

# U.S. Health Engagement in Africa

*A Decade of Remarkable Achievement—Now What?*



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# U.S. Health Engagement in Africa: A Decade of Remarkable Achievement—Now What?

J. Stephen Morrison<sup>1</sup>

In the past decade, there has been a steep and historic expansion of U.S. health engagement in Africa, principally through the President's Emergency Plan for AIDS Relief (PEPFAR) and the President's Malaria Initiative (PMI). U.S. commitments to global health, of which over 70 percent is directed to Africa, rose from \$1.7 billion in FY 2001 to \$8.9 billion in FY 2012.<sup>2</sup>

This dramatic shift in U.S. foreign assistance—spurred by the “exceptionalism” of HIV/AIDS—has rested on a consensus that substantial U.S. investments in health in Africa do indeed advance U.S. interests. They fulfill American humanitarian values by saving and enhancing lives; they strengthen health security against common and emerging threats; and they promote the stability and long-term development of vulnerable communities in low-income countries.<sup>3</sup>

Over the past decade, several key factors account for the robust, sustained U.S. health engagement in Africa and the widely held view that these U.S. investments are a foreign-assistance success story.

High-level U.S. leadership—by the president, most importantly—has been an essential ingredient. Witness the July 2013 appearances by both Presidents Obama and Bush in Tanzania, at which Obama lauded Bush's landmark contributions to health in Africa; so too, the African First Ladies' Summit at which both Michelle Obama and Laura Bush affirmed their commitments to advancing women's health in Africa, reinforcing former secretary of state Hillary Clinton's determined efforts to champion women's health and gender equality.

Critical also has been an enduring and exceptional bipartisan foundation in Congress, reinforced by a relatively small, but vocal and resilient base of popular support in American society that encompasses religious communities, universities, foundations, nongovernmental organizations, advocacy groups, the private sector, and media. Congressional travel to Africa to see firsthand the results of U.S. health partnerships in Africa has had powerful impacts on members personally and back home in discussions of U.S. policies and programs.

A third vital factor has been the ability to measure and demonstrate significant concrete progress in improving the health status of millions of individuals in Africa, and the surprising success in recent years in improving operational efficiencies, which made possible significant expansion of U.S. programs even as budgets flattened. Among the remarkable public health achievements: Supporting 5.1 million persons by early 2013 on life-sustaining antiretroviral treatment, the vast majority in Africa, up from 50,000 a decade earlier, and on course to reach 6 million by the end of 2013. Similarly impressive claims can be made for the swift reductions in malaria seen in Ethiopia, Zanzibar, Zambia, Tanzania, and Rwanda.

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<sup>1</sup> J. Stephen Morrison is senior vice president and director of the Global Health Policy Center at the Center for Strategic and International Studies (CSIS) in Washington, D.C.

<sup>2</sup> In this same period, aggregate investments in global health—from all sources—rose from \$10 billion in 2001 to \$28 billion in 2010.

<sup>3</sup> J. Stephen Morrison, ed., *Global Health Policy in the Second Obama Term* (Washington, D.C.: CSIS, February 2013), [https://csis.org/files/publication/130214\\_Morrison\\_GHTransitionVolume\\_Web\\_FINAL.pdf](https://csis.org/files/publication/130214_Morrison_GHTransitionVolume_Web_FINAL.pdf).

There have of course been sharp critiques of the U.S. approach: that it exaggerated, especially in the early days of 2002–2003, the true threat HIV/AIDS posed to the stability of nations; that U.S. programs are too vertical versus focused on essential health infrastructure; that the HIV/AIDS investments are grossly outsized vis-à-vis other health priorities and the financial capacities of partner countries; and that they crowd out other worthy foreign assistance concerns and create a long-term dependency—a “mortgage” or “entitlement”—with no clear end game. Debate has persisted over whether the United States is doing enough to reach with essential prevention services those highly marginalized groups that are at high risk of HIV infection, for example, sex workers, men who have sex with men, and injection drug users.

Congress made valuable contributions to U.S. leadership on health in Africa through two successive five-year authorizations. The *United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003* outlined a five-year, \$15 billion emergency initiative focused on 14 (later 15) high-burden countries, 12 in Africa, and established powerful authorities in a new Office of the Global AIDS Coordinator (OGAC). Appropriations from Congress 2003–2008 eventually reached \$18.8 billion.<sup>4</sup>

Congress subsequently passed the *Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008*. This five-year \$48 billion reauthorization called for a transition from an emergency response to sustainable country programs. That shift, it was argued in the legislation, requires expanded efforts to strengthen partner government capacity—especially the training of skilled personnel—and a higher priority to winning greater country ownership, for example, higher political, financial, and staff commitments. It requires expansion of prevention, care, and treatment programs; better integration and coordination of HIV/AIDS programs with other health and development programs; higher investments in innovation and operations research to better evaluate impacts; and improvements in service delivery to maximize outcomes.<sup>5</sup>

Given the present acute polarization in Congress, which constrains action across countless fronts, there is a low probability that there will be a third five-year reauthorization in 2013. Hence it will be through alternative, more discrete actions—appropriations language, congressional travel, targeted resolutions—that Congress will address pressing policy challenges on health in Africa and help update the U.S. strategy for the future.

