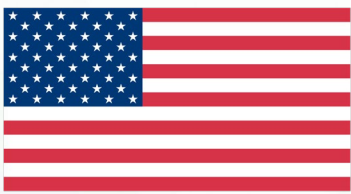


AMERICA FIRST GLOBAL HEALTH STRATEGY

SEPTEMBER 2025



United States of America

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→ Echantillon des sels : échantillon adéquat
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→ Communication : (dire)
+ INDICATEURS DU STOCK DE GESTION EN VACCIN

* Besoin en vaccin =

Pop. Globale objectif de couverture / dose et
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* Qte période =

* Stock minimum

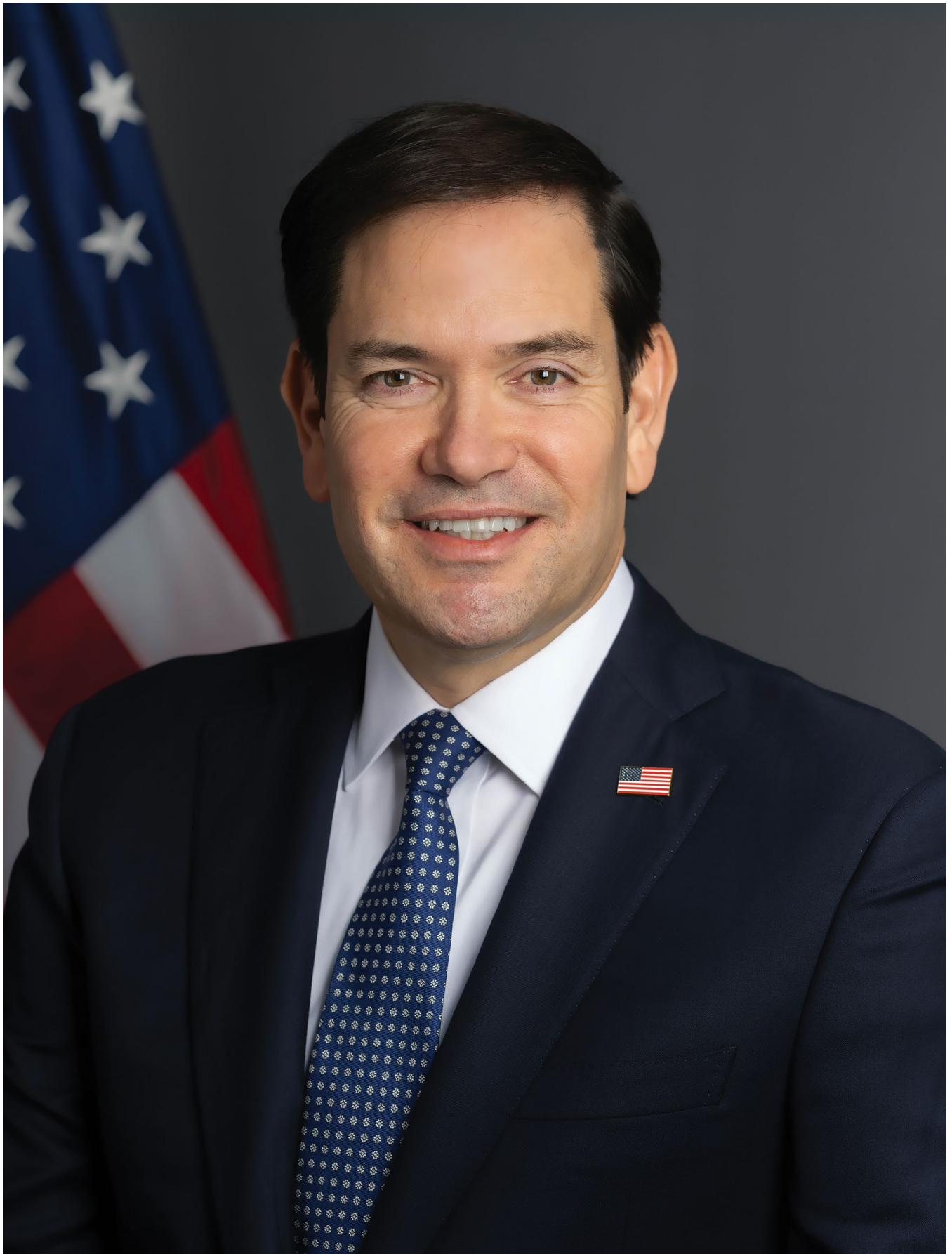


America First Global Health Strategy

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Letter from Secretary Rubio

To the American People:

The United States is the world's health leader. More innovative drugs and medical devices are developed in the United States than anywhere else in the world. If you are sick, there is nowhere you would rather be cared for than in the United States.

Over the past several decades, we have extended our health leadership globally. We have helped contain thousands of infectious disease outbreaks around the world, stopping numerous potential pandemics in their tracks before they could reach our shores. Our health foreign assistance programs, most notably the President's Emergency Plan for AIDS Relief (PEPFAR), have saved over 26 million lives and prevented 7.8 million babies from being born with HIV / AIDS. There is much to be proud of.

But there are also many problems – our foreign assistance programs are deeply broken. Our health foreign assistance programs in particular have become inefficient and wasteful, too often creating parallel healthcare delivery systems and a culture of dependency among recipient countries. Many of the NGOs who support these programs have committed many times to helping transition the work to local governments, but little progress has been made. This is often not because of a lack of willingness on behalf of recipient countries but rather because of our broken foreign aid system and the perverse incentives that encourage NGOs to self-perpetuate.

We must keep what is good about our health foreign assistance programs while rapidly fixing what is broken – and this strategy lays out a plan to do just that. We detail an America First Global Health Strategy that uses global health diplomacy and foreign assistance to make America safer, stronger, and more prosperous. We lay out a vision to end the inefficiencies, waste, and dependency of our current system. In its place, we cast a positive vision for a future where we stop outbreaks before they reach our shores, enter strong bilateral agreements that promote our national interests while saving millions of lives, and help promote and export American health innovation around the world.

We will continue to be the world's health leader and the most generous nation in the world, but we will do so in a way that directly benefits the American people and directly promotes our national interest. We look forward to making this vision a reality in the months and years ahead.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Rubio', with a stylized flourish at the end.

Marco Rubio
United States Secretary of State

Executive Summary

The United States is the world's global health leader. Over the last 25 years, the United States' global health programs have prevented thousands of infectious disease outbreaks from reaching American shores, saved over 26 million lives, and prevented 7.8 million babies from being born with HIV / AIDS.

However, our global health programs have become inefficient and wasteful. Today, less than 40% of health foreign assistance funding goes to frontline supplies and healthcare workers. This includes approximately 25% of funds that are used for the purchase of commodities (e.g., diagnostics, drugs) and approximately 15% of funds that are used to employ over 270,000 frontline healthcare workers (e.g., mostly nurses and community health workers). The remaining 60% of funding is spent on technical assistance, program management, and other forms of overhead.

This inefficiency has built up over time for a number of reasons. In the early days of the HIV / AIDS response, there was minimal health delivery capacity in many of the most affected countries. As a result, the United States often chose to invest in directly building health delivery capabilities, often minimally connected to national health systems. While this strategy was successful in dramatically improving health outcomes, it has also too often resulted in parallel procurement systems, parallel supply chains, program-specific healthcare workers, and program-specific data systems.

This problem has only been exacerbated by the significant amount of funding Congress has continued to dedicate to global health programs in recent years, which has provided little incentive to change. The problem is further exacerbated by NGOs who are the recipient of much of this funding (especially for technical assistance and program management) who have perverse incentives to self-perpetuate rather than work towards turning functions over to local governments. As a result, even though the last three presidential administrations have developed strategies to transition global health programs to increased local ownership, very little progress has been made. It is time for that to change.

In the following pages, we lay out a positive and forward-looking vision for United States leadership in global health – an America First Global Health Strategy. We lay out a plan that will prioritize the interests of Americans and make America safer, stronger, and more prosperous. And as we do so, we will help save millions of lives around the world and assist foreign countries in developing resilient and durable health systems.

SAFER. We will keep Americans safe by continuing to support a global surveillance system that can detect an outbreak within seven days. We will accomplish this through bilateral relationships with countries that include having a U.S. government staff presence on the ground where possible, with a larger number of staff dedicated to geographies with the highest risk of an outbreak. When there is an outbreak, we will be prepared to work with local governments to respond promptly. We will be prepared to surge resources to ensure the outbreak is contained, travelers are appropriately screened, and – to the maximum

extent possible – the outbreak does not reach American shores or harm Americans living abroad.

STRONGER. Our global health foreign assistance program is not just aid – it is a strategic mechanism to further our bilateral interests around the world. Moving forward, we will utilize our health foreign assistance to advance U.S. priorities and move countries towards resilient and durable local health systems. We will do this thoughtfully, by entering multi-year bilateral agreements with recipient countries that lay out clear goals and action plans.

