Centering Country Ownership of Health Systems: A Response to the America First Global Health Strategy

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In September 2025, the Department of State launched the America First Global Health Strategy. Overall, the strategy:

- Narrows America's global health assistance to a smaller set of disease priorities and outbreak response.
- Emphasizes a compact model of shared investment in health with partner countries.
- Prioritizes assistance to support commodity procurement and healthcare worker salaries.

While meant to increase local ownership and accountability of health systems, the strategy:

- Continues fragmentation in global health, as it centers U.S. Government support to countries for a narrow set of donor-driven priorities.
- Does not address existing financing timelines, strategies and initiatives in partner countries, but instead asks partner countries to enter into a new, narrowly defined U.S.-led agreement.
- Focuses solely on outbreak response, HIV, malaria, tuberculosis (TB), and polio, the strategy does not describe support for primary healthcare services, especially maternal, child health (MCH).

In this brief, we outline the risks inherent to this strategy, ending with a set of further recommendations. Overall, we emphasize that:

- A U.S. global health strategy should be integrated into existing country health priorities and investments.
- Investment in primary health services and health systems is critical, including for outbreak detection and surveillance.
- Implementing the strategy requires locally-based, expert U.S. government staff who have a long-term presence in the country to assist negotiation, implementation, and oversight.

Implementing proposed compacts: what is lacking?

U.S. Embassies are putting relevant steps in place to set up bilateral compacts through government to government Memorandum of Understandings (MOU) before the end of 2025 in 16 countries: Cameroon, Côte d'Ivoire, Democratic Republic of Congo (DRC), Eswatini, Ethiopia, Ghana, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, Rwanda, Tanzania, Uganda, and Zambia. The MOUs are intended to be active from April 1, 2026 through 2030 and cover 85% of health assistance to the country. We outline our significant concerns about this rapid compact timeline, and clarify more appropriate steps to consider for successful execution of a U.S. Government Global Health Strategy.

Pillar 1: SAFER. What is needed for an effective global health security response?

The strategy notes that in the past, the U.S. invested in multiple disease outbreak surveillance, data, and laboratory investment activities, which will now be consolidated into one global mechanism. Further, the strategy notes that multilateral engagements, including through the World Health Organization (WHO), will be limited, and instead the U.S. will work to set up bilateral relationships for surveillance and outbreak response. Consolidating all levers of support into one globally led grant, strategy, or program will bypass local detection efforts and opportunities to strengthen these systems. In addition, most outbreak detection occurs in routine primary health settings, as patients present with high fevers or unusual symptoms. Strengthening existing local systems and primary care is imperative in global health security efforts.

Last, removing local oversight, especially with the drastic cuts to U.S. government personnel at USAID and CDC, leaves massive gaps in outbreak detection and rapid response. U.S. Embassies must have dedicated, local staff to direct global health security efforts in partnership with multilateral institutions and host country governments. Without such expertise, the strategy's stated goal to mobilize an outbreak response within 72 hours of detection will most certainly not be met. Without dedicated expertise on the ground, a stable of pre-vetted global experts who are available and under contract to be deployed within hours a moment's notice, the U.S. Government response risks being too late to effectively address an outbreak. The WHO commits to deploying such teams and releasing funds within 48 hours. In countries with persistent visa and convoy hold-ups, on-the-ground expertise is our only lifeline.

What is required for effective government to government (G2G) assistance?

Direct G2G assistance is an effective tool for the U.S. Government to invest in strengthening country transparency, accountability, procurement, and oversight of health systems. However, G2G arrangements require multiple well-constructed and well-executed accountability safeguards to ensure the partner government uses the funding as intended and with the transparency the U.S. Government requires. In 2019, Congress passed a law requiring partner governments meet certain eligibility requirements before a G2G arrangement can be considered: Recipient governments must demonstrate they have sufficient staff with necessary technical, financial, and management capabilities, competitive public procurement policies and systems, effective internal oversight, transparent public financial management, no affiliation with sanctioned individuals/organizations, and safeguard protection of human rights.