There are risks and uncertainties as we look forward, but also opportunities for U.S. policy to continue to advance global health.

It remains to be seen whether, in the midst of budgetary austerity, a durable bipartisan congressional consensus can be successfully preserved in support of continued strong U.S. leadership on health and Africa.

Congress will also certainly be called upon to help define how—and with what level of long-term resource commitments and what U.S. political leverage—the United States can effectively build partner-country capacities and facilitate real and timely transitions to greater country ownership. One challenge is whether, in its interactions with the more competent and able partner countries, the United States can systematically scale back its high-cost delivery of services, without convulsive disruptions to the health of beneficiaries, and become mainly a source of technical expertise. At the same time, of interest is what transition strategy the United States pursues with partner countries that are poorer and have weaker capacities, and in which the United States will be called upon for a longer period to deliver programs and services. Progress in these critical areas depends of course on whether partner countries themselves can and will increasingly take

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<sup>4</sup> Kaiser Family Foundation, “Fact Sheet: The U.S. President’s Emergency Plan for AIDS Relief (PEPFAR),” March 2013, <http://kaiserfamilyfoundation.files.wordpress.com/2013/04/8002-05.pdf>.

<sup>5</sup> Office of the U.S. Global AIDS Coordinator, “About PEPFAR,” 2011, <http://www.pepfar.gov/about/>.

the lead in service delivery, financing, and managerial responsibility. At present, the process of transition, and how the United States is to facilitate change, better manage its partnerships, and measure progress, are neither clearly understood nor defined. There is a continued need for better data collection and evaluation, new, reliable scorecards of country performance, and an updated vision of U.S. goals, expectations, and commitments for each of these transitions.

In recent years, the United States has come to rely more and more on multilateral partners, most importantly the Global Fund to Fight AIDS, Tuberculosis and Malaria, but that change has happened with little discussion of what the desired specific balance should be between U.S. bilateral programs like PEPFAR and PMI versus the Fund. Similarly, in recent years the U.S. global health agenda in Africa has steadily broadened: there is today a far bigger emphasis on gender, maternal health (including the often divisive issue of family planning), child survival, and polio (especially as regards Nigeria). But at present there is no coherent delineation of U.S. priorities. Related to that, an important but quickly evolving debate has begun over noncommunicable diseases (diabetes, cancer, hypertension/heart disease, lung disorders), the behavioral, policy, and medical interventions to lower their rising incidence in Africa, and what the appropriate U.S. contribution in this area should be.

One can argue, of course, that any revised, updated global health strategy can and should rely heavily on executive branch leadership. But experience to date has been disappointing and problematic. The Obama administration unveiled its Global Health Initiative (GHI) in the spring of 2009 with a focus on seven valuable guiding principles: a women- and girls-centered approach; strategic coordination and integration of programs; strengthening and leveraging key multilateral institutions and other partners; country-ownership; sustainability through health systems strengthening; improving metrics, monitoring, and evaluation; and promoting research and innovation. Operationally, GHI was charged with tackling fragmentation and tensions across competing U.S. agencies—most significantly, OGAC and the Centers for Disease Control and Prevention (CDC) versus the U.S. Agency for International Development (USAID). In reality, the GHI directorate never acquired the political sway, budgetary authority, and staff capacity to fulfill its mandate; interagency clashes often escalated in the first Obama term. The State Department's Office of Global Health Diplomacy, established in late 2012, is the designated heir to GHI. It remains to be seen what its exact mission will be and if it is more successful than its predecessor.