These bilateral agreements will ensure funding for 100% of all frontline commodity purchases and 100% of all frontline healthcare workers who directly deliver services to patients. We will also partner with each country to ensure there are data systems in place that can both monitor potential outbreaks and broader health outcomes. We will ensure these systems are integrated into the long-term health information systems of a country so that we can monitor outbreaks and health outcomes well into the future. We will also work to rapidly transition technical assistance from supporting individual clinical sites to supporting governments in taking over key functions. This will include more government-to-government assistance as well as leveraging the private sector and faith-based organizations. Finally, we will ask governments to co-invest in these efforts and work with the United States to align on performance benchmarks that will be required for releasing future U.S. health foreign assistance funding.

We aim to complete bilateral agreements with recipient countries receiving the vast majority of U.S. health foreign assistance by December 31, 2025 with the goal of beginning to implement these new agreements by April 2026.

MORE PROSPEROUS. We will first and foremost make America more prosperous by helping contain outbreaks at their source, protecting American lives and the American economy. We will also leverage our foreign assistance to promote American companies and American innovations abroad, including continuing to procure goods from American companies as part of our foreign assistance programs. We will also leverage our bilateral relationships with countries to promote American health innovations and products more broadly globally, helping ensure that American innovation becomes a cornerstone of health systems around the world.

Success of U.S. Health Foreign Assistance

The United States has been and remains the world's health leader. This leadership has helped keep America secure by preventing thousands of infectious disease outbreaks from reaching our shores. Every year, there are hundreds of concerning infectious disease outbreaks around the world, including outbreaks of Ebola, mpox, and highly pathogenic strains of influenza. The African continent alone had more than 100 outbreaks in 2024.

The United States has taken a proactive approach to fighting these outbreaks where they occur and – for the most part – has been successful in keeping them away from American shores. As of September 2025, the Department of State and Department of Health and Human Services (HHS) have more than 1,700 global health professionals working overseas.

This year alone, the U.S. government has already helped stop significant outbreaks of Ebola in Uganda and Marburg in Tanzania. The United States' efforts have included deploying lab diagnostics to identify and sequence samples, deploying U.S. trained personnel to conduct contact tracing, providing vaccines and therapeutics to affected patients and their contacts, and supporting countries in conducting effective border screenings at points of entry and exit. In both outbreaks, zero cases reached American shores, thanks in large part to the proactive efforts of the U.S. government.

The United States has also been the world's leader in global health foreign assistance, providing more than \$204 billion in foreign health assistance since 2001. This is \$100 billion more than any other country and represents nearly one-third of the world's total global health assistance over this time period. The vast majority of this funding has gone towards fighting HIV / AIDS, malaria, and tuberculosis (TB), three of the most prevalent and lethal (yet preventable and treatable) infectious diseases in the world.

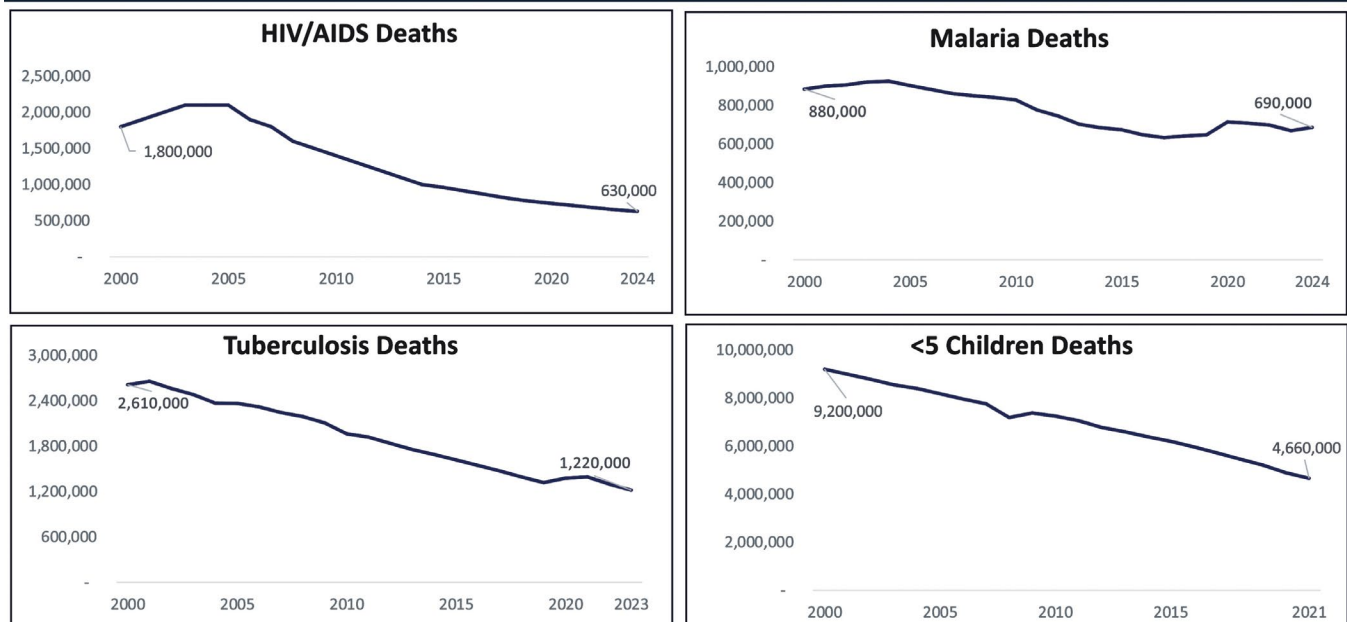
These investments have helped fuel tremendous improvements in health outcomes over the last 25 years. PEPFAR alone has saved 26 million lives and prevented 7.8 million babies from being born with HIV. From 2000 to 2024, the annual number of deaths from AIDS-related illness declined from 1,800,000 to 630,000, and the number of new annual HIV infections fell from 2,900,000 to 1,300,000. From 2000 to 2024, malaria deaths around the world decreased by about 200,000 annually. TB incidence declined by nearly 25%, and TB annual deaths by 1,400,000 from 2000 to 2023.

The results are even more dramatic in Sub-Saharan Africa where HIV mortality declined over 70%, TB mortality by 51%, and malaria mortality by 63% from 2000 to 2023. Overall life

Since 2003, PEPFAR has saved 26 million lives and prevented 7.8 million babies from being born with HIV.

expectancy in Sub-Saharan Africa improved by 11 years between 2000 and 2023, up from 52 years to 63 years. These are amazing accomplishments.

Figure 1: Reductions in Global Mortality



The returns from U.S. health foreign assistance have extended far beyond improvements in health outcomes, generating stability and economic development in many recipient countries. For example, an independent assessment found PEPFAR-supported countries experienced a 2.1% higher increase in GDP per capita growth than they would have experienced without PEPFAR. Controlling infectious diseases has also improved political stability, as often disease outbreaks and health crises exacerbate political instability in countries where governance is weak. From 2004 to 2011, PEPFAR-supported countries saw a 40% reduction in political instability compared to just a 3% reduction in non-PEPFAR countries in the same region. Given that instability can be a breeding ground for national security threats, targeted U.S. health foreign assistance has helped preempt those threats from emerging.

The United States has also been able to deploy American scientific innovations as part of the United States' health foreign assistance programs. For example, the Department of State just this month announced a ground-breaking partnership to roll out the American-developed HIV prevention drug lenacapavir to 2 million people in high HIV-burden countries. This drug was developed by Gilead Sciences, based in California, and the U.S. government's market-shaping investment will help Gilead and lenacapavir gain an early footprint in many emerging markets.

Other global health organizations are also investing in American innovation. For example, the Global Fund has procured more than \$3.5 billion in goods and services from U.S.

corporations since 2010 while other multilateral health organizations have purchased over \$12.5 billion of goods from U.S. companies since 2012.

Health foreign assistance has also improved America's military relationships with foreign countries. The PEPFAR program alone has established 19 military-to-military collaborations primarily throughout Sub-Saharan Africa, including in many countries where there is significant coordination between the U.S. and foreign militaries against Islamic militants.



Problems with U.S. Health Foreign Assistance

While U.S. global health programs have unquestionably been some of the most successful foreign assistance programs of the past several decades, there are also some very significant problems with the United States' current global health programs. The two primary challenges are the alarming inefficiencies and waste that have built up in the current U.S.-funded global health delivery system and the culture of dependency these programs have created in many recipient countries, often undermining local ownership and dulling incentives to progress towards integrated and resilient locally-owned health systems.

