.0***	***8,181.0***	***-228.0***	***-3%***
CDC	362.8	416.8	416.5	448.1	+31.6	+8%
NIH	389.2	453.6	451.2	462.2	+11.0	+2%
Labor-HHS Total	***752.0***	***815.9***	***867.7***	***910.3***	***+42.6***	***+5%***
DOD	7.4	8.0	8.0	0.0[c]	n/a[c]	n/a[c]
Total Global Health	**8,825.2**	**9,317.9**	**9,284.7**	**9,091.3**	**-185.4**	**-2.1%**

Source: Created by CRS from correspondence with the OMB and OGAC, appropriations legislation, and budgetary requests.

Acronyms: Global Health Programs (GHP), United States Agency for International Development (USAID), State Foreign Operations Appropriations (State-ForOps) Centers for Disease Control and Prevention (CDC), National Institutes of Health (NIH), Department of Labor, HHS, and Education Appropriations (Labor-HHS), Appropriations (Apps.)

Notes: Excludes emergency appropriations for international responses to the Ebola epidemic.

a. FY2015 figures are budget authority designated in the Explanatory Statement for H.R. 83 (P.L. 113-235).

b. According to the FY2016 CBJ, an additional $4.3 million was transferred to the USAID GHP account from the State Department International Organizations and Programs account. Because the report did not explain the purpose of the transfer, this amount is not included in the FY2014 total. Additional funds are available for supporting global health programs through other USAID accounts. Funds from these accounts are not included in the above table.

c. The Department of Defense has not requested funds for global HIV/AIDS programs for several fiscal years. Nonetheless, military-to-military HIV/AIDS prevention activities remain an important part of PEPFAR programs and Congress has provided roughly $8 million to DOD annually for global HIV/AIDS activities since FY2008.

Coordinating U.S. Government Global Health Programs

In FY2015, Congress provided roughly $9.3 billion for global health programs. More than 60% were appropriated to the State Department for the coordination and oversight of global HIV/AIDS programs through PEPFAR and for a $1.3 billion contribution to the Global Fund. At

the same time, USAID coordinates and implements global health programs that amount to roughly 30% of U.S. spending on global health. The Department of Health and Human Services, including CDC, also plays a growing role in global health through its leadership in the Global Health Security Agenda, as well as the National Public Health Institutes. During the first term of the Obama Administration, President Obama announced the Global Health Initiative to improve the coordination and integration of U.S. bilateral global health programs. Other stated goals of GHI were to:

- strengthen health systems,
- expand results-based funding,
- increase the impact of U.S. global health investments,
- advance country ownership of U.S.-funded health programs,
- enhance program monitoring and evaluation, as well as research and innovation.

As part of GHI, the Department of State, USAID, and HHS jointly planned how U.S. global health aid would be spent and aligned this strategy with the national health plans of 28 priority recipient countries. The extent to which the strategy is being used is in question, as the prior coordinating mechanism for the initiative has lapsed and a new GHI Coordinator was not identified.

Some groups advocate for a Global Health Coordinator and see the Global AIDS Coordinator as an appropriate model. Through the Lantos-Hyde Act, Congress mandated that all agencies follow the policy guidance and implementing strategy developed by the Department of State (in collaboration with implementing agencies) while carrying out global HIV/AIDS programs. Similar to the Global AIDS Coordinator, the Global Health Coordinator could be responsible for developing a global health assistance strategy under which all U.S. global health programs operate. The coordinator could be responsible for reducing redundancy among implementing agencies, ensuring that the planning and implementation of U.S. global health programs are conducted collaboratively, and that each agency operates within its area of comparative advantage. Critics of establishing a Global Health Coordinator might argue that this approach could add bureaucracy and exacerbate interagency tensions. Concerns about addressing disparate legislative oversight authorities have also been raised.

Addressing Calls for Strengthening Health Systems

As discussed earlier, the international community has made significant strides in addressing key health issues, like maternal and child health. The Ebola epidemic has demonstrated some deficiencies in this approach and has prompted calls for investing "diagonally" in both vertical and "horizontal" health systems-based programs. According to WHO, there are six components of a health system:

- **Human resources.** The people who provide health care and support health delivery.
- **Governance and leadership.** Policies, strategies, and plans that countries employ to guide health programs.
- **Financing.** Mechanisms used to fund health efforts and allocate resources.