Figure 1. Aggregate Funding for Global Health<sup>6</sup>

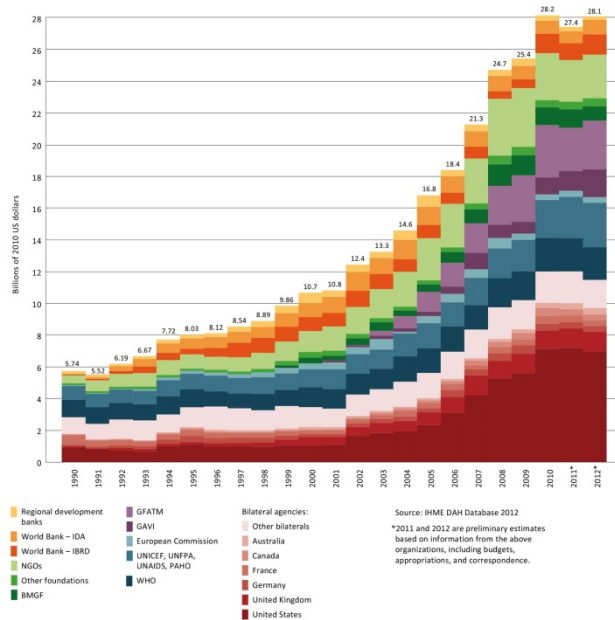
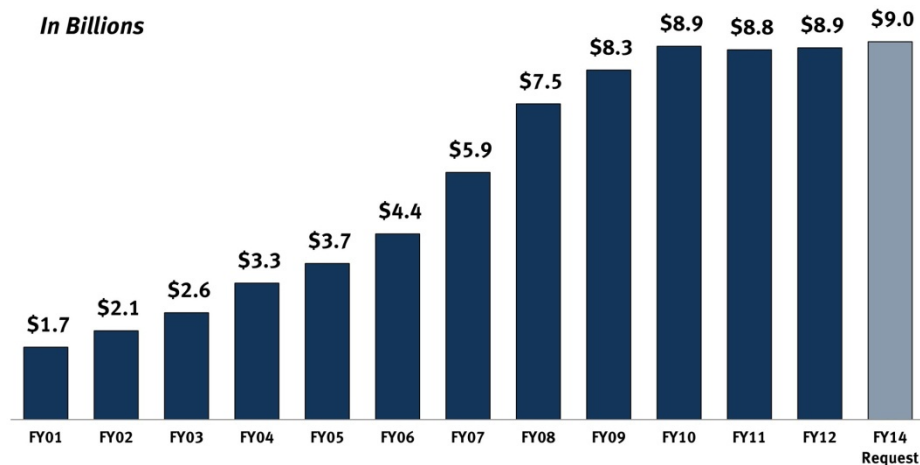


Figure 2. U.S. Funding for Global Health (FY 2001–FY 2014)<sup>7</sup>



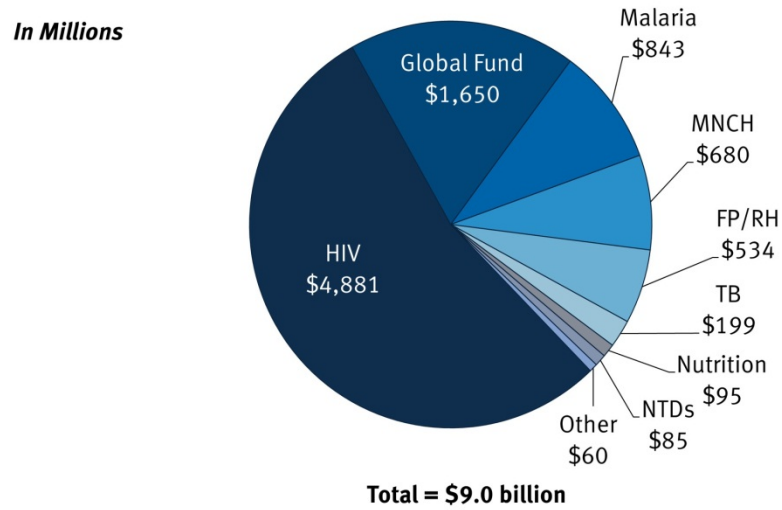
Notes: Global health funding represents accounts in the Global Health Initiative (GHI) only. FY 2013 funding levels are not yet available.

<sup>6</sup> Institute for Health Metrics and Evaluation, *Financing Global Health 2012: The End of the Golden Age?* (Seattle, WA: IHME, 2012), [http://www.healthmetricsandevaluation.org/sites/default/files/policy\\_report/2011/FGH\\_2012\\_full\\_report\\_high\\_resolution\\_IHME.pdf](http://www.healthmetricsandevaluation.org/sites/default/files/policy_report/2011/FGH_2012_full_report_high_resolution_IHME.pdf).

<sup>7</sup> Kaiser Family Foundation, “U.S. Funding for Global Health: The President’s FY 2014 Budget Request,” May 2013, <http://kff.org/global-health-policy/fact-sheet/u-s-funding-for-global-health-the-presidents-fy-2014-budget-request/>.

