



LANDSCAPE ANALYSIS · JUNE 4, 2026

The U.S. Global-Health Funding Landscape

The **capital structure** beneath U.S. global-health funding

Source: **SciRise** Mission-Driven Capital Intelligence Dataset

EXECUTIVE SUMMARY

The field looks diversified. The risk underneath it is not.

U.S. global health looks diversified. Money comes from public and private sources, from a federal aid budget and from hundreds of foundations, spread across multilaterals, research universities, and operating NGOs. Read at the level of the organizations that actually carry the field, that picture is misleading.

The field rests on two concentrated bets. On the private side, one foundation, Gates, accounts for roughly three-quarters of all U.S. foundation global-health dollars, and that foundation has set a date to spend down and close. On the public side, a single federal global-health channel that was the larger of the two (led by USAID, since folded into the State Department) has fallen by more than half in one year. The two are not a balanced base. They are two concentrated channels landing on the same recipient base: thirteen of the fifteen largest global-health recipients draw from both channels, and each channel is itself a single dominant source. So "diversified across public and private" describes the labels on the money, not the risk underneath it. The hedge does not hold, and the larger of the two sources has already been cut by more than half.

The federal cut was not across the board. It fell hardest on grant-funded delivery to mission-driven organizations and on work performed in low- and middle-income countries, while obligations to for-profit implementers and the U.S.-based research enterprise held or grew. The clearest illustration is geographic: global-health funding delivered on the ground in the Democratic Republic of the Congo and Uganda fell about two-thirds in the year before an Ebola outbreak emerged in those same two countries. The cuts did not cause the outbreak. They drew down the surveillance and response capacity that an outbreak calls on.

SO WHAT FOR A FUNDER, INVESTOR, OR OPERATOR

A grantee that reads as resilient because it holds "public and private" support may in practice be carrying two single points of failure on one balance sheet: one federal line already down sharply, and one foundation that is winding down toward a 2045 close. The parts that held up best are not the delivery and in-country capacity the field exists to sustain: they are for-profit implementers and domestic research.

The report at a glance

LAYER	FINDING
Private side	Gates ~78% of U.S. foundation global health (\$3.48B of \$4.44B); now spending down to close by 2045
Public side	Federal global health fell ~58% in one year (FY2024 \$12.7B → FY2025 \$5.4B), and keeps falling FY2026
Overlap	13 of the 15 largest recipients draw both channels; for most, the federal leg is the larger one
Why they overlap	Not coincidence: Gavi, the Global Fund, the Global Financing Facility, and joint challenges were built as public-private co-financing through the same institutions
Where the cut landed	Hardest on nutrition/food, multilaterals, and grant-funded delivery; malaria, for-profit implementers, and U.S. research held or grew
On the ground	Funding delivered in DRC + Uganda fell ~66% (FY2024 → FY2025), as an Ebola outbreak tests response capacity there

The two channels are shown **side by side and never summed**. They rest on different sources, definitions, and time bases, and combining them would misstate both (see Methodology).

ORIENTATION

How to read this report

A few related figures recur. They are not in conflict; they answer different questions.

NUMBER	WHAT IT IS	USED FOR
\$12.7B	Federal international global health, FY2024 (the headline federal figure)	The public channel's size and decline
\$18.1B	The same, plus U.S.-performed global-disease research (NIH)	Sensitivity: how much the definition moves the total
\$4.44B	U.S. foundation global health, latest filed year per funder	The private channel's size
\$3.48B	Gates's share of the foundation figure	Single-funder concentration
-58%	Federal FY2024 → FY2025 (full year)	The headline decline

The federal figure is measured as obligations and reconciles to the U.S. Treasury's own USAspending agency totals to within 0.2% for the foreign-assistance agencies (USAID, State). The foundation figure is an observed sum from filed IRS records, not a modeled estimate. Where a federal number could be misread (a partial year, a same-period comparison), the report does the reconciliation in the text.