Once these requirements are met, a specialist from the U.S. government, a Government Agreement Technical Representative (GATR), initiates a co-creation process of negotiation between the two governments. Before an agreement is finalized, highly specialized U.S. government Controllers and technical staff undertake a numerous fiduciary risk assessments of the partner government using a Public Financial Management Risk Assessment Framework, identifying any mitigation steps a partner government must undertake before the G2G mechanism can be executed. This assessment reviews mechanisms for internal controls, audit and compliance, human resources, governance, and information technology and is very labor intensive for both the U.S. and host governments.

The GATR is the primary point of contact for implementation across the life of the G2G mechanism. Funding to the government is provided through cost-reimbursement agreements or fixed amount reimbursement awards, both of which require considerable routine oversight by technical U.S. government staff. Of note, several countries on the target list for the new GH Strategy have never received G2G support, including Nigeria, DRC, and Cameroon. Further, the number of U.S. technical staff with familiarity on G2G regulations and procedures has been drastically reduced. It is not clear if these agreements will be entered into with full transparency, nor is it clear how the U.S. will ensure critical oversight of the agreements during implementation. There are serious risks that these G2G arrangements will lead to waste, fraud, and abuse, significantly damaging the potential impact of health investments.

Pillar 2: STRONGER. What is required to directly support frontline healthcare workers?

U.S. foreign assistance has traditionally allowed for financial support for community health worker (CHW) and clinical health worker salaries and stipends. The practice was so widespread in Africa, that with USAID's closure, an estimated 50% of CHWs were left without support, while hundreds of thousands of clinical health workers' salaries were cut. The GH Strategy notes that the U.S. government will support 100% of frontline healthcare worker costs, including 270,000 doctors, nurses, and CHWs previously supported by the U.S. government, but that they will then transition to country budget payrolls after FY 2026.

While direct payment of healthcare workers by donors is a stop-gap in this challenging environment, it is neither a sustainable strategy, nor does it promote a full health systems approach. It is not clear in this GH Strategy if healthcare workers will be paid only to provide HIV, malaria, TB, and polio services, or if CHWs and clinic workers will be supported to provide the full range of primary healthcare services. Supporting healthcare workers in vertical disease detection and treatment fragments health systems, reduces efficiency, increases time and financial costs to both providers and patients, and does not respond to the full range of healthcare needs that populations face. In addition, given past challenges with the sustainability of direct health workforce compensation, it is critical that under the Compact models, health workforce payments are made using government employment status and payroll mechanisms, not parallel U.S. Government compensation systems.

Ensuring that governments are able to support salaries from FY 2026 onwards will be a significant challenge, given the constraints low and middle income countries now face in global health financing. To ensure sustainability, equity, and transparency of frontline healthcare worker support beyond the compacts, the U.S. Government must work in close partnership with host country government finance and health ministries now, in addition to multilateral development banks and other donors to identify clear financing streams to support all cadres of healthcare workers, including CHWs, by the very ambitious timeline set out in the strategy.

What is required to have an effective global health commodity supply chain?

In addition to ensuring good value for money by pooling procurement, maximizing USG supply chain investments and ensuring products reach end users requires investment in in-country supply chains. To ensure the supply chain is functioning from the central store to the clinic shelf, locally-based, specialized technical staff are required within government,

private sector, and donor partners to ensure compliance and oversight. Recipient countries are faced with a range of supply chain landscapes; some have robust 3PL operators for warehousing and distribution, while others have fewer private sector options. Governments should be supported in leveraging the supply chain actors and options available in their context to shape a coherent, integrated system that provides flexibility and reduces risk. In all contexts, governments retain a governance function so partnering with them to enhance data visibility, through GS-1 and related initiatives, will continue to increase efficiency and reduce opportunities for product leakage.

Pillar 3: MORE PROSPEROUS. What does a conducive global health business environment require?