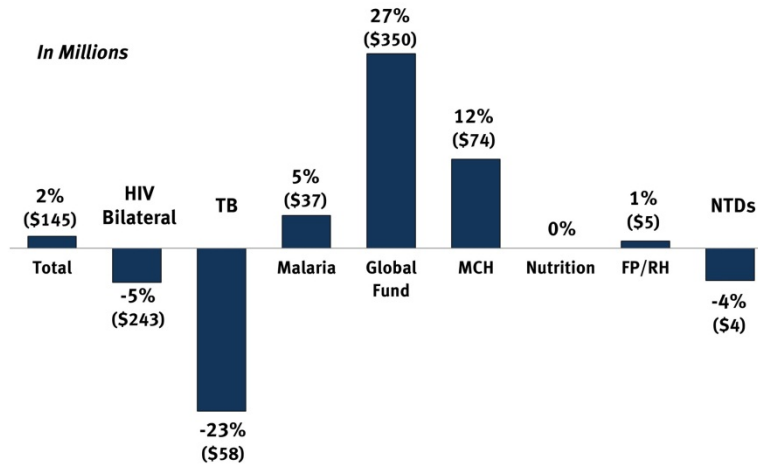


Figure 3. The President's Global Health Budget Request by Sector (FY 2014)<sup>8</sup>



Note: Global health funding represents accounts in the Global Health Initiative (GHI) only.

Figure 4. U.S. Global Health Funding, Percent Change by Sector (FY 2012–FY 2014)<sup>9</sup>



Note: Global health funding represents accounts in the Global Health Initiative (GHI) only.

<sup>8</sup> Ibid.

<sup>9</sup> Ibid.

## Additional Detail by Sector

### PEPFAR, HIV/AIDS, and the Global Fund

The PEPFAR program, launched in 2003 by President George W. Bush, became the largest and most successful U.S. global health initiative. To date, the estimated cumulative U.S. spending overseas on HIV/AIDS is \$44.3 billion, including contributions to the Global Fund. Outlays in 2012 totaled \$6.6 billion.

The United States directly supports antiretroviral treatment for more than 5.1 million HIV-positive individuals as of September 30, 2012. This puts the United States on track to reach a goal set by the Obama administration to reach 6 million HIV-positive individuals by the end of 2013. In FY 2012, the United States also supported HIV counseling and testing for more than 11 million pregnant women, 15 million people with care and support, and HIV counseling and testing for 46.5 million people.

The International AIDS Conference—*AIDS 2012*—returned to the United States, after a 22-year hiatus, in July 2012 in Washington D.C. A special session featuring congressional leaders—Senator Mike Enzi (R-WY), Senator Chris Coons (D-DE), Senator Marco Rubio (R-FL), and Representative Barbara Lee (D-CA)—focused on the historical legacy and future trajectory of congressional involvement in addressing the global AIDS epidemic.

At *AIDS 2012*, there was considerable optimism surrounding recent scientific discoveries in the field of HIV prevention: specifically proof that early antiretroviral treatment can significantly lower the risks of new HIV infections, along with evidence that male circumcision and prevention of transmission from mothers to infants can also be highly effective in reducing HIV incidence. In late November 2012, the Obama administration released its *Blueprint for an AIDS-Free Generation*,<sup>10</sup> which laid out a detailed, impressive strategy for building systematically upon these gains, but without budgeting costs or offering a game plan for financing the strategy.

The United States has entered a new phase of its global HIV/AIDS response, where it has begun to transition PEPFAR support from direct service delivery to the provision of technical assistance. Transitions will occur on a country-by-country basis guided by framework agreements with partner countries. This process has advanced in Botswana,<sup>11</sup> South Africa,<sup>12</sup> and Namibia. However, there is no clear method to track progress and measure country ownership. Part of this new phase also includes a transition to increased U.S. support to the Global Fund. At present, how this shift will evolve into the future has also not yet been clearly defined.

As part of the 2008 PEPFAR reauthorization, the U.S. Congress tasked the Institute of Medicine (IOM) to evaluate PEPFAR programs. Completed in February 2013, the IOM report was overwhelmingly affirmative: “Since it was first authorized by Congress in 2003, PEPFAR has saved and improved lives of millions; supported HIV prevention, care and treatment; strengthened systems; and engaged with partner countries to facilitate HIV policy and planning. PEPFAR has expanded global expectations for what can be accomplished in partner countries with resource constraints and limited infrastructure.” The report also highlighted critical needs: to address unmet demand for HIV/AIDS services, diversify financing, improve data collection and evaluation,

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<sup>10</sup> U.S. Department of State, *PEPFAR Blueprint: Creating an AIDS-Free Generation*, November 2012, <http://www.pepfar.gov/documents/organization/201386.pdf>.

<sup>11</sup> Sharon Stash et al., *Competing Pressures for U.S. PEPFAR in Botswana: Rising Ambitions, Declining Resources* (Washington, D.C.: CSIS, November 2012), [http://csis.org/files/publication/121128\\_Stash\\_PEPFARBotswana\\_Web.pdf](http://csis.org/files/publication/121128_Stash_PEPFARBotswana_Web.pdf).