SECTION 1

Two channels, and why they are not added

The public and private channels are close in size and serve the same field, which is exactly why the instinct to add them is dangerous.

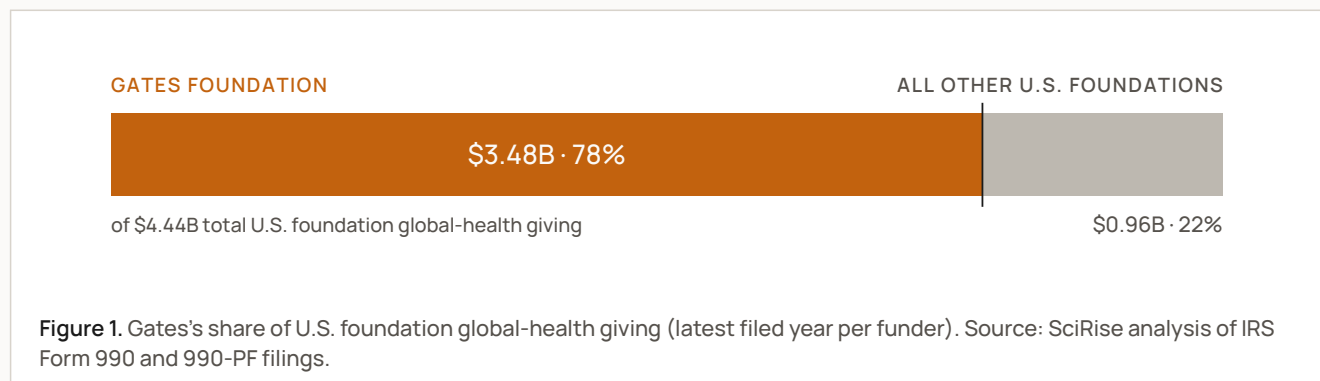
Federal international global health was **\$12.7 billion in FY2024**. U.S. foundations directed about **\$4.44 billion** to global health in their latest filed year. Reported side by side, the federal channel was roughly three times the foundation channel before its decline, and only modestly larger after the FY2025 cut. But the two cannot be summed. They are measured on different clocks (federal fiscal years through April 2026; foundation tax years that, for many funders, close in mid-2024), under different definitions (federal by program, agency, and award purpose; foundation by grant purpose), and from different sources. Summing them would merge two incompatible vintages and recipient layers into a single misleading total, especially where the same intermediaries carry both federal and foundation-funded work.

What the two channels share is their destination. That is the subject the rest of the report builds toward.

SECTION 2

The private side: one foundation, with an end date

U.S. foundation global health is the most single-funder-concentrated field of any we have measured. The **Gates Foundation alone accounts for roughly 78%** of all U.S. foundation global-health dollars, **\$3.48 billion** of the **\$4.44 billion** total. The entire rest of the field, every other foundation combined, is under **\$1 billion**.



That concentration was always the field's defining structural feature. Two developments make it more consequential, not less.

First, Gates is **spending down**. In May 2025 the foundation announced it will give away more than **\$200 billion by 2045** and then close, roughly doubling its annual giving in the interim.¹ The dominant private pillar of U.S. global health is therefore ramping up now and disappearing

later. In the near term, rising Gates spending can mask a decline elsewhere: an organization's total support can look stable while its composition concentrates further into one funder. In the long term, the anchor has a termination date.