- **Commodities.** Goods that are used to provide health care.
- **Service delivery.** The management and delivery of health care.
- **Information.** The collection, analysis, and dissemination of health statistics for planning and allocating health resources.

Consensus is emerging that health system strengthening is important for global health objectives and for international security, though debate abounds regarding the appropriate approach for achieving this goal and the role the United States might play in such efforts, especially in relation to other U.S. global health assistance priorities. Supporters of health system strengthening argue that systems-based funding is cost-efficient because it can reduce redundancies, boost country ownership, and could ultimately eliminate the need for funding vertical programs. On the other hand, some groups caution that a global framework still needs to be developed that would identify indicators for measuring the impact of health systems programs, coordinating such efforts, and overseeing related resources.

The Growing Role of Non-State Actors

The global health funding system is becoming increasingly diverse as a variety of new actors become involved, particularly non-state actors like the private sector and private foundations. In 2013, 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 2013, the Gates Foundation spent some $2.2 billion on global health, almost $1 billion more than United Kingdom, the country that provided the second largest amount of health aid.[30]

Documents released by the Obama Administration and some pieces of legislation appear to welcome broader engagement in global health, particularly by 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.[31] 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?

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

[30] OECD online database at http://stats.oecd.org/, accessed on March 19, 2015.

[31] 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.

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.

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.[32] 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 address 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.[33] 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

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

[33] See the IHP+ website at http://www.internationalhealthpartnership.net/en/.

- **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 11, 2015, 52 countries have signed the International Health Partnership Compact. Other signatories include United Nations agencies, international lending institutions, multilateral organizations, and the Bill & Melinda Gates Foundation.[34] While the Obama Administration endorsed the agreement,[35] 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 noncommunicable 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 policy. 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 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.

[34] See http://www.internationalhealthpartnership.net/.

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

Appendix. U.S. Global Health Funding, FY2001-FY2016 Request

Table A-1. U.S. Global Health Funding, by Agency: FY2001-FY2016 Request

(current U.S. $ millions)

Agency/ Department	FY2001 Enacted	FY2002 Enacted	FY2003 Enacted	FY2004 Enacted	FY2005 Enacted	FY2006 Enacted	FY2007 Enacted	FY2008 Enacted	FY2009 Enacted	FY2010 Enacted	FY2011 Enacted	FY2012 Enacted	FY2013 Enacted	FY2014 Enacted	FY2015 Enacted	FY2016 Request
State HIV/AIDS	0.0	0.0	0.0	488.1	1,373.9	1,777.1	2.869.0	4,116.4	4,559.0	4,609.0	4,585.8	4,242.9	3,870.8	4,020.0	4,275.0	4,319.0
USAID	1,115.1	1,297.5	1,572.0	1,451.4	1,314.6	1,456.9	1,653.9	1,834.2	2,030.0	2,518.6	2,498.0	2,625.0	2,626.0	2,769.5	2,784.0	2,755.0
Global Fund	100.0	50.0	248.4	397.6	248.0	445.5	625.0	545.5	700.0	750.0	748.5	1,300.0	1,569.0	1,650.0	1,350.0	1,107.0
SFOPS	***1,215.1***	***1,347.5***	***1,820.4***	***2,337.1***	***2,936.5***	***3,679.5***	***5,147.9***	***6,496.1***	***7,289.0***	***7,877.6***	***7,832.3***	***8,167.9***	***8,065.8***	***8,439.5***	***8,409.0***	***8,181.0***
CDC	224.1	315.5	344.0	427.9	302.1	311.7	307.6	302.3	319.1	345.2	340.7	347.6	362.8	416.8	416.5	448.1
NIH Global AIDS	160.1	218.2	278.5	317.2	369.5	373.0	361.7	411.7	451.7	485.6	375.7	392.4	389.2	453.6	451.2	462.2
Global Fund	0.0	125.0	99.0	149.0	99.2	99.0	99.0	294.8	300.0	300.0	297.3	0.0	0.0	0.0	0.0	0.0
DOL HIV/AIDS	10.0	10.0	9.9	9.9	2.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Labor-HHS	***394.2***	***668.7***	***731.4***	***904.0***	***772.8***	***783.7***	***768.3***	***1,008.8***	***1,070.8***	***1,130.8***	***1,013.7***	***740.0***	***752.0***	***870.4***	***867.7***	***910.3***
DOD HIV/AIDS	10.0	14.0	7.0	4.3	7.5	5.2	0.0	8.0	8.0	8.0	10.0	8.0	7.4	8.0	8.0	0.0
Total Global Health	**1,619.3**	**2,030.2**	**2,558.8**	**3,245.4**	**3,716.8**	**4,468.4**	**5,916.2**	**7,512.9**	**8,367.8**	**9,018.4**	**8,856.0**	**8,915.9**	**8,825.2**	**9,317.9**	**9,284.7**	**9,091.3**

Source: Created by CRS from appropriations legislation and correspondence with OMB and implementing agencies.