<sup>12</sup> J. Stephen Morrison et al., *The Future of the U.S.-South Africa HIV/AIDS Partnership: Trip Report of the CSIS Delegation to South Africa, January 2013* (Washington, D.C.: CSIS, March 2013), [http://csis.org/files/publication/130313\\_Morrison\\_SouthAfricaHIV\\_Web.pdf](http://csis.org/files/publication/130313_Morrison_SouthAfricaHIV_Web.pdf).

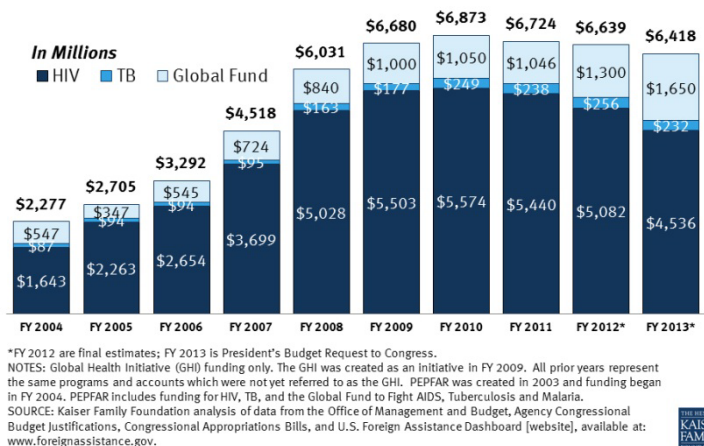
improve access to prevention services by sex workers, injection drug users, and men who have sex with men, tackle HIV co-infection with TB, and put in place a measurable gender strategy.

The Global Fund began operations in January 2002 as an independent, multilateral financing instrument to address HIV/AIDS, tuberculosis, and malaria in low- and middle-income countries. To date, the Global Fund has approved more than \$26 billion in grants to over 150 countries. The United States has played an integral role in the Global Fund since its creation, providing the Fund with its founding contribution and continuing to be its single-largest donor. U.S. contributions to the Global Fund between FY 2001 and FY2012 totaled \$8 billion.<sup>13</sup> From the Fund's inception, Congress has mandated that U.S. contributions to the Fund be matched by other donors by at least a 2:1 ratio.

Over the last several years the United States has increased collaboration and coordination with the Global Fund. The United States remained a strong proponent of the Global Fund even as the Fund experienced considerable financial, managerial, and governance adversity in 2011 and entered a period of promising restructuring in 2012.<sup>14</sup>

The Fund operates on three-year funding cycles. In 2010, the Obama administration announced a three-year (FY 2011–FY 2013), \$4 billion pledge to the Global Fund, which met with a mixed response from Congress. Current annual U.S. funding stands at an all-time high of \$1.65 billion. It remains to be seen if the Obama administration commits to another formal three year pledge, during the Fund's 2013 replenishment cycle, or chooses instead to commit year-by-year. Given their budgetary woes, other major donors to the Fund (e.g., France, the UK, Japan, Germany, the Scandinavians, Canada, Australia) may not be able to reach twice the level of the U.S. contribution of \$1.65 billion, which might trigger a reduction of the U.S. contribution.

Figure 5. U.S. Global Health Funding for PEPFAR (FY 2001–FY 2013)<sup>15</sup>



<sup>13</sup> Kaiser Family Foundation, “Fact Sheet: The U.S. & The Global Fund to Fight AIDS, Tuberculosis and Malaria,” March 2013, <http://kff.org/global-health-policy/fact-sheet/the-u-s-the-global-fund-to-fight-aids-tuberculosis-and-malaria/>.

<sup>14</sup> J. Stephen Morrison and Todd Summers, *Righting the Global Fund* (Washington, D.C.: CSIS, February 2012), [https://csis.org/files/publication/120227\\_Morrison\\_RightingGlobalFund\\_Web.pdf](https://csis.org/files/publication/120227_Morrison_RightingGlobalFund_Web.pdf).

<sup>15</sup> Kaiser Family Foundation, “The U.S. President’s Emergency Plan for AIDS Relief (PEPFAR).”