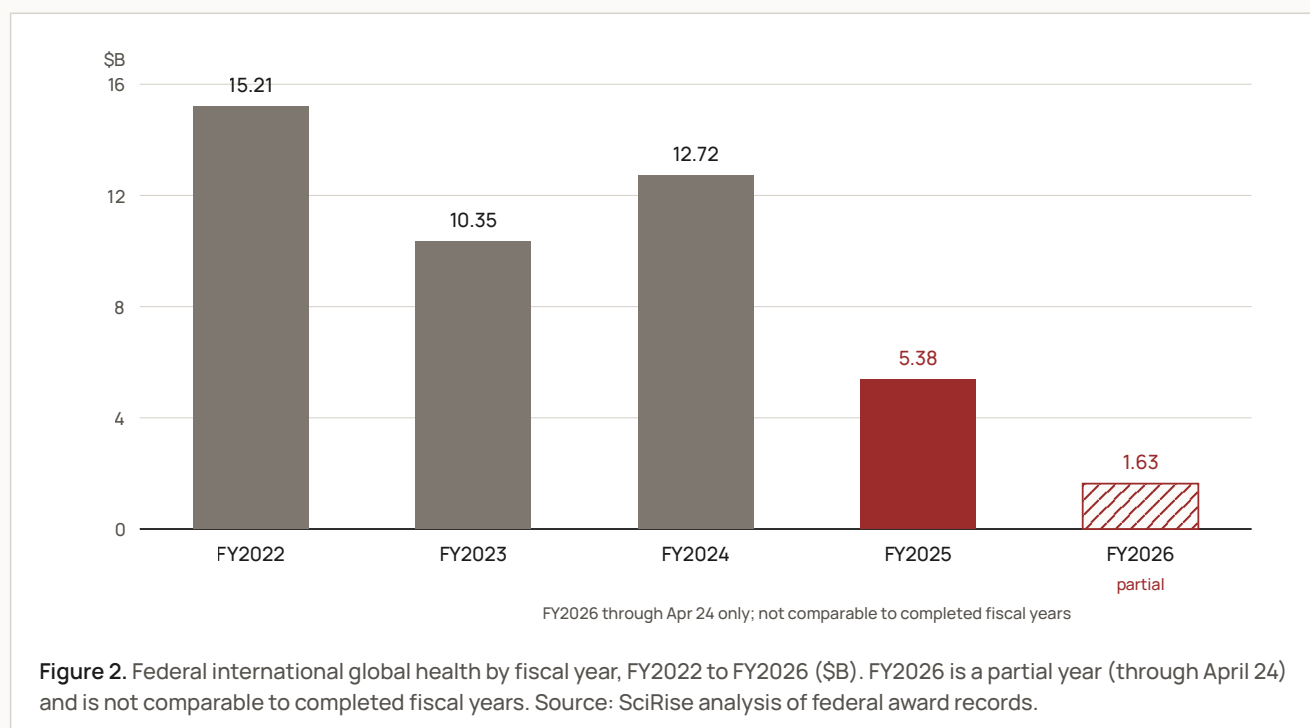
Second, the non-Gates field is not a redundant backstop. It is a thin tier of dedicated funders (reproductive health, malaria, neglected tropical disease) and generalists, plus donor-advised-fund conduits, that collectively supply roughly a quarter of what Gates does and tilt toward areas Gates underweights. It is a different market, not a spare copy of the same one. A shift in Gates's priorities is not absorbed by the rest of the field; it moves the field.

Method note: the foundation figure is an observed sum of grants classified to global health by stated purpose, using each funder's latest complete filed tax year. Gates's share is computed on the same basis. See Methodology for why a single calendar year cannot be used.

SECTION 3

The public side: a channel that fell by more than half

Federal international global-health funding fell from **\$12.7 billion in FY2024 to \$5.4 billion in FY2025, a 58% drop**, and continued falling into FY2026.



The decline is real on a like-for-like basis, not an artifact of an incomplete year. Measured over the identical Oct 1 to Apr 24 window in each year (the window FY2026 data currently covers), the channel went from **\$4.48 billion (FY2024) to \$2.31 billion (FY2025), down 48%**, and then to **\$1.63 billion (FY2026), a further 29%**. The same-period view is the honest one: it shows the cut

is not only a full-year FY2025 event but a contraction still underway. (Global-health obligations are back-loaded within a fiscal year, and recent federal reporting lags, so the FY2026 figure is a floor, not a settled level.)