Acronyms: U.S. Department of State (State), U.S. Agency for International Development (USAID), Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund), State, Foreign Operations, and Related Programs Appropriations (SFOPS), Centers for Disease Control and Prevention (CDC), National Institutes of Health (NIH), State-Foreign Operations Appropriations (SFOPS), U.S. Department of Labor (DOL), Labor, Health and Human Services, Education, and Related Appropriations (Labor-HHS), U.S. Department of Defense (DOD).

Notes: Additional resources that agencies may provide for global health programs through other accounts are not included here. CDC, for example, spends a portion of its tuberculosis budget on global activities.

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-FY2014 only include appropriations to the Global Health Programs account.

The FY2015 figure for NIH Global AIDS research reflects the budget request. The program is funded through the Office of AIDS Research (OAR), which reports annually the amount it spends on global AIDS research.

Table A-2. State-Foreign Operations Funding: FY2001-2016 Request

(current U.S. $ millions)

Agency/Program	FY2001 Enacted	FY2002 Enacted	FY2003 Enacted	FY2004 Enacted	FY2005 Enacted	FY2006 Enacted	FY2007 Enacted	FY2008 Enacted	FY2009 Enacted	FY2010 Enacted	FY2011 Enacted	FY2012 Enacted	FY2013 Enacted	FY2014 Enacted	FY2015 Enacted	F2016 Request
HIV/AIDS	305.0	395.0	587.7	513.5	347.2	346.5	325.0	347.2	350.0	350.0	349.3	350.0	332.9	330.0	330.0	330.0
Tuberculosis	50.0	60.0	64.2	74.7	79.4	81.8	80.8	148.0	162.5	225.0	224.6	236.0	224.5	236.0	236.0	191.0
Malaria	55.0	65.0	64,6	79.6	79.4	98.9	248.0	347.2	382.5	585.0	618.8	650.0	656.4	665.0	669.5	674.0
Global Fund	100.0	50.0	248.4	397.6	248.0	247.5	247.5	0.0	100.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
MCH	295.3	315.0	411.9	328.1	347.5	369.6	392.6	449.0	440.1	474.0	548.9	605.6	627.3	705.0	715.0	770.0
Nutrition[a]	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	54.9	75.0	89.8	95.0	95.1	115.0	115.0	101.0
Vulnerable Children	14.9	25.0	26.8	27.8	24.5	12.6	6.5	14.9	15.0	15.0	15.0	17.5	16.6	22.0	22.0	14.5
FP/RH	376.2	402.5	391.0	398.1	396.8	393.5	396.5	398.0	455.0	528.6	527.0	523.9	532.4	524.0	524.0	538.0
NTDs[b]	n/a	n/a	n/a	n/a	n/a	14.8	14.9	14.9	25.0	65.0	76.8	89.0	85.6	100.0	100.0	86.5
GHS	18.7	35.0	25.8	29.6	39.8	139.2	189.6	115.0	145.0	201.0	47.9	58.0	55.2	72.5	72.5	50.0
USAID Total	***1,215.1***	***1,347.5***	***1,820.4***	***1,849.0***	**1,562.6**	***1,704.4***	***1,901.4***	***1,834.2***	***2,130.0***	***2,518.6***	***2,498.0***	***2,625.0***	***2,626.0***	***2,769.5***	***2,784.0***	***2,755.0***
HIV/AIDS[c]	n/a	n/a	n/a	488.1	1,373.9	1,777.1	2,869.0	4,116.4	4,559.0	4,609.0	4,585.8	4,492.9	3,870.8	4,020.0	4,275.0	4319.0
Global Fund[d]	n/a	n/a	n/a	n/a	n/a	198.0	377.5	545.5	600.0	750.0	748.5	1,300.0	1,569.0	1,650.0	1,350.0	1,107.0
State Total	***0.0***	***0.0***	***0.0***	***488.1***	**1,373.9**	***1,975.1***	***3,246.5***	***4,661.9***	***5,159.0***	***5,359.0***	***5,334.3***	***5,792.9***	***5,439.8***	***5,670.0***	***5,625.0***	***5,426.0***
SFOPS Total	**1,215.1**	**1,347.5**	**1,820.4**	**2,337.1**	**2,936.5**	**3,679.5**	**5,147.9**	**6,496.1**	**7,289.0**	**7,877.6**	**7,832.3**	**8,417.9**	**8,065.8**	**8,439.5**	**8,409.0**	**8,181.0**