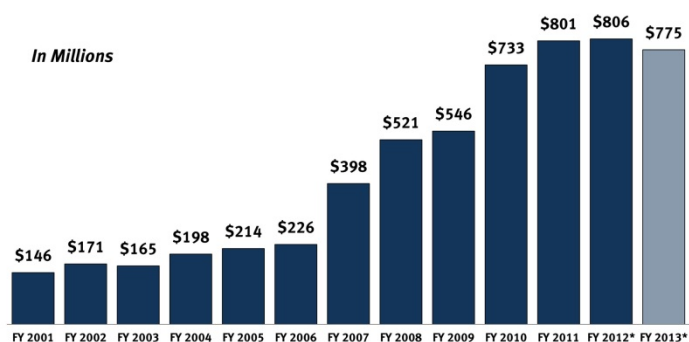
## The President's Malaria Initiative (PMI)

PMI was launched in 2005 by President George W. Bush as a 5-year \$1.2 billion effort originally targeting 15 African countries. Housed at USAID and co-implemented with CDC, in partnership with the Department of Defense (DOD) the National Institutes of Health (NIH), and other agencies, PMI aims to reduce malaria-related deaths by 50 percent.<sup>16</sup>

U.S. bilateral funding for malaria totaled \$3.6 billion between FY 2004–FY 2011 and was approximately \$806 million in FY 2012. The Obama administration requested \$775 million in FY 2013, a 4 percent decrease over the FY 2012 level.<sup>17</sup>

The costs to Africa of malaria are steep. In 2010 there were an estimated 660,000 malaria fatalities of which 91 percent occurred in sub-Saharan Africa.<sup>18</sup> Malaria is the third-biggest killer of children under five globally, with over 90 percent of malaria deaths occurring in Africa.<sup>19</sup> Malaria imposes an estimated \$12 billion in lost economic output per year. Indirectly, malaria is a leading cause of school absence. A 2005 survey found that nearly 75 percent of companies in Africa reported that malaria negatively affects their business.<sup>20</sup>

Figure 6. Total U.S. Bilateral Funding for Malaria (FY 2011–FY 2013)<sup>21</sup>



\*FY 2012 are final estimates; FY 2013 is President's Budget Request to Congress.  
SOURCE: Kaiser Family Foundation analysis of data from the Office of Management and Budget, Agency Congressional Budget Justifications, Congressional Appropriations Bills, and U.S. Foreign Assistance Dashboard [website], available at: [www.foreignassistance.gov](http://www.foreignassistance.gov).



Increased funding and political support have resulted in big gains in malaria control. An external evaluation conducted in 2011 detailed strong leadership, an effective integration of malaria control interventions, solid procurement and host-country partnerships, and significant declines in malaria disease burden and child mortality.<sup>22</sup> Delivered in combination and on a dramatically

<sup>16</sup> Kaiser Family Foundation, “The Global Malaria Epidemic,” March 2013, <http://kff.org/global-health-policy/fact-sheet/the-global-malaria-epidemic-4/>.

<sup>17</sup> Ibid.

<sup>18</sup> World Health Organization (WHO), “10 facts on malaria,” March 2013, <http://www.who.int/features/factfiles/malaria/en/>.

<sup>19</sup> UN Children’s Fund (UNICEF), “Malaria Prevention,” 2013, <http://www.unicefusa.org/work/malaria/>.

<sup>20</sup> Roll Back Malaria, “Business Investing in Malaria Control: Economic Returns and a Healthy Workforce for Africa,” May 2011, <http://www.rbm.who.int/ProgressImpactSeries/report6.html>.

<sup>21</sup> Kaiser Family Foundation. “The Global Malaria Epidemic.”

<sup>22</sup> Jonathon Simon et al., *External Evaluation of the President’s Malaria Initiative Final Report* (Washington, D.C.: USAID, December 2011), [http://www.pmi.gov/news/docs/audit\\_fullreport.pdf](http://www.pmi.gov/news/docs/audit_fullreport.pdf).

expanded basis, the principal tools for malaria control have brought about swift gains: investments in long-lasting insecticide-treated nets, indoor residual spraying, intermittent prevention treatment for pregnant women, and artemisinin combination therapies delivered results in a relatively rapid fashion.

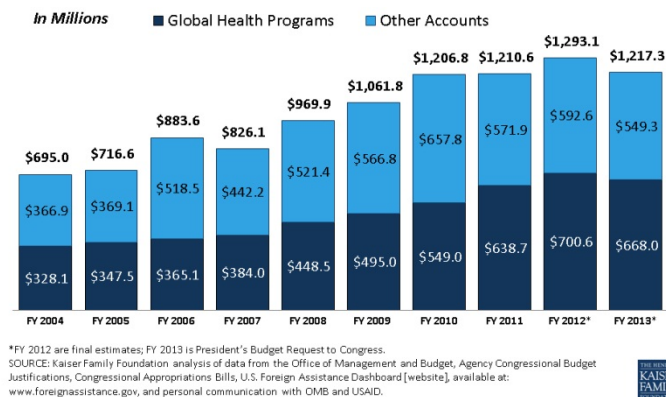
Nonetheless, progress remains fragile; it can be reversed swiftly if there is a loss of focus. In the meantime, several challenges are outstanding. For malaria control and elimination to succeed, bed nets must be replaced every three years once insecticide loses potency and nets become worn, ripped, or torn. An inexpensive, rapid diagnostic to confirm cases and prevent overuse of antimalarial drugs is needed. Drug and insecticide resistance need to be addressed. And there is need to better clarify the division of responsibility between PMI and the Global Fund.