The headline figure reconciles to the external record. KFF, a health-policy research nonprofit, independently puts U.S. global-health funding for FY2024 at about \$12.3 billion, against our \$12.7 billion.² The agency-level obligations reconcile to USAspending's own totals to within 0.2% for USAID and State. The Center for Global Development, working from obligation data, reports USAID's FY2025 obligations down 43%, consistent in direction and rough magnitude with what we see once the USAID-to-State reorganization is accounted for.³

Where the cut landed

The contraction was selective, and the selection is the finding.

By channel (\$M, FY2024 → FY2025):

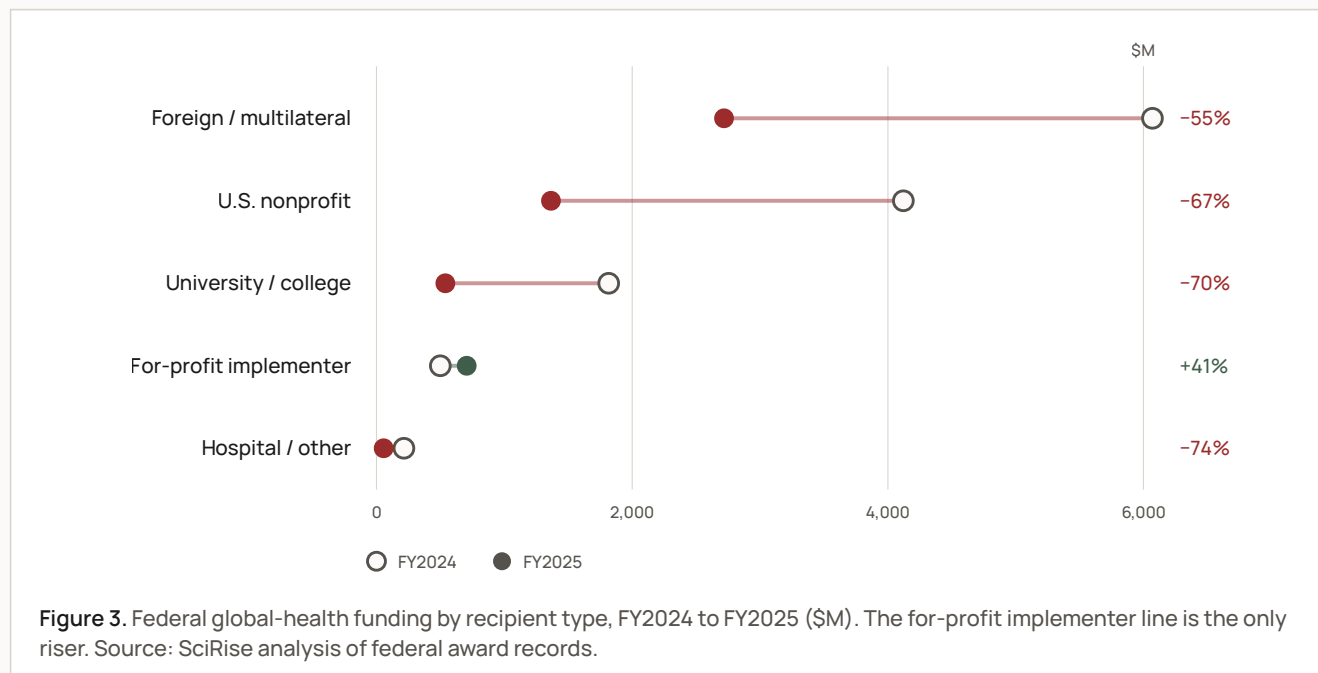
CHANNEL	FY2024	FY2025	CHANGE
Multilateral transfers	4,431	1,738	-61%
Nutrition / food	2,991	615	-79%
HIV / PEPFAR	1,849	789	-57%
Tuberculosis	1,307	588	-55%
Malaria	634	919	+45%
Maternal & child health / immunization	318	197	-38%
Family planning / reproductive	175	63	-64%
Other global health	1,016	474	-53%
Total (international)	12,721	5,383	-58%

Nutrition and food assistance took the largest absolute cut. Multilateral transfers, the money that flows to the Geneva platforms, took the second largest. Malaria was the single channel that grew.