Significant Inefficiency and Waste

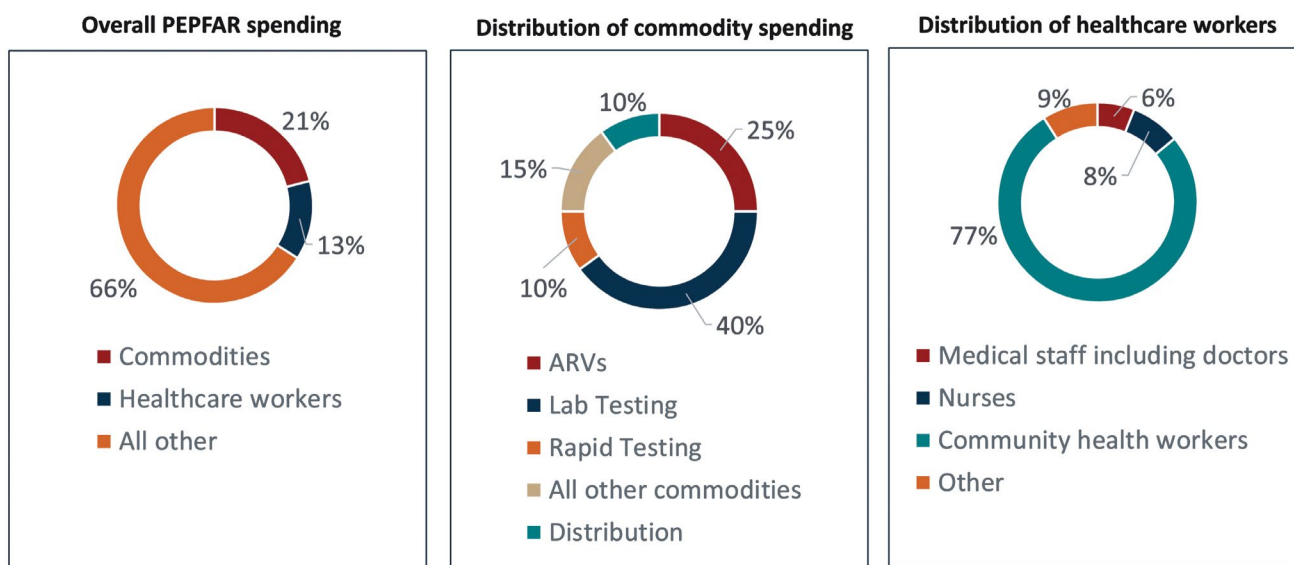
The United States' health foreign assistance programs are inefficient. PEPFAR has built one of the most robust data reporting and monitoring systems of any foreign assistance program in history, creating the ability to track where each dollar of spending goes in a high level of detail. Shockingly, this data shows that only about 40% of PEPFAR's budget goes directly to finance on-the-ground service delivery, specifically health commodities and health workers.

Of PEPFAR's \$4.7 billion bilateral budget, only approximately \$1.0 billion goes to support medical commodity purchases and their related transport and delivery. This figure includes all purchases for diagnostic tests, lab equipment, vaccines, treatments (like anti-retroviral drugs), and ancillary medical supplies (e.g., gloves, masks, pipets) along with the costs required to transport these products to their final destination.

In addition, PEPFAR spends approximately \$600 million on funding more than 270,000 individuals who work in clinics that treat patients. This predominantly includes community health workers (208,800) and nurses (22,700) who are primarily responsible for providing infectious disease prevention, testing, and treatment services. It also includes a small number of doctors to support more complicated cases of advanced infectious disease.

The remaining \$3.1 billion funds wrap-around activities including training, mentorship, supervision, quality management, technical assistance, program management, and U.S. government staff. The reason for this significant level of technical assistance and other related costs has much to do with the history of the program. When the program started, there was very little capacity in many countries to deliver the necessary interventions including diagnostic testing and antiretroviral treatments. As a result, the United States contracted with organizations (which became known as "implementing partners") to help build this capacity on the ground.

Figure 2: Breakdown of PEPFAR Budget by Type of Support

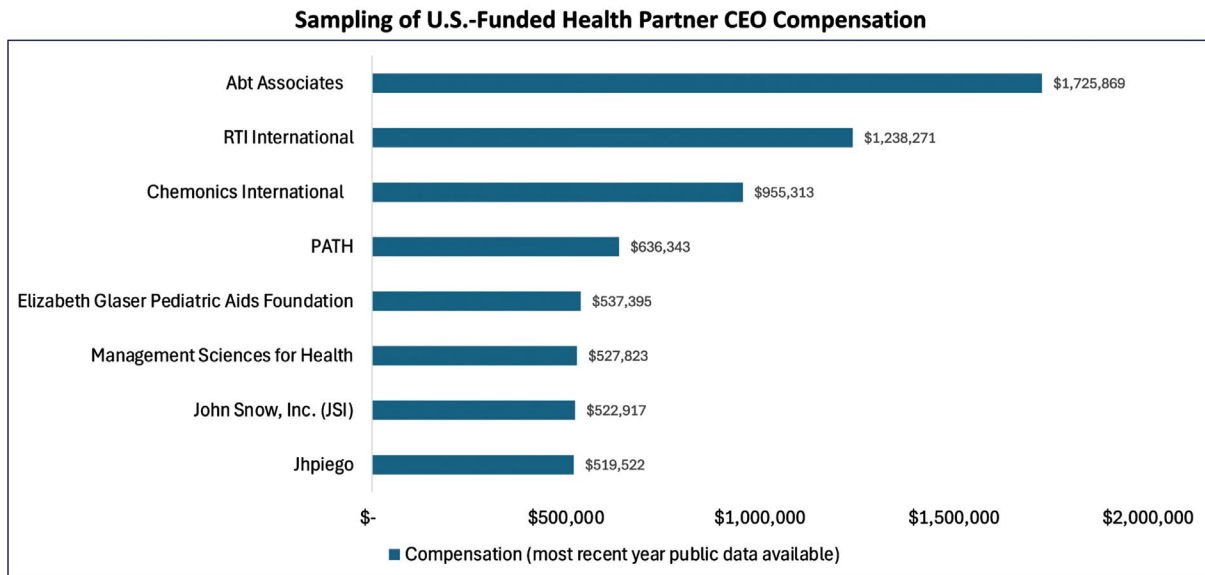


While initially necessary, today the U.S.-created structure of implementing partners is often duplicative and highly inefficient. Far too often, multiple implementing partners have been given very similar tasks that result in significant duplication. The complexity of this implementing partner structure meaningfully increases the multiple layers of overhead cost. For example, in FY 2024, Uganda alone had 57 implementing partners and more than 300 sub-recipients, and Tanzania had 38 implementing partners and more than 350 sub-recipients. Implementing partners spent \$678 million on program management in FY 2024, including one implementing partner who spent \$61.3 million just on program management that year. This cost is exacerbated by many implementing partners who have significant overhead costs, with many implementing partners having executives making over \$500,000 (Figure 3) and several having executives whose salary is over \$1,000,000.

The United States has also historically run its disease programs in silos, with HIV / AIDS, tuberculosis, malaria, and outbreak response all running as separate programs. This often resulted in separate disease-specific planning processes and implementing partners within an individual country that had little connection or collaboration with one another. This lack of coordination inevitably resulted in duplication and missed opportunities to maximize and leverage investments across multiple diseases. This vertical disease-specific approach has also made integrating programs into countries' existing health infrastructure more difficult, as country health systems are almost always integrated across diseases.

U.S. partner countries are well aware of the inefficiencies of the United States' global health programs. In one of their publicly available reports, one of our largest recipient countries notes "high overhead costs remain opaque to both donors and government" and "multiple contracts with implementing NGO partners create fragmentation and duplication of resources."