## Women’s Health

Despite the often-polarized atmosphere in Washington, bipartisan successes have been achieved in support of women’s health. The Bush administration’s PEPFAR program developed gender strategies to reach women and girls, and the Obama administration elevated women’s health and gender equality as a key foreign policy goal.

New public-private partnerships are illustrating innovative ways to maximize U.S. investments in women’s health and promote sustainability. The Obama administration has participated in several such partnerships, including Together for Girls, the Alliance for Reproductive, Maternal and Newborn Health, Pink Ribbon Red Ribbon (PRRR), and Saving Mothers Giving Life (SMGL).<sup>23</sup>

Figure 7. U.S. Funding for Global Maternal, Newborn & Child Health (MNCH) and Nutrition (FY 2004–FY 2013)<sup>24</sup>



<sup>23</sup> CSIS led a delegation of congressional staff to Zambia in March 2013 to examine the successes and challenges of two of these partnerships—SMGL and PRRR. A trip report outlines recommendations to engage high-level leadership from congressional leaders from both political parties and from the Obama administration to prioritize women’s health, protect and expand U.S. investments in this area, measure the impact of new partnerships, invest where progress is being made, and plan for scale and sustainability of programs. See Janet Fleischman and Alisha Kramer, *Strengthening U.S. Investments in Women’s Global Health: A Trip Report of the CSIS Delegation to Zambia, March 2013* (Washington, D.C.: CSIS, May 2013), [https://csis.org/files/publication/130521\\_Fleischman\\_ZambiaDelegation\\_Web.pdf](https://csis.org/files/publication/130521_Fleischman_ZambiaDelegation_Web.pdf).

<sup>24</sup> Kaiser Family Foundation, “The U.S. Government and Global Maternal, Newborn & Child Health,” January 2013, <http://kff.org/global-health-policy/fact-sheet/the-u-s-government-and-global-maternal-newborn-and-child-health/>.

With policies and strategies largely in place, the next step is to ensure that these policies are supported by political commitment and financial resources to accelerate program implementation. In April 2013, the IOM PEPFAR evaluation dedicated a section to PEPFAR's gender-focused programs, recommending the development of precise objectives with desired outcomes within gender-focused efforts. To ensure continued success of these programs the United States will need to maintain high-level leadership and embed new policies into U.S. government agencies; better leverage the PEPFAR platform and existing funding to support research and programmatic investment in women and girls; shift to program implementation; and expand access to voluntary family planning and maternal health.<sup>25</sup>

## Child Survival

During the first Obama administration, USAID put child survival<sup>26</sup>—in Africa and South Asia—at the top of its health agenda. The importance of childhood vaccinations, the need to address neonatal deaths, and the link between maternal health and child survival came to the forefront.

In 2010, 7.6 million children died before the age of 5. This was a 35 percent reduction from the 12 million children who died before the age of 5 in 1990. Much of this reduction can be attributed to progress in preventing pneumonia, diarrhea, and measles through vaccinations. Pneumonia, preterm birth complications, diarrhea, intrapartum-related events, and malaria represent more than 50 percent of the global burden of under-5 mortality. Experts stress the importance of addressing neonatal complications, which account for approximately 40 percent of child deaths globally. Progress has been unevenly distributed across regions, countries, population groups, and specific causes of mortality, and national averages can mask important subnational differences.

Ethiopia is an example of considerable recent progress in Africa. It launched its Health Extension Program in 2004. Salaried health extension workers promote health education at household and village levels, including preventive services in water and sanitation, child health, and family planning. The program has reached significant scale since 2004, having trained 35,000 health workers and built 15,000 health posts. In this period, Ethiopia has seen a decline in under-5 mortality from 123 deaths/1,000 live births in 2005 to 88/1,000 in 2011, which constitutes an average annual rate of decline of 5.4 percent. The percentage of under-5 stunting also was reduced by 14 percent during the same period, while the percentage of married women who use a modern contraception increased by 93 percent.<sup>27</sup>