By recipient type, the pattern is sharper still. As the channel fell, dollars to mission-driven recipients collapsed while obligations to for-profit implementers rose (\$M):

RECIPIENT TYPE	FY2024	FY2025	CHANGE
Foreign / multilateral	6,070	2,719	-55%
U.S. nonprofit	4,121	1,365	-67%
University / college	1,817	538	-70%
For-profit implementer	499	705	+41%
Hospital / foundation / unmatched	214	56	-74%
Total (international)	12,721	5,383	-58%

This is the non-obvious core of the federal story. The cut was not a uniform retrenchment from global health. It fell on grants to nonprofits and universities, on transfers to multilaterals, and on delivery abroad. It spared, and in places increased, obligations to for-profit implementers. And it left the U.S.-based research enterprise almost untouched: the same disease programs are studied in U.S. labs (NIH infectious-disease and child-health research), which is why the broader "international plus U.S. research" definition that includes them fell only 40% against the international channel's 58%. The retrenchment hit the part of the field that delivers, not the part that researches, and not obligations to for-profit implementers.



SECTION 4

The same recipients: a hedge that is not one

The two channels are now closer in size, with the public side contracting and the private side finite. The risk is not in either fact alone. It is that they land on the same organizations.

Of the fifteen largest global-health recipients, **thirteen draw both foundation and federal global-health dollars:**

RECIPIENT	FOUNDATION GH (\$M)	FEDERAL GH (\$M)	BOTH, THIS WINDOW
Global Fund	871	7,214	✓
UNICEF	549	3,653	✓
WHO	1,061	1,801	✓
Gavi	1,034	1,170	✓
FHI 360	2	1,061	✓
PATH	294	151	✓
EGPAF	9	418	✓
Johns Hopkins	33	387	✓
Save the Children	21	347	✓
Jhpiego	11	357	✓
Rotary	327	0	no
MSH	7	229	✓
PSI	17	215	✓
IRC	22	126	✓
CHAI	139	0	no

Both columns are three-year totals: foundation grants received, TY2022–2024; federal prime obligations, FY2022–2024. Foundation tax years vary by funder, so the windows align only approximately. CHAI = Clinton Health Access Initiative; FHI 360 = Family Health International; EGPAF = Elizabeth Glaser Pediatric AIDS Foundation; MSH = Management Sciences for Health; IRC = International Rescue Committee; PSI = Population Services International. Two of the fifteen, CHAI and the Rotary Foundation, show no federal global-health prime obligations in this window, though both have prior and ongoing federal ties: their relevant awards were obligated before the window, and some also fall outside the report's global-health purpose coding (CHAI a roughly \$7.5 million USAID cooperative agreement obligated in FY2019–2021 with performance running through 2025; Rotary roughly \$5 million for polio obligated in FY2020). Both are foundation-dominant. EGPAF's foundation total counts its pediatric HIV and AIDS grants, which fund work in low- and middle-income countries.