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

Acronyms: Maternal and Child Health (MCH), Family Planning and Reproductive Health (FP/RH), Neglected Tropical Diseases (NTDs), Global Health Security (GHS), State-Foreign Operations Appropriations (SFOPS)

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-FY2014 only include appropriations to the Global Health Programs Account.

a. Congress began to appropriate funds for nutrition after the announcement of GHI in 2009. Until then, nutrition funds were included in appropriations for maternal and child health programs.

b. Congress made the first appropriation for NTDs in FY2006.

c. The Department of State received its first appropriation for managing PEPFAR funds through FY2004 State Foreign Operations appropriations.

d. Congress first appropriated funds for a contribution to the Global Fund through the State Department in the FY2006 State-Foreign Operation Appropriations.

Table A-3. Labor-HHS Funding: FY2001-FY2015

	FY2001 Enacted	FY2002 Enacted	FY2003 Enacted	FY2004 Enacted	FY2005 Enacted	FY2006 Enacted	FY2007 Enacted	FY2008 Enacted	FY2009 Enacted	FY2010 Enacted	FY2011 Enacted	FY2012 Enacted	FY2013 Enacted	FY2014 Enacted	FY2015 Enacted	FY2016 Request
HIV/AIDS	104.5	168.7	182.6	266.9	123.8	122.6	121.0	118.9	118.9	119.0	118.7	117.1	125.3	128.7	128.4	128.4
Immunizations	106.6	133.8	148.8	137.8	144.4	144.3	142.4	139.8	143.3	153.7	150.9	160.3	159.5	200.9	208.6	218.6
Polio	*91.2*	*107.4*	*106.4*	*96.8*	*101.2*	*101.1*	*99.8*	*98.0*	*101.5*	*101.8*	*101.6*	*111.3*	*110.4*	*150.9*	*158.8*	*168.8*
Other Global/ Measles	*15.4*	*26.4*	*42.4*	*41.0*	*43.2*	*43.2*	*42.6*	*41.8*	*41.8*	*51.9*	*49.3*	*49.0*	*49.1*	*50.0*	*49.8*	*49.8*
Parasitic Disease/ Malaria[a]	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	19.8	19.9	19.4	23.7	24.4	24.4	24.4
Malaria	13.0	*13.0*	*12.6*	*9.2*	*9.1*	*9.0*	*8.9*	*8.7*	*9.4*	*n/s*	*n/s*	*n/s*	*n/s*	*n/s*	*n/s*	*n/s*
Global Public Health Protection	0.0	0.0	0.0	14.0	24.8	35.8	35.3	34.9	47.5	52.7	51.2	50.8	54.3	62.8	55.1	76.7
CDC Total	***224.1***	***315.5***	***344.0***	***427.9***	***302.1***	***311.7***	***307.6***	**302.3**	**319.1**	**345.2**	**340.7**	**347.6**	**362.8**	**416.8**	**416.5**	**448.1**
NIH Global AIDS Research	160.1	218.2	278.5	317.2	369.5	373.0	361.7	411.7	451.7	485.6	375.7	392.4	389.2	453.6	451.2	462.2
HHS Global Fund	0.0	125.0	99.0	149.0	99.2	99.0	99.0	294.8	300.0	300.0	297.3	0.0	0.0	0.0	0.0	0.0
DOL	10.0	10.0	9.9	9.9	2.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Labor-HHS	**394.2**	**668.7**	**731.4**	**904.0**	**772.8**	**783.7**	**768.3**	**1,008.8**	**1,070.8**	**1,130.8**	**1,013.7**	**740.0**	**752.0**	**870.4**	**867.7**	**910.3**

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

Acronyms: Not Applicable (n/a), Not Specified (n/s)