Figure 3: Sampling of U.S.-Funded Health Partner CEO Compensation

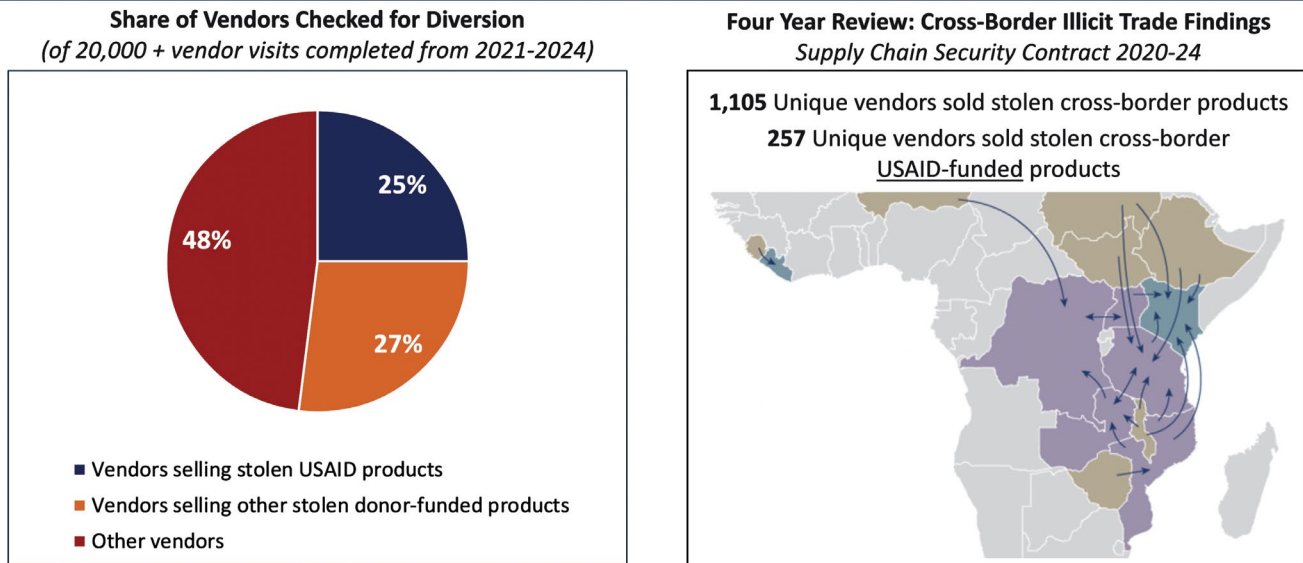


Today, there is substantial opportunity to materially reduce these technical assistance, program management, and overhead costs without materially impacting outcomes and, in fact, reducing these costs is critical if the programs are ever to move to local country ownership, as local governments will never support the current amount of overhead costs. For example, for programs to be sustainable long-term, much of the training, quality, and program management work ultimately needs to be led by local ministries of health. Other investments, such as those in data systems, need to be made in such a way as to integrate with the country's own health data systems. A recent analysis by the Kaiser Family Foundation and Boston University found that these technical assistance, program management, and overhead costs are negatively correlated with improvements in health outcomes, highlighting the imperative to critically reduce and transform these investments.

Beyond inefficiency, there continues to be evidence of waste, theft, and abuse in the supply chain in certain countries. An audit of global health commodities from 2020 to 2024 conducted across 10 countries at the request of USAID found that half of vendors visited were selling stolen donor-funded health commodities, including 25% who were selling stolen USAID-funded commodities. A sizeable minority of the commodities were distributed cross-border, pointing to a level of scale and sophistication indicative of transitional organized crime. It is likely that this diversion is costing U.S. taxpayers millions of dollars each year.

Worse still, a violation of abortion-related restrictions in Mozambique was reported to Congress in January 2025 that PEPFAR had funded four nurses who performed at least 21 abortions between April 2022 and June 2024 in violation of U.S. law codified in the Helms Amendment. This deepened concerns that the program had drifted from its original mission, as outlined by a June 2023 letter from 131 parliamentarians and religious, health, and law leaders from 13 countries who asked Congressional leadership to ensure the program and

Figure 4: U.S.-Funded Global Health Commodity Diversion



partner organizations do not “cross over into promoting divisive ideas and practices that are not consistent with those of Africa.”

For the American people to have confidence in our nation’s health foreign assistance programs and for our programs to remain maximally effective in the future, this inefficiency, waste, and abuse must – and will – be eliminated.

Culture of Dependency

As Secretary Rubio has stated, success for foreign assistance programs should mean that programs actually get smaller over time. This is because successful health programs not only deliver concrete results (e.g., fewer deaths from infectious diseases) but also should become integrated into a country’s healthcare system over time to avoid creating long-term dependency.

The concept of ensuring health programs are resilient and country-owned is not a new one. Each of the last three presidential administrations has developed strategies to transition public health programs to local ownership. Unfortunately, despite bipartisan political support for moving towards this goal, minimal progress has been made. For example, across the 23 largest programs supported by the U.S. government, recipient governments only cover on average 30-40% of the costs of the response, with the remaining covered almost entirely by the U.S. government and the Global Fund. This ratio has not substantially changed over the past five years.

It is now time to begin moving these programs to long-term country ownership. We are now at a different phase of the HIV / AIDS, malaria, TB, and polio epidemics. The massive

progress from the last 25 years, coupled with increasing incomes in lower- and-middle income countries, create the opportunity to redesign health foreign assistance to responsibly facilitate country ownership in many countries while continuing to close the remaining gaps in public health outcomes. There is unprecedented energy to move in this direction from recipient countries themselves, and that is exactly what we intend to do in a thoughtful and strategic way that leverages the gains of the past and ensures continued control of the epidemics in the future.

“Africa must no longer be the patient; it must be the architect and advocate of its own health destiny... We are called to build systems that do more than respond to crises.”

***– Ghanaian President John Dramani Mahama
August 5, 2025***

PILLAR 1: Making America Safer

Ebola. COVID-19. Swine Flu. Zika. The world has experienced multiple epidemics and pandemics in the 21st century, and the threat of a future pandemic is increasing with global connectivity amongst humans and between humans and animals at an all-time high. 60% of infectious diseases in humans can be spread by animals, and 75% of emerging infectious diseases spread from animals. Medical interventions to stop disease are improving; however, deadly pathogens are also evolving in a fight for survival.

For these reasons, the first pillar of the America First Global Health Strategy is ensuring Americans are protected by making every effort to prevent deadly diseases from reaching our shores or harming American citizens abroad. As we have unfortunately seen all too frequently, an outbreak anywhere in the world can quickly become a threat to Americans. The U.S. government's global health strategy is aimed at quickly detecting and responding to outbreaks that are the deadliest, cause the most severe symptoms, are the most transmissible, and are most likely to cause a global pandemic or severe economic disruptions.

Surveillance

Goal 1: Enable detection of an outbreak with epidemic potential within seven days of its emergence.

While health experts are unable to identify exactly where the next pandemic or threat to human health will emerge, there are some pathogens and geographic locations that are of higher likelihood. This includes many geographies in Sub-Saharan Africa, Southeast Asia, and South and Central America where there has been rapid urbanization, close human proximity to animals (which often serve as vectors for animal-to-human pathogen transmission), and poor underlying health systems that are less likely to detect a novel pathogen when it first emerges.

The United States will engage bilaterally to the maximum extent possible to strengthen global surveillance for disease threats, with increased focus in the countries where there is the highest risk. Today, the United States already has dedicated health staff in more than 60 countries, including health diplomats from the State Department and technical disease control experts from the U.S. Centers for Disease Control and Prevention (CDC).

The United States will assign U.S. government staff with a health portfolio to every country with a U.S. mission. Countries with a higher burden of infectious disease or a higher likelihood of being the source of a future outbreak will have a larger number of U.S. government staff dedicated to the health portfolio. These staff will come from across the U.S. government including the State Department, Department of Health and Human Services, and the Department of Defense.

The United States has historically invested in laboratory capacity and data systems across



multiple global health programs. We will now consolidate these investments into a single surveillance, data, and laboratory investment strategy that can serve all aspects of our global health strategy in a country including outbreak surveillance, HIV / AIDS, tuberculosis, malaria, and polio. We will also coordinate data exchange as appropriate with countries both to monitor potential outbreaks as well as to manage our health foreign assistance programs.

While the United States will start with a preference for bilateral relationships, the U.S. government will also engage in multilateral relationships for targeted purposes, such as when there is not the ability to develop a bilateral relationship with a specific country for the purposes of surveillance. These multilateral engagements will be limited and specific, with a focus on identifying surveillance capabilities that the United States is not able to obtain through a bilateral relationship alone.

Outbreak Response

Goal 2: Contain outbreaks that originate outside of the United States rapidly at their source.

The first 72 hours of the response to an epidemic are often the most critical to keep a pathogen contained. The U.S. government will prioritize mobilizing a response to every outbreak that threatens the United States within 72 hours of detection. The U.S. government will use a combination of U.S.-funded disease surveillance capabilities, technical collaborations, and diplomacy to obtain real-time information about an outbreak's trajectory and any mutations to the pathogen causing disease. We will engage counterparts in the local government to understand the risks for additional spread and obtain basic genetic sequencing information or physical samples of the pathogen to inform the response and development or deployment of medical countermeasures.

The U.S. government's investment in the Field Epidemiology Training Program (FETP) has been one of our highest returns on investments in this area, as it has trained a large number of locally employed public health experts across a number of countries who have served as the frontline response to many recent outbreaks. U.S. government personnel will support local government officials in each response and deploy U.S. government in-country staff to support response activities as needed. The United States will also mobilize surge capacity from the region or domestically to support responses as warranted.

When necessary, the United States will also surge diagnostics, vaccines, therapeutics, personal protective equipment, and other commodities to aid in the response. These surge resources will be maintained centrally by the U.S. government, with contract mechanisms in place in each country or region onto which we can rapidly deploy resources for outbreak response as needed.

If U.S. health experts determine travel measures are needed to contain an outbreak, we will coordinate implementation with other countries. We will also provide information to U.S.

citizens on the outbreak to enable them to make informed decisions on travel and health measures in the country.

The United States will also leverage the health system assets that have been developed through bilateral health foreign assistance programs to support outbreak response. Often the same health infrastructure (including labs and healthcare workers) used for HIV / AIDS, TB, and malaria can be mobilized to address new outbreaks.

