



# GOALS AND GAPS: IMPLEMENTING THE AMERICA FIRST GLOBAL HEALTH STRATEGY

On September 18, the U.S. Government (USG) released its America First Global Health Strategy, which changes the business model for U.S. global health investments. While the envisioned reforms promise to make programming more efficient and effective, the Strategy makes assumptions that could lead to gaps in its implementation.

To help the *Strategy* succeed,  
**ONE** offers the following 15 recommendations.

# PILLAR 1: MAKING AMERICA SAFER

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

**IMPLEMENTATION GAP: Creating networks of the right people with the right skills and access in the right places, including through longstanding, respected multilateral mechanisms, matters most.**

The *Strategy* states an intent to “assign U.S. government staff with a health portfolio to every country with a U.S. mission” and to consolidate U.S.-funded data and laboratory capacity into a central system. Tasking embassy officials “with a health portfolio” – who do not necessarily have the training and epidemiological expertise needed to work quickly with public health professionals and surveillance systems across borders, does not meet this challenge. Not every country has the risk profile to justify the expense of posting direct-hire staff focused on health security to the U.S. embassy.

Global surveillance is challenging, and no one country has the capacity at scale to ensure comprehensive tracking. Local communities play a critical role in detecting and managing disease outbreaks, and the U.S. would benefit by investing in the local medical infrastructure and personnel required to aid in such efforts. The smart application of technology can be a force-multiplier as well.

Diseases do not respect borders. If not contained and managed properly, diseases can quickly become global crises. Multilateral mechanisms to ensure proper surveillance and detection are essential to proper containment and response. In 2024, the World Health organization (WHO) conducted more than 13,000 screenings for public health threats, triaged 1.2 million raw signals, and provided risk assessments for 494 events. WHO’s access to data depends on the sharing of others. Without the U.S. at the table of WHO disease management, we relinquish our influence over multilateral global disease containment, management, and eradication strategies. A prime example of this is the WHO’s Global Influenza Surveillance and Response System (GISRS), which protects people from influenza by collecting global monitoring, surveillance, preparedness, alert, and response for seasonal

influenza. The WHO gives all participants access to the GISRS-generated data, which then provides them with an early warning of changes to the virus. Then, a subset of WHO Collaborating Centers part of the GISRS make recommendations for the influenza strains manufacturers should include in the annual vaccine for seasonal flu in the Northern and Southern Hemispheres. The system only works because of partner buy-in and sharing.

## RECOMMENDATIONS:

01

The USG should foster innovation in scaling comprehensive surveillance by creating a network that includes private-sector and non-governmental partners that are actively collecting information on dangerous pathogens. For example, the U.S. should partner with governments like Qatar that are investing in advanced surveillance at major travel hubs; the ICDDR,B in Bangladesh, which has used its experience detecting and managing cholera outbreaks in the country to support global surveillance and real-time relief efforts; the Gorgas Institute in Panama which produces cutting-edge research on zoonotic diseases; and regional groups like Africa CDC and the Institute Pasteur that have surveillance capacities at state and sub-national levels across the African continent and elsewhere. The USG should conduct a mapping exercise to connect partners that are collecting high-quality data and identify the gaps that exist in detecting an emerging outbreak with pandemic potential (i.e., who is monitoring changes to avian influenza and coronaviruses in China?).

02

Rather than assigning health-surveillance duties to diplomats, the U.S. should reverse recent cutbacks to the global footprint of the Centers for Disease Control and Prevention (CDC) and supplement these direct-hire personnel with contracted experts embedded in ministries of health on-governmental partner institutions in key locations.

03

The USG should make its investments in global health security based on a clear risk analysis that prioritizes the pathogens most likely to cause public health

emergencies of international concern, and the places from which outbreaks with pandemic potential are most likely to emerge.

04

To ensure more fulsome capacity beyond U.S. mission sites, the U.S. should maintain connections to multilateral institutions like Gavi, CEPI, and the WHO, which coordinates data and outbreak responses across the globe and is uniquely equipped to handle outbreak detection, response, tracking, and surveillance. The WHO should also be pressed to go further, for example in driving more effective disease surveillance globally that does not depend on national governments.