Markets for U.S. healthcare goods require more than smoothing the way for regulatory approval. They require a thriving private market with sufficient funds to procure, ship, and distribute U.S. global health commodities. Most low- and middle-income countries lack the resources needed to access expensive U.S. health commodities, which is why USAID, the Clinton Health Access Initiative, UNITAID, The Gates Foundation, and other actors routinely embarked on market shaping activities, including volume guarantees and bulk procurement to reduce costs, making access more feasible for these countries.

Historically, low- and middle-income countries have either turned to more affordable, questionable quality Chinese global health commodities, manufactured their own, or procured regionally available health commodities. The price countries have paid for such commodities is substandard pharmaceuticals that exacerbate drug resistance. Without concomitant U.S. Government investment to support enabling environments that promote economic growth, markets for U.S. global health commodities are unlikely to develop overnight.

What else is missing from the strategy?

Prevention: The GH Strategy notes a target to end maternal to child transmission of HIV, but otherwise does little to discuss how the U.S. will invest in critical prevention strategies for HIV, TB, and malaria. While frontline healthcare workers and commodities are important for disease detection and treatment, prevention requires a larger social and behavior change strategy that implicates non-health sectors like education and water, sanitation, and hygiene (WASH). For HIV specifically, there is no discussion of outreach to key populations which are known drivers of transmission.

Maternal and child health (MCH): The strategy does not discuss routine maternal, infant, and child health services that are essential to safeguard against spikes in morbidity and mortality. Routine MCH services are often the best place to address other infectious diseases and outbreaks in detection and treatment, but they are not highlighted in the strategy. Nor is it clear how investments in healthcare workers and commodities will function beyond the four disease priorities mentioned. Not including MCH is a missed opportunity for providing Americans greater protection against measles and other infectious diseases of childhood that are growing in frequency inside our borders.

Investments in global goods and research: Gains in global health in the last decades have relied heavily on biomedical innovations and research investments from the U.S. government. While the GH Strategy notes bilateral agreements will leverage scientific innovation from the U.S., it is not clear how the Department of State, or other federal agencies, will support critical investments in global health research and global goods. This points to the need for a holistic foreign assistance strategy that can tap into the collective strength of development investments—global health, economic growth, education, governance, WASH—to amplify U.S. Government investments to greater benefit partner country and U.S. populations alike.

Beyond the health sector: Lower income countries are facing significant financing challenges, especially with disruptions in overseas development assistance, and it is not clear how partner governments in the GH Strategy will manage their required investments on the timeframe outlined. Countries require innovative, sustainable, and feasible financing models to ensure a functioning health system. To improve health outcomes, countries require functional governance institutions that support critical infrastructure, financing, WASH, nutrition and agriculture in addition to training cadres of healthcare workers through investments in education. A realistic strategy for global health requires a companion, comprehensive foreign assistance strategy that enumerates how the U.S. will help countries in supporting additional sectors that significantly impact the health sector—either negatively or positively.

Recommendations

1. **Expand the narrow remit**

   While the GH Strategy focuses attention on four disease areas and outbreak detection and response, there are numerous areas of health that are missing. Ensuring support for data systems, healthcare workers, and supply chains support the entire health system and provision of primary healthcare is critical to achieve population level reductions in morbidity and mortality.

2. **Restore local expertise**

   All elements of the GH Strategy require highly specialized technical staff embedded in partner countries. This will ensure rapid and appropriate technical responses, that legal requirements are met, and relevant oversight is conducted to safeguard against waste, fraud, and abuse.

3. **Lay the foundations of sustainability now**

   In addition to ministries of health, the U.S. must be in conversation with partner government finance ministries, multilateral development banks, and other donors to identify clear longer-term financing strategies that will pave the way for the strategy's stated goals to be achieved.

4. **Embed the global health strategy into a wider foreign assistance framework**

   Attempts at health system strengthening often confront issues of weak governance and resource mobilization, while critical levers of population health—education, water and sanitation, nutrition—are necessary to ensure countries achieve improvements in population health outcomes.