The Child Survival Call to Action was convened in Washington, D.C., by Ethiopia, India, and the United States in collaboration with UNICEF in June 2012. At this conference, the United States launched its Commitment to Child Survival: A Promise Renewed. Eighty countries were represented at the conference by governments and partners. The conference set out a goal to reduce child mortality to 20 or fewer child deaths per 1,000 live births by 2035. Fifty-six governments and over 100 civil society partners signed the pledge and the first iteration of a global roadmap was unveiled. Congressional participation at the Call to Action included Senator

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<sup>25</sup> On a global scale, women's health issues have received growing attention. The July 2012 London Summit on Family Planning convened more than 150 leaders from developing and donor countries, international agencies, civil society, foundations, and the private sector. Donors made new financial commitments totaling \$2.6 billion with a goal to provide an additional 120 million women and girls in the world's poorest countries access to voluntary family-planning services, information, and supplies by 2020. See Family Planning 2020, <http://www.londonfamilyplanningsummit.co.uk/fp2020more.php>.

<sup>26</sup> U.S. Agency for International Development (USAID) et al., *Child Survival Call to Action: Ending Preventable Child Deaths: Summary Roadmap, Version 1* (Washington, D.C.: USAID, June 2012), <http://5thbday.usaid.gov/pages/responsesub/roadmap.pdf>.

<sup>27</sup> J. Stephen Morrison and Suzanne Brundage, *Advancing Health in Ethiopia with Fewer Resources, an Uncertain GHI Strategy, and Vulnerabilities on the Ground* (Washington, D.C.: CSIS, June 2012), [https://csis.org/files/publication/120605\\_Morrison\\_AdvancingHealthEthiopia\\_Web.pdf](https://csis.org/files/publication/120605_Morrison_AdvancingHealthEthiopia_Web.pdf).

Johnny Isakson (R-GA) and Senator Mary Landrieu (D-LA). Ethiopia and India hosted their own Calls to Action in January and February 2013, respectively.

Recognizing the importance of childhood vaccination and the high return on investments in vaccines, the United States has increased collaboration and engagement with the GAVI Alliance. GAVI began operations in January 2000 and by the end of 2010 had received over \$5 billion in donor financing and disbursed \$2.8 billion to support immunization programs in 76 low- and middle-income countries. The United States is one of GAVI's largest donors providing 12.5 percent of all contributions through 2010. Obama has cited GAVI as an important multilateral partner for the United States, and in 2011, the Obama administration made the first-ever multiyear funding commitment to GAVI, pledging \$450 million over 3 years. The United States sits on the GAVI Board and multiple advisory committees and provides technical support and expertise.<sup>28</sup>

## Polio and Africa

Nigeria is the last African country to harbor endemic polio. While polio cases globally were at a historic low in 2012, eliminating the virus from the country's northern states, as well as in remaining strongholds in Afghanistan and Pakistan, will be a challenge.<sup>29</sup> As long as the virus continues to circulate anywhere, outbreaks are possible where immunization rates are low. This year, for example, both Somalia and Kenya, previously polio-free, are grappling with new cases. In addition, poliovirus has been detected in sewer systems in Egypt and Israel.

The presidents of Nigeria, Afghanistan, and Pakistan, along with the international community, are rallying behind a major push to finally eradicate the disease. The World Health Organization-led Global Polio Eradication Initiative, also spearheaded by UNICEF, CDC, and Rotary International, with support from the Bill & Melinda Gates Foundation, recently launched a six-year strategy to end poliovirus transmission and plan the program's legacy. The \$5.5 billion "Eradication and Endgame Strategic Plan" outlines responses to the initiative's enduring challenges: intensified engagement with religious and community leaders to overcome resistance to vaccination; facilitating provision of needed health services beyond polio immunization; and using polio program resources to better support immunization for other childhood diseases. It also begins laying the groundwork for a global switch to a more appropriate vaccine for the later stages of the eradication effort. Shorter, low-profile campaigns and better risk analysis are being employed to ward against further lethal extremist attacks on polio vaccinators in Nigeria and Pakistan.

The U.S. government along with Rotary International and the Bill & Melinda Gates Foundation have been major supporters of polio eradication, together providing nearly half of the \$10.8 billion pledged to the program through 2013. They also have contributed critical technical assistance, advocacy, and personnel. Without continued focus, a hard-fought opportunity to permanently eliminate polio could be lost.

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<sup>28</sup> Kaiser Family Foundation, "The U.S. & the GAVI Alliance," December 2011, <http://kff.org/global-health-policy/fact-sheet/the-u-s-and-the-gavi-alliance/>.

<sup>29</sup> Nellie Bristol, *The U.S. Role in Global Polio Eradication* (Washington, D.C.: CSIS, December 2012), [https://csis.org/files/publication/121217\\_Bristol\\_USRolePolio\\_Web.pdf](https://csis.org/files/publication/121217_Bristol_USRolePolio_Web.pdf).





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