Responding to Ebola in Uganda

Uganda has experienced nine known Ebola outbreaks in the past 25 years. The United States has played a key role in stopping these outbreaks, including a 2025 outbreak that reached Uganda's capital city of Kampala. Since 2001, the United States has provided Uganda funding for laboratory and disease surveillance capabilities as well as global health security programming. During the 2025 Ebola outbreak, the United States' strong support enabled the Ugandan government to detect the Ebola outbreak in eight days. Responders leveraged U.S.-supported laboratories and transport mechanisms to test specimens, U.S.-supported surveillance and reporting systems to share information, and U.S.-supported healthcare workers to investigate suspected cases and trace their contacts. The United States was also able to mobilize resources rapidly to augment the response with checkpoint screening and provision of life-saving therapeutics. Uganda's Ministry of Health declared an end to the outbreak in April 2025, with zero cases transmitted outside of the country or to the United States.



PILLAR 2: Making America Stronger

Leveraging U.S. Global Health Leadership to Compete with China

Global health foreign assistance will remain a key strategy for strengthening the United States' bilateral relationships with countries around the world – not only making our country safer, stronger, and more prosperous, but helping other countries develop resilient and durable health systems. The United States has long been the world's most generous country and remains the largest provider of official development assistance globally via grants, technical assistance, and humanitarian aid.

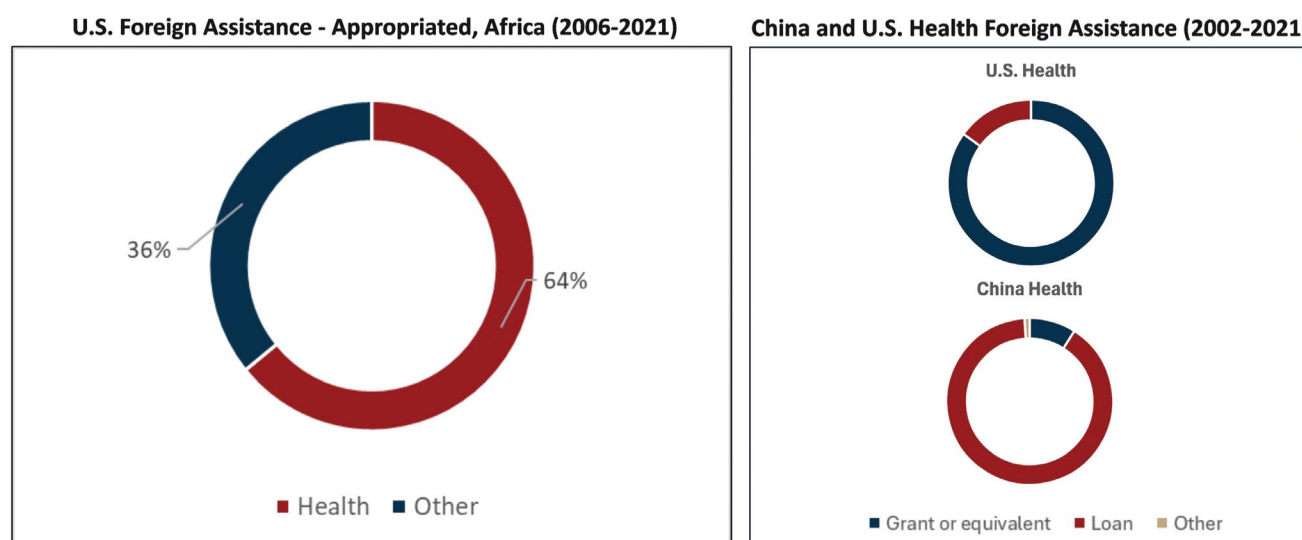
China's foreign assistance, by contrast, is intentionally difficult to quantify due to its lack of transparency. China's Belt and Road Initiative (BRI) has mobilized hundreds of billions of dollars, primarily through loans for infrastructure projects for roads, railways, ports, and energy projects that focus on creating trade connectivity and economic integration favorable to China. These loans, however, often come with high interest rates that raise concerns about debt sustainability. Moreover, China prefers to deliver its support through the country's network of state-owned enterprises, using China-backed concessional loans with repayment terms that can create dependency. China often requires employment of its own workforce and too often conditions its support on political favors such as votes in multilateral bodies that favor China's interests or for technology transfer that benefits China's own companies. Moreover, limited public data about China's foreign assistance masks whether such aid is exacerbating corruption and governance challenges among recipients.

U.S. health foreign assistance has the potential to be an important counterweight to China especially in Africa, a continent of strategic importance to U.S. national interests. The continent is on a trajectory to contain a quarter of the world's population by 2050, up from 10% in 1960, and is home to 12 of the world's top 20 fastest growing economies. Several countries continue to be hotbeds for pockets of Islamic extremism, often in the sub-geographies with the poorest health and development outcomes. Africa also contains several of the largest deposits of key minerals and rare earth elements needed as inputs into advanced technologies that fuel critical military and commercial applications.

From 2002 to 2021, China invested approximately \$339 billion in foreign assistance in Africa. Approximately 85% of this was through loans, primarily for large infrastructure projects. By comparison, the United States invested \$216 billion over this period, with 90% coming in the form of grants, over 60% of which has been for global health. While this aid has contributed to longer life expectancies, healthier populations, and increased GDP growth across the continent, too often the United States decided how to deploy our funds independently from local governments and only small amounts of our funding went directly to national and local government ministries of health. As a result, recipient

countries did not always have clarity on where the United States was spending funds, and often the aid was not directed to the recipient government's top infectious disease priorities. By moving towards bilateral global health agreements directly with recipient country governments, the United States will be able to maximize the impact of our aid to strength our bilateral relationships while simultaneously ensuring we save lives and help countries move towards more resilient and durable health systems.

Figure 5: China and U.S. Development Finance Breakdown



Strong Global Health Bilateral Agreements

Goal 3: Strengthen bilateral relationships with key countries by entering multi-year bilateral agreements that contain the spread of infectious diseases, save lives, and enable economic growth.

U.S. health foreign assistance is grounded in three realities. First, we must continue to make progress saving lives. Ultimately, most foreign leaders want to create economic growth to better the lives of their people; lengthening life expectancy and saving lives is one of the most critical ways to invest in human capital and long-term economic growth. Second, we must make investments that recipient governments are supportive of and that move countries to self-sufficiency at an appropriate pace. Third, we must ensure that health foreign assistance is promoting American interests, with a focus on bilateral relationships that offer concrete benefits to the American people.

A key component of all our bilateral agreements will be staying committed to the ambitious goals that have been set over the past decades for HIV / AIDS, TB, malaria, and polio, with the acknowledgment that countries themselves are ultimately accountable for their outcomes and U.S. government support will be but one component of the contribution towards

national outcomes. The U.S. will also prioritize ending mother-to-child transmission of HIV / AIDS in a number of countries by the end of President Trump’s second term. Details on the global goals to which U.S. health foreign assistance will contribute are outlined in Figure 6.

Figure 6: Global Goals that U.S. Health Foreign Assistance Will Contribute Towards			
HIV/AIDS	Tuberculosis	Malaria	Polio
<ul style="list-style-type: none"> • Ensure that 95% of people living with HIV know their HIV status, 95% of people who know their status are receiving HIV treatment, and 95% of people on treatment are virally suppressed • 90% reduction in HIV infections by 2030 (from 2010 levels) • 90% reduction in AIDS-related deaths by 2030 (from 2010 levels) • Ending Mother-to-Child Transmission in several high-burden countries. 	<ul style="list-style-type: none"> • Reduce TB incidence rate by 80% by 2030 (from 2015 levels) • Reduce TB mortality rate by 90% by 2030 (from 2015 levels) 	<ul style="list-style-type: none"> • Reduce malaria mortality globally by at least 90% by 2030 (from 2015 levels) • Reduce malaria case incidence globally by at least 90% by 2030 (from 2015 levels) • Eliminate malaria in at least 35 countries by 2030 • Prevent re-establishment of malaria in all countries that are malaria-free 	<ul style="list-style-type: none"> • Eradication of wild poliovirus type 1 (WPV1) by the end of 2027 • Elimination of circulating type 2 variant poliovirus (cVDPV2) by the end of 2029

Four principles will guide the U.S.’s global health bilateral agreements.

Maintain 100% of Frontline Support, Including All Commodity Purchases and Funding for Frontline Healthcare Workers

Approximately \$1.0 billion of PEPFAR funding and more than \$325 million of non-PEPFAR funding goes to the purchase of commodities including diagnostics, drugs, and insecticide-treated bed nets. In addition, approximately \$600 million of PEPFAR funding and more than \$227 million of non-PEPFAR funding provides salary and benefits for healthcare workers directly serving patients. As part of its bilateral agreements, the United States will require that funding for these frontline investments be maintained at 100% of its current levels during the agreement period, unless the recipient country and the United States agree to a different level of funding for reasons that both parties agree will not impact the recipient country's ability to deliver critical services.