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

**IMPLEMENTATION GAP: Disease outbreaks spread quickly, impact vulnerable communities disproportionately, and require both global and localized solutions to ensure proper containment, but the USG has decimated its international surge capacity.**

The *Strategy* highlights the importance of emergency surge resources and highlights the cost effectiveness of the U.S. CDC's Field Epidemiology Training Program (FETP), which trains foreign health workers to detect and respond to outbreaks. The *Strategy* does not take into account the CDC's diminished capacity for FETP and other international response efforts due to staff cuts over the last several months, including those responsible for international disease detection, response, and training for local workers. These cuts, in parallel with the loss of USAID's health Disaster Assistance Response Team (DART) capacity, means the U.S. is currently ill-equipped to respond to an outbreak with the speed the strategy envisions. Effective response to outbreaks depends not just on external resources, but on the existence of strong local health systems and capacity to deliver in times of need, especially to the most vulnerable, while also protecting frontline healthcare workers.

## RECOMMENDATIONS:

05

To effectively respond to an outbreak in 72 hours, the USG must ensure it has on-the-ground capacity in times of health emergencies. This will require procurement mechanisms to surge staff and funding, flexible contracts with pre-identified partners that can deploy anywhere in the world to respond to health outbreaks at their source, and preparedness initiatives to equip local systems to respond. Every USG award (contract, grant, or cooperative agreement) in global health must include a crisis modifier that allows for immediate shifts in scope of work and funding to respond to a health emergency. Beyond existing multilateral mechanisms like the WHO, the USG should explore opportunities to partner with U.S.-based private companies utilizing AI and other advanced mechanisms to detect and respond to outbreaks.

06

The USG should invest in mechanisms that build local capacity for crisis preparedness, prevention, and response, with particular attention to the unique needs of disproportionately impacted communities like women and children. Awards under the bilateral compacts envisioned in the Strategy should provide resources in high-risk countries to ensure that local healthcare staff – the first line of defense in any outbreak – are properly trained, paid, and protected, and know who to quickly notify in an emergency. The USG should also work with state and non-state actors – local suppliers and production centers, distribution centers, transportation suppliers, clinics, community leaders, caregivers, schools, religious institutions, and multilateral efforts like Gavi the Vaccine Alliance – to ensure that healthcare workers and other vulnerable populations have consistent access to resources, including vaccines, if outbreaks occur.

## PILLAR 2:

# MAKING AMERICA STRONGER

***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.*

**IMPLEMENTATION GAP:** Disease burdens impact different demographics uniquely and must be matched by holistic approaches that involve both public and private actors.

To ensure U.S. health investments save lives, move recipient countries to self-sufficiency, and promote American interests, the *Strategy* envisions a shift towards time-limited bilateral agreements. However, these top-level government-to-government compacts risk not reaching especially vulnerable and hard-to-reach communities. In the absence of implementers operating across target countries, the USG should develop partnerships with state and non-state actors and train and equip them to deliver adequate care. This will take more resources up front. The *Strategy* focuses on engagement with religious institutions and the private sector, which is especially important; this can be taken a step further to include other relevant non-state actors that are unique to target beneficiary countries and their individual health care architecture.

The compact model offers an opportunity to create mutual accountability, but to be effective it must ensure the right players are involved at various levels to prevent aid from being misused or wasted. With the reduction or absence of community-level partners to deliver services in many countries — especially the kind required to address the unique needs of HIV/AIDS, TB, malaria, and polio — the capacity on the ground to deliver on timebound health goals is greatly reduced. The time-limited nature of a compact agreement requires the governments of partner countries to meet certain guarantees to continue to receive funding. In the health space, this requires governments and other institutions to have the capacity to pay for and deliver medical resources and meet the stated goals. Many countries also lack available resources to co-invest in compacts. If the US wants to “stay committed to the ambitious goals that have been set over the past decades for HIV/AIDS, TB, malaria, and polio,” we need much more than bilateral compact agreements with governments.

## RECOMMENDATIONS:

07

In addition to the faith community, the USG must also engage a broader range of state and non-state actors, such as public and private healthcare workers, healthcare institutions, distribution and supply centers, representatives from other governments and organizations supporting interventions, laboratories, community organizations, translators, pharmacies, and more. This will help ensure resources are appropriately targeted to high-need communities, and advances local capacity to own and deliver on healthcare needs.

08

Health compacts must prioritize investments for local health care workers, facilities, laboratories and testing/tracing capacities, and community services to address the highly specialized needs of containing and managing HIV/AIDS, TB, malaria, and polio-impacted populations and to detect outbreaks at the speed the *Strategy* envisions.

09

The USG must take into consideration the complexity of ensuring healthcare delivery in particular countries and provide appropriate timeframes for compact benchmarks that realistically allow governments and local actors to deliver on those goals. Rushed deadlines — especially to address complicated disease burdens — will not secure sustainable progress and will potentially harm vulnerable populations.