Notes: Since FY2013, CDC has utilized the Working Capital Fund (WCF) and distributed funding for its Business Services Support in its programmatic budgets, in adherence with language in the FY2013 Consolidated Appropriations Act. The Working Capital Fund (WCF) is a revolving fund that finances centralized business services across CDC and is expected to bring greater efficiency and transparency of business services. Funding columns FY2013-FY2015 reflect this new structure and does not necessarily reflect a programmatic increase for related programs. For more information on the Working Capital Fund, see http://www.cdc.gov/fmo/topic/Budget%20Information/appropriations_budget_form_pdf/FY2015_CJ_CDC_FINAL.pdf.

a. In the FY2012 Congressional Budget Justification, the Administration proposed creating a new line item, Parasitic Diseases/Malaria, that combined funding for programs aimed at addressing parasitic diseases (like neglected tropical diseases) with those aimed at combating malaria.

Table A-4. U.S. Global HIV/AIDS Funding: FY2001-FY2016 Request

(current U.S. $ millions)

Agency/ Department	FY2001 Enacted	FY2002 Enacted	FY2003 Enacted	FY2004 Enacted	FY2005 Enacted	FY2006 Enacted	FY2007 Enacted	FY2008 Enacted	FY2009 Enacted	FY2010 Enacted	FY2011 Enacted	FY2012 Enacted	FY2013 Enacted	FY2014 Enacted	FY2015 Enacted	FY2016 Request
State HIV/AIDS[a]	0.0	0.0	0.0	488.1	1,373.9	1,975.1	3,246.5	4,661.9	5,159.0	5,359.0	5,334.3	5,542.9	5,439.8	5,670.0	5,625.0	5,426.0
State Global Fund[b]	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*	*198.0*	*377.5*	*545.5*	*600.0*	*750.0*	*748.5*	*1,300.0*	*1,569.0*	*1,650.0*	*1,350.0*	*1,107.0*
USAID HIV/AIDS	405.0	445.0	836.1	911.1	595.2	594.0	572.5	347.2	450.0	350.0	349.3	350.0	332.9	330.0	330.0	330.0
USAID Global Fund	*100.0*	*50.0*	*248.4*	*397.6*	*248.0*	*247.5*	*247.5*	*0.0*	*100.0*	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*
SFOPS	***405.0***	***445.0***	***836.1***	***1,399.2***	***1,969.1***	***2,569.1***	***3,819.0***	***5,009.1***	***5,609.0***	***5,709.0***	***5,683.6***	***5,892.9***	***5,772.7***	***6,000.0***	***5,955.0***	***5,756.0***
CDC HIV/AIDS	104.5	168.7	182.6	266.9	123.8	122.6	121.0	118.9	118.9	119.0	118.7	117.1	125.3	128.7	128.4	128.4
NIH Global AIDS Research	160.1	218.2	278.5	317.2	369.5	373.0	361.7	411.7	451.7	485.6	375.7	392.4	389.2	453.6	451.2	462.2
HHS Global Fund	0.0	125.0	99.0	149.0	99.2	99.0	99.0	294.8	300.0	300.0	297.3	0.0	0.0	0.0	0.0	0.0
DOL HIV/AIDS	10.0	10.0	9.9	9.9	2.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Labor-HHS	***274.6***	***521.9***	***570.0***	***743.3***	***594.5***	***594.6***	***581.7***	***825.4***	***870.6***	***904.6***	***791.7***	***509.5***	***514.5***	***582.3***	***579.6***	***590.6***
DOD HIV/AIDS	10.0	14.0	7.0	4.3	7.5	5.2	0.0	8.0	8.0	10.0	10.0	8.0	7.4	8.0	8.0	0.0
Total Global HIV/AIDS	**689.6**	**980.9**	**1,413.1**	**2,146.5**	**2,571.1**	**3,168.9**	**4,400.7**	**5,842.5**	**6,487.6**	**6,623.6**	**6,485.3**	**6,410.4**	**6,294.6**	**6,590.3**	**6,542.6**	**6,346.6**
Total Global Fund	***100.0***	***175.0***	***347.4***	***546.6***	***347.2***	***544.5***	***724.0***	***840.3***	***1,000.0***	***1,050.0***	***1,045.8***	***1,300.0***	***1,569.0***	***1,650.0***	***1,350.0***	***1,107.0***

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.

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