In FY 2026, the United States will continue to cover 100% of all frontline costs that the U.S. government is currently supporting in all countries. After FY 2026, the United States will cover a proportion of these costs as countries will have required co-investment levels based on each country's income level. The commodities covered will include:

HIV/AIDS

- Anti-retroviral medications for HIV treatment, including pediatric formulations
- HIV / AIDS diagnostic testing including rapid tests, viral load testing, and early infant diagnostics
- HIV / AIDS preventative medications with a particular focus on deploying the most innovative solutions such as long-acting lenacapavir that can prevent mother-to-child transmission
- Diagnostics and drugs that detect and treat advanced HIV disease

Malaria

- Insecticide-treated nets and spray
- Malaria diagnostic tests
- Anti-malaria medicines, including seasonal malaria chemoprevention for children
- Malaria vaccines

Tuberculosis

- TB diagnostics, including innovations in molecular diagnostics
- TB treatments, including drug-resistant treatments
- TB preventative therapy

Polio

- Commodities needed to support polio vaccination programs

The U.S. government will establish or contribute towards one or more pooled procurement mechanisms for purchasing these commodities. Pooled procurement is essential for ensuring that the United States, other donors, and recipient countries can purchase high-quality commodities at the lowest possible price, including innovative treatments and diagnostics from U.S. companies.

Frontline healthcare service personnel consist of all frontline healthcare workers, including the 270,000 doctors, nurses, and community health workers currently supported by U.S. government funding and responsible for delivering prevention, testing, and treatment services.

In FY 2026, the United States will cover 100% of these frontline healthcare worker costs that the U.S. government is already supporting in all countries. After FY 2026, the United States will work with countries to begin integrating these staff into countries' healthcare budgets at a pace that is appropriate based on the income level of each country. As a general rule, the United States will work with recipient countries to ensure that all frontline healthcare staff are maintained long-term, unless the recipient country and the United States agree to a different level of staffing for reasons that both parties agree will not impact the recipient country's ability to deliver critical services.

Streamline and Maintain a Robust Performance Monitoring System

The United States will work with each country to develop a streamlined approach for ensuring robust performance monitoring. In many cases, countries – often with U.S. funding and encouragement – have developed overly complex and often parallel, disease-specific data monitoring systems that are outside of or only loosely connected to the country's broader health information systems. While these parallel systems were often necessary in the early stages of the epidemics to guide the scale-up of effective health interventions, running parallel data systems is not an effective long-term strategy.

As part of each bilateral agreement, the United States will partner with recipient countries to develop a streamlined and robust performance monitoring system that at a minimum will be able to monitor data in four areas:

- **Service Delivery:** Monitoring program service delivery including # of individuals on preventative therapies, # individuals on ART, # of malaria nets delivered, # of individuals tested and treated for malaria, and # of individuals treated for TB
- **Epidemiology:** Monitoring epidemic control with a focus on HIV, malaria, TB, and polio cases and deaths by geography and major demographic categories
- **Supply Chain:** Mechanisms to prevent and detect fraud, waste, and abuse in supply chain delivery systems
- **Co-Investment:** Tracking government co-investment

The U.S. government will work with recipient countries to develop long-term plans for monitoring service delivery and epidemiology data. This will include aligning on the minimum set of data fields that need to be collected and ensuring data governance frameworks are in place to ensure appropriate security and privacy controls. The U.S. government will also ensure long-term data sharing agreements are in place to provide the United States necessary data on emerging threat surveillance, program management, and legislatively required reporting.

In addition to core public health monitoring, the U.S. government will also ensure there are robust processes in place to facilitate inventory management for health commodities. For example, where possible, the U.S. government will work with recipient governments to ensure common private sector supply chain best practices such as barcoding and GS-1 labelling to ensure visibility from port to clinic.

Finally, the United States will work with countries to establish formal transition metrics to track country co-investment. Performance on all these metrics will be required to trigger future year U.S. health assistance funding. Specific performance requirements will be negotiated with each country as part of its respective bilateral agreement.

Significantly Reduce All Other Non-Frontline Investments

As discussed above, over 60% of health foreign assistance funding does not go to frontline investments in commodities or healthcare workers. The United States will work to rapidly decrease this funding that is not focused on commodities or frontline healthcare workers. This restructuring is long overdue, as the current cost structure of U.S.-funded global health foreign assistance is inefficient and not a sustainable financial model for countries to adopt. Several principles will be important as the United States works to rapidly reduce these non-frontline investments.

Integrate U.S. Health Foreign Assistance Programs Across All Disease States

The consolidation of all U.S. government health foreign assistance programs into the State Department offers a tremendous opportunity to integrate across disease-specific programs including HIV / AIDS, TB, malaria, and polio. Done well, integration can lead to greater efficiency in delivering disease-specific outcomes. For example, if a cadre of community health workers is being supported to deliver HIV testing and HIV drug refills in a rural community, that same cadre can be trained and equipped to distribute malaria testing and refer potential TB clients who are symptomatic for effective diagnostic testing.

Program integration is also an opportunity to facilitate greater integration with local health systems, as country government health systems are not managed by separate disease programs but rather are fully integrated across disease states. Key areas where an integrated approach across disease programs could improve efficiency are:

- **Supply Chains:** Integrated supply chain management approaches to warehousing, distribution, and inventory management to ensure products for HIV / AIDS, TB, malaria, and polio are available and delivered efficiently all the way to the last mile
- **Community Health Workers:** Integrated community health worker cadres adequately trained and equipped to conduct community-based testing and prevention for HIV, TB, malaria, and polio
- **Lab Systems:** A singular approach to develop a molecular diagnostic network for outbreak surveillance as well as HIV and TB to ensure efficient use of laboratory capacity in central sites and at point of care
- **Data Systems:** Common data collection, data infrastructure, and data analysis processes across disease states to facilitate understanding of program performance and to support country-owned, sustainable data systems

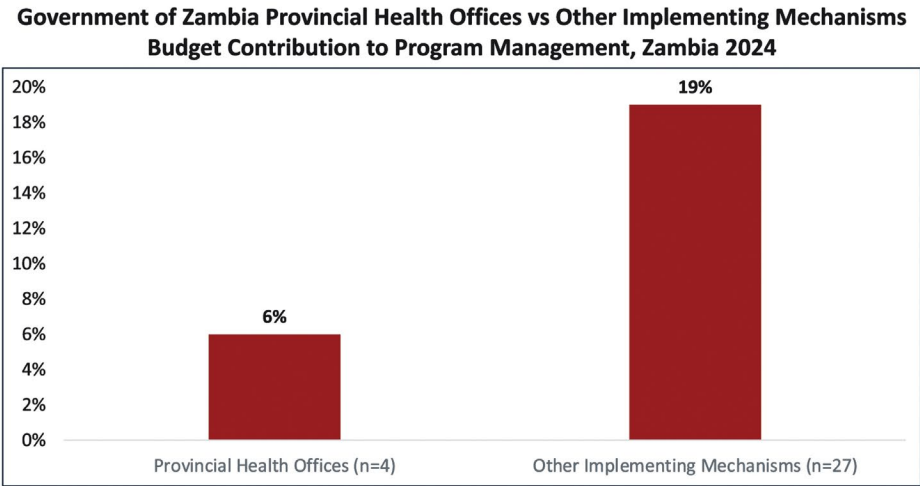
Integrate Within a Country's Broader Healthcare System

U.S. health foreign assistance has an opportunity to be better integrated with the way recipient country governments deliver other health services. Historically, U.S. health assistance programs, especially PEPFAR, often relied on parallel structures including parallel commodity procurement mechanisms, parallel distribution networks, program-specific healthcare workers, and program-specific data systems. This parallel infrastructure is one of the reasons that outcomes improved so quickly but also will not be sustainable for recipient countries to maintain long-term.

Going forward, where possible, U.S. health assistance will integrate with national health systems to deliver HIV, TB, malaria, and polio services. This will include increasing utilization of government-to-government (G2G) funding for service delivery and technical assistance

where appropriate, including enabling health commodities to move through national distribution systems and healthcare worker salaries to be aligned to local cost structures. G2G implemented programs tend to have significantly lower management costs (see Figure 7) and have been shown to be successful in many instances.