## PILLAR 3: MAKING AMERICA MORE PROSPEROUS

*GOAL 4: Promote American health innovations through health foreign assistance programs.*

**IMPLEMENTATION GAP: Investments in health innovation should extend beyond immediately life-saving interventions and focus on the most vulnerable.**

The *Strategy* largely prioritizes immediately lifesaving investments, which are not enough to secure “long-term country ownership” and continued returns on investment. To meet these goals, the USG should catalyze investment in underlying local health care systems and innovations in data-sharing, AI, and medical infrastructure. This will ensure that lifesaving assistance has a greater impact in the long-term and reduce ultimate international reliance on U.S. resources. The *Strategy* rightly cites the importance of multilateral mechanisms such as the Global Fund to Fight AIDS, Tuberculosis, and Malaria, which has returned \$3.5 billion to the U.S. economy over the last 15 years and to which the Trump Administration just made a \$4.6 billion pledge. It also notes the groundbreaking promise of Lenacapavir, which has the potential to end the AIDS epidemic by providing both a prevention and treatment pathway for individuals impacted by HIV. The USG has invested in these efforts, but must go further.

The *Strategy*'s singular focus on addressing disease burdens ignores other important efforts that enable countries to develop independent, sustainable healthcare delivery. Strong systems, supply chains, commodity distribution, a trained healthcare workforce, and equipped facilities are essential to enduring healthcare and economic returns. For example, the *Strategy* makes no mention of child and maternal health programs, which are vital to ensuring the safety of women and their families in the long-term. Disease burdens impact women and children disproportionately, which is why their care must be prioritized.

## RECOMMENDATIONS:

- 10  
The USG must restore funding for Gavi, which saves lives and strengthens the U.S. economy. Investments in Gavi not only save the lives of children everywhere (more than 21 million so far), but also directly benefit the U.S. economy. As the single largest purchaser of U.S.-produced vaccines, Gavi spends more in the United States each year than the USG spends on Gavi.
- 11  
The USG must invest more resources for healthcare innovation in target countries. Specifically, the USG should work with companies that support voluntary licensing arrangements for innovative medications and supplies, which will in turn enable real access in low- and middle-income countries and create sustainable supply pathways. For example, the Administration's partnership with Gilead and the Global Fund to support Lenacapavir production and licensing is an important step that will enable breakthrough innovations to save lives. The administration should consider other innovative partnerships with pharmaceutical, medical technology, data, and financial sectors to strengthen impact and return on taxpayer investments. For example, SC Johnson recently introduced the first new vector-control products to combat malaria in more than 25 years (a spatial repellent called Guardian™). As malaria rates continue to rise, innovations like these will directly address root causes and provide target populations with cost-effective means for preventing infections, all while supporting U.S. businesses.
- 12  
The USG should connect investments under the Strategy with the U.S. International Development Finance Corporation, which helps mobilize private sector capital for use in emerging markets.
- 13  
If the USG wants to continue progress in combatting major diseases, it should also invest in programs that support overall health security, especially for vulnerable populations. The Administration must also take local demands into account in balance with U.S. interests. If a country raises

The importance of child and maternal health as a direct need for example, the USG should be responsive to those needs, while also remaining anchored in U.S. core commitments through PEPFAR, the Global Fund, etc.

14

To genuinely promote the health of vulnerable populations, the USG must develop indicators that effectively measure progress in reaching them. Without confirmation of whether and how vulnerable populations are gaining access to healthcare, they risk falling further through the cracks.

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

**IMPLEMENTATION GAP:** While the Strategy rightly points out the importance of increasing investments in emerging markets for U.S. healthcare and pharmaceutical companies, it fails to identify target regions for such opportunities and is vague about how it would engage partners, benefit U.S. interests, and contribute to long-term sustainability in those emerging markets.

## RECOMMENDATION:

15

The USG should focus on emerging markets in Africa, especially where there are vital opportunities to engage cutting-edge entrepreneurs, the largest global youth population, and nations in high need of health care infrastructure, investment, and production capacity. These investments have a direct return on the safety and prosperity of Americans. For example, there is an opportunity to partner with African-led institutions like Botswana University, which developed 3-D printing technology to cure rare diseases; the Health Tech Platform, which works with the African Institute for Development Policy and African Union Development Agency to support research and awareness on emerging healthcare technologies; or the Timbuktoo organization that supports an African health innovation hub that has led to improved access to healthcare across the continent.