Figure 7: Program Management Budgets by Partner Type



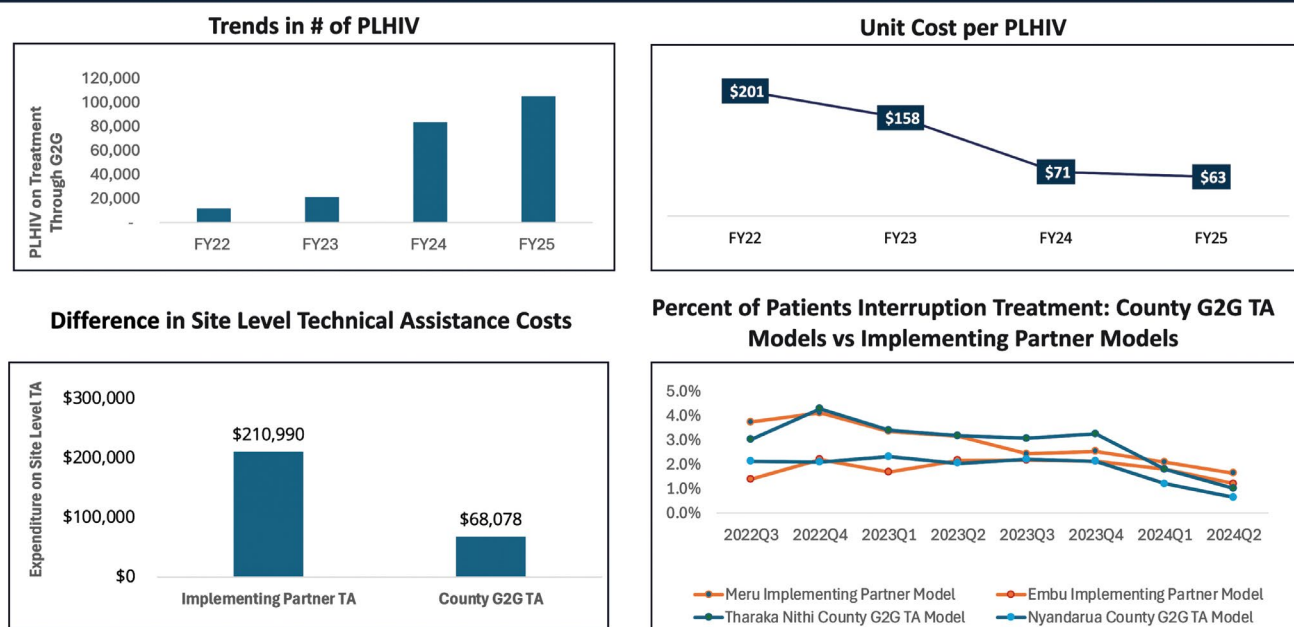
One example of where the U.S. government has been successful in integrating service delivery into the broader public health ecosystem is in Zambia. Across four large provinces in Zambia, the United States successfully shifted direct service delivery support for core HIV services from U.S.-based implementing partners to provincial governments through G2G agreements. This process not only resulted in an increase of HIV treatment coverage and viral suppression by 31%, but also reduced the underlying cost of support by 44% per person living with HIV.

Similarly, in Kenya, the United States transitioned funding and site level technical assistance from implementing partners to county government staff in multiple counties. In these counties, technical assistance costs decreased by 70% as a result of this transition. At the same time, the proportion of patients that interrupted treatment was reduced by over 50%, and the number of people on treatment increased more than five-fold from 20,000 to over 100,000.

By implementing through G2G arrangements where possible, the United States will not only help build more durable and resilient local health systems but also help further strengthen the United States’ bilateral relationships, as many countries will see increased value in U.S. foreign assistance when the national government is involved directly in implementation in a way that aligns with the country’s broader national health strategy.

Where G2G funding is not possible, U.S.-funded implementing partners will align their own

Figure 8: Efficiencies within Kenya G2G Mechanisms (FY17-FY25)



cost structures to local rates and integrate their planning and implementation processes into the public health performance management processes of the national government. The United States will also encourage governments to integrate essential infectious disease services (e.g., diagnostic testing, ART treatment) into public health financing schemes like national health insurance programs where they exist.

Utilize the Private Sector to the Maximum Extent Practical

There are substantial opportunities to leverage the private sector to drive better efficiencies in the delivery of foreign health assistance. The role of the private sector will vary depending on the specific country context, but in general will aim to follow a set of guiding approaches by type of support provided:

- **Procurement of Health Commodities:** In almost all countries, utilize pooled procurement mechanisms to purchase high-quality commodities for the lowest prices from private sector manufacturers
- **Distribution of Health Commodities:** Utilize in-country private sector logistics capabilities unless there is a strong cost or performance-driven reason to utilize fully government-managed health supply chain infrastructure
- **Service Delivery:** Utilize mixed models depending on the level of private sector lab, clinic, and pharmacy infrastructure in a country and invest where appropriate in models that leverage the private sector, as private sector solutions are more likely to consistently deliver lower cost and higher quality services long-term

- **Data Systems:** Where possible, utilize off-the-shelf private sector solutions instead of fully government-designed and managed data systems to keep costs down and ensure ongoing capital investment

Leverage Faith-Based Organizations

Faith-based hospitals and clinics are a meaningful part of the health delivery system in many of the highest burden countries. For example, faith-based providers represent over 50% of the delivery capacity in Eswatini and Uganda and over 40% in many other countries.

Faith-based organizations have a 20+ year track record of partnering with the U.S. government to deliver health foreign assistance. Faith-based programs have been successful because faith leaders are highly trusted by the community, especially in many countries across Africa where there are very high rates of religiosity. Moreover, faith-based programs tend to be successful because they go to where people already are, including into rural areas. Models of faith-based community service provision also tend to be highly cost-efficient, as they

Figure 9: Reach and Influence of Faith-Based Providers in Select Countries

Country	Faith reach	Total faith-based health facilities	Faith-based health facility market share
Zambia	98% Christian	142	40%
Zimbabwe	87% Christian	174	35%
Tanzania	61% Christian, 35% Muslim	968	42%
Malawi	83% Christian, 13% Muslim	198	37%
Uganda	87% Christian, 12% Muslim	626	50%
Lesotho	97% Christian	53	40%
Kenya	85% Christian, 10% Muslim	998	40%
Botswana	72% Christian	unavailable	18%
Rwanda	92% Christian, 2% Muslim	153	40%
Eswatini	90% Christian, 2% Muslim	157	52%

build upon existing infrastructure and have lower overhead costs. In addition, faith-based services have the potential to be sustained independently of U.S. foreign assistance over time, as these services can be supported by either private donors or by the tithes and offerings collected by local faith organizations.

Circle of Hope Zambia

The U.S. government has a long history of partnering with faith-based organizations to improve global health. In Zambia, a faith-based organization called Circle of Hope developed a new “Community Posts” (CP) model to support decentralized HIV testing, treatment, and prevention services with the support of faith-based staff. The model is grounded in three key components: (1) It is located near where people work, live, socialize, and worship; (2) It engages local trusted faith leaders as outreach workers to help identify and accompany those who need services; and (3) All staff are trained to exhibit the core values of the ‘RECIPE,’ in their delivery of care - Responsibility, Empathy, Compassion, Integrity, Passion, and Ethics.

Circle of Hope’s CP program has been scaled to seven of the 10 provinces in Zambia, and the provincial government has assumed all associated costs for two of these provinces. The program has achieved greater viral load suppression (95%) than other programming (90%). Successes in Zambia have led to the model being replicated in Côte d’Ivoire, Kenya, South Sudan, and Zimbabwe.



Require Co-Investment from Recipient Countries

Historically, U.S. health foreign assistance has been provided without explicit commitments from recipient country governments. Going forward, the United States will implement health assistance through multi-year bilateral agreements between the U.S. government and recipient countries that require both parties to follow through on key terms in order to facilitate accountability and unlock future U.S. funding.

However, rather than following the China model of loan-based agreements, which is aimed at extracting painful concessions from the country, the requirements that the United States will build into its agreements will be directed squarely at achievement of public health goals and better facilitating transition towards country self-reliance. This will ensure the U.S. government and countries are mutually incentivized to develop actionable, robust plans and follow-through over the length of the agreement.

The nature of the agreements will vary by country depending on the context including the country's income, disease burden, and political stability. Core components of each agreement will include:

- **Financial Contribution:** A schedule and timeline for transitioning financing of frontline service delivery (e.g., commodities, health workers) from U.S. government funding to recipient government funding where possible
- **Program Benchmarks:** The U.S. government and recipient government will jointly establish targets for key service delivery (e.g., # diagnostic tests, # individuals on ART) and epidemiology (# cases, # deaths) metrics by year

The United States will employ dedicated staff members in each country with significant foreign health assistance to focus on validating and auditing this data. These individuals will also be responsible for ensuring compliance with all rules and regulations, including compliance with the Helms Amendment.

The majority of 71 U.S.-supported countries will transition to full self-reliance during the term of the agreement. If certain financial contributions or program benchmarks are not achieved, the United States will have the right to withhold funding in future years. The United States will coordinate with other donor countries and organizations as appropriate to ensure resources from all donors are maximized and fully leveraged in each country.

Future U.S. Health Foreign Assistance Planning

To effectively execute on these principles, the U.S. government will launch a new, integrated health planning process across all disease programs including HIV, TB, malaria, polio, and global health security starting in October 2025. The process will require intensive engagement with recipient country governments, other donors, and other in-country partners to shape a set of mutually agreeable priorities for future U.S. health assistance. The conclusion of this planning process will be multi-year bilateral agreements between the U.S. government and each recipient country government to guide the next several years of health assistance.

The intensity and complexity of each agreement will be tailored to the context, based on disease burden, current dependence on U.S. government assistance, and current health system capacity. Most agreements will include requirements around co-financing from recipient governments, and all agreements will include requirements around developing data systems and setting program benchmarks for relevant diseases including HIV / AIDS, TB, malaria, and polio.

Agreements for the majority of the 71 U.S.-supported countries will include a full transition to country self-reliance over the timeframe of the agreement. By streamlining U.S. foreign assistance to focus on a smaller number of countries with the deepest relationships with the United States and the highest burden of disease, the United States will not only be able

to target its resources to best fight the epidemics but also to the bilateral relationships of the most strategic importance to the United States.

The U.S. government's goal will be to reach signed bilateral agreements with recipient countries receiving the vast majority of U.S. health foreign by December 31, 2025, and to develop detailed implementation plans with shared responsibilities, targets, and accountability mechanisms by March 31, 2026 to guide the next round of health foreign assistance implementation that will start in April 2026. Between October 2025 and March 2026, the U.S. government will execute a six-month bridge funding plan by which existing life-saving activities will be continued while these multi-year agreements are designed and put into place.

The outcome of this planning process will launch a new approach to U.S. health foreign assistance that facilitates accountability and self-reliance, continues to pursue increasingly ambitious health outcomes, and significantly reduces costs to the U.S. taxpayer.



PILLAR 3: Making America More Prosperous

Preventing outbreaks from reaching our shores is a critical element of making America more prosperous. Epidemics have the potential to significantly disrupt global supply chains and depress global commerce. By preventing outbreaks, we are not only saving lives – we are also protecting American industry and American workers.

In addition, America is home to the most innovative biomedical products and healthcare service delivery models in the world, and a key focus of our global health strategy will be promoting these innovations abroad. This will include supporting American companies both within the context of our health foreign assistance programs as well as within the broader context of bilateral relationships with recipient countries who are working to increase the sophistication and quality of their health systems.

Preventing Pandemics

The United States' work to contain outbreaks and prevent pandemics is a critical effort in protecting Americans and safeguarding our economy. Each pandemic has the potential to cost more than 1% of gross domestic product.

In the past 25 years, outbreaks of Ebola, Marburg, Severe Acute Respiratory Syndrome (SARS), Zika, Middle East Respiratory Syndrome (MERS), and other infectious diseases have cost billions due to lost productivity and travel and trade impacts. For example, the MERS outbreak in 2015 cost an estimated \$8 billion after it spread from Saudi Arabia to the Republic of Korea. In the Republic of Korea alone, MERS caused 38 fatalities, a 37% reduction in the number of tourists visiting the country, and an estimated \$2.6 billion in lost tourism activity.

Similarly, the 2014 to 2016 West African Ebola outbreak killed 11,000 people and caused \$53 billion in global economic losses. The United States mobilized \$5.4 billion in emergency supplemental funding in response to the outbreak and deployed nearly 3,000 U.S. troops and thousands of other U.S. government staff to support the international response. Domestically, the United States spent more than \$5 million to treat 11 infected patients and \$66 million to establish Ebola Treatment Centers at 55 U.S. locations.

By helping contain outbreaks before they reach American shores, the United States is able to protect our economy and the health of Americans both at home and abroad.

Foreign Assistance Procurements

Goal 4: Promote American health innovations through health foreign assistance programs.

The United States will continue to use health foreign assistance funds to procure supplies from U.S. companies, creating opportunity for those companies to grow their presence in emerging markets. In FY 2024 alone, the U.S. government procured over \$120 million in diagnostics tests from U.S.-based companies including Abbott, Cepheid, and Hologic. 50% of malaria rapid diagnostic tests and 70% of HIV rapid diagnostic tests have been purchased from American manufacturers, representing over \$350 million of procurements. This support has facilitated market entry for these diagnostic companies into many emerging markets, where these companies are now able to sell products that are not at all supported by U.S. foreign assistance.

This strategy also extends to new American innovations that are just entering the market. On September 4, 2025, the Trump Administration announced a new initiative with the American company Gilead Sciences to roll out a novel, six-month injectable for HIV prevention (lenacapavir). The U.S. government leveraged its scale to provide a pre-market advance commitment to Gilead to allow the company to build out its manufacturing capability. The U.S. government was also able to get other donors to participate in this initiative, resulting in additional investment from other countries into American technology.

U.S. health foreign assistance programs also heavily utilize American logistics companies to transport commodities internationally. For example, the United States has spent \$102 million since 2016 on transportation on U.S. flag ocean carriers including American President Lines, Hapag Lloyd, and Maersk Line Limited and over \$50 million on U.S.-based third-party logistics companies that specialize in managing international (and in some cases in-country) transportation of commodities. As foreign governments play a greater role in financing and managing their own health commodity supply chains, there is meaningful opportunity to facilitate greater use of private sector logistics capacity, including U.S. companies that have substantial networks in these emerging markets.

U.S. contributions to large multilateral funds such as the Global Fund have also created new markets for U.S. products. Since 2010, the Global Fund has procured \$3.5 billion in goods and services from U.S. corporations while other multilateral health organizations purchased over \$12.5 billion in goods from U.S. manufacturers between 2012 and 2023.

The U.S. government will continue to make the purchase of innovative American products a key component of future U.S. health foreign assistance programs including ensuring that pooled procurement mechanisms are designed in a manner that facilitates access to the most critical medical innovations developed by U.S. companies. To the extent appropriations from Congress exceed funds needed to support bilateral agreements, the United States will seek to invest some of these funds in innovative, breakthrough technologies from American companies that have the potential to change the course of epidemics globally.

Figure 10: Foreign Assistance Procurements from U.S. Companies

Program	Commodity Type	Funding
PEPFAR	Diagnostics	\$1.1 billion (FY16-25)
PEPFAR	Health Products	\$1.1 billion (FY16-25)
Non-PEPFAR USG	Health Products	\$139 million (FY16-25)
Global Fund	Goods & Services	\$3.5 billion (2010-2024)
Other Multilateral Health Organizations	Health Products	\$12.5 billion (2012-2023)

Commercial Partnerships

Goal 5: Create a conducive environment for American businesses to deploy their innovative health products and services globally.

Beyond direct foreign assistance, U.S. engagement in global health can promote broader bilateral partnerships, trade, and investment that increase access to emerging markets for U.S. healthcare and pharmaceutical companies. This is especially promising in many of the regions where the United States is making the largest global health investments including Asia, Africa, and Latin America. For example, the healthcare market in Asia alone is expected to reach \$5 trillion by 2030, contributing 40% of global growth in the sector. Similarly, the healthcare market in Africa is projected to grow rapidly to more than \$250 billion by 2030. As these markets develop, there are several concrete opportunities where the U.S. government can play a role in advancing commercial diplomacy.

The most direct opportunity will be to increase access for U.S. company produced pharmaceuticals in emerging markets. Beyond direct assistance, U.S. diplomacy has a key role in reducing barriers to entry, such as ensuring that countries recognize U.S. Food and Drug Administration (FDA)-approved products and promoting regional regulatory harmonization initiatives (e.g., African Medicines Agency).

As healthcare markets mature, demand for diagnostic tools typically increases disproportionately. Building upon the large U.S. health assistance investments in the laboratory ecosystem, the U.S. government can help facilitate partnerships with both public and private laboratory networks, which can then leverage product offerings from American diagnostic companies in a market that is set to exceed \$40 billion by 2030.

Beyond health commodities, there are larger opportunities across the health service delivery value chain where U.S. companies can capitalize on growing markets, including healthcare logistics, private pharmacies and clinics, and health data solutions. The U.S. government will work closely with companies looking to deliver services to identify critical barriers and facilitate partnerships with local entities to enable speedy market entry and scale-up wherever possible.

Conclusion

The United States has been and remains committed to being the world's health leader. This begins with protecting the homeland by ensuring that infectious disease outbreaks around the world do not reach our shores. This requires a comprehensive outbreak surveillance plan in every country as well as dedicated resources to rapidly respond to outbreaks.

The United States will also remain a leader in global health foreign assistance through entering multi-year, bilateral agreements that help move countries along the path to developing durable and resilient country-led health systems. This will require ensuring that funding for key frontline services (commodities and frontline healthcare workers) is maintained, strong data systems are in place, and that technical assistance responsibilities are thoughtfully transitioned from U.S. implementing partners to local governments, the private sector, and faith-based organizations. This will also include meaningful and concrete co-investments by local governments into their national health systems' infectious disease capabilities.

The United States will continue to promote American health innovation around the world through its foreign assistance programs and bilateral commercial partnerships. This will include promoting our global-leading capabilities in diagnostics, pharmaceuticals, and healthcare services.

With our new America First Global Health Strategy, we will not only save millions of lives and assist countries around the world in developing resilient and durable health systems, but we will also make Americans safer, make our country stronger, and make our people more prosperous.