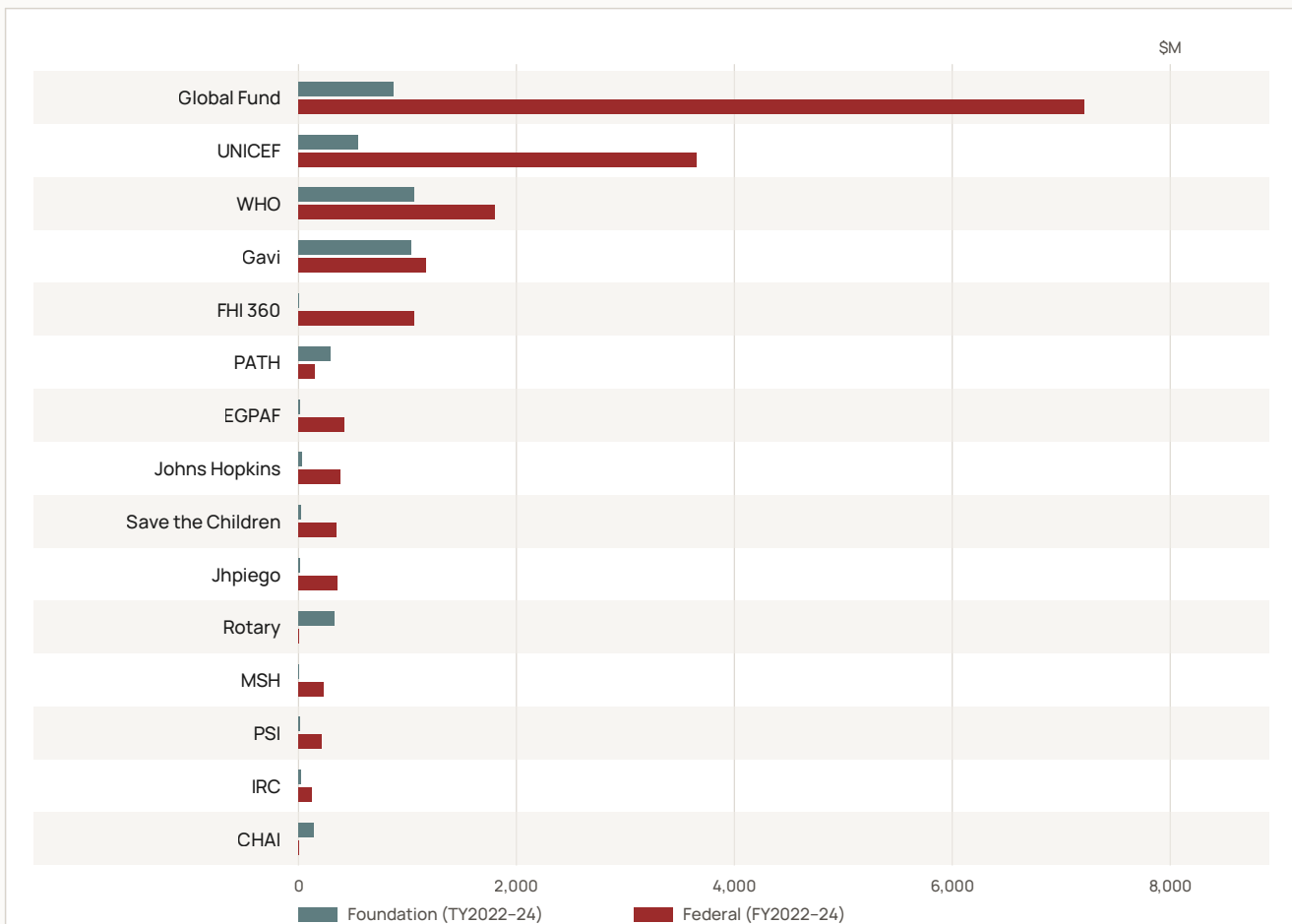


Figure 4. The fifteen largest global-health recipients: foundation and federal funding side by side, both three-year totals (foundation TY2022–2024; federal FY2022–2024). Source: SciRise analysis of IRS filings and federal award records.

Two things follow. First, the public and private legs land on the same organizations, not independent ones, so they do not diversify each other. A shock to either hits the same balance sheets. Second, the exposure is **lopsided toward the federal leg**: for most of these recipients the federal dollars exceed the foundation dollars, often by a wide margin. So the larger of an organization's two concentrated sources is the one that just fell, and the smaller, private one cannot backfill it. A foundation field of \$4.44 billion, three-quarters of it from one institution that is winding down, does not have the capacity to absorb a multi-billion-dollar federal withdrawal from the same recipients.

This reframes what "diversification" means here. The diversification a grantee reports, public plus private, is diversification of funder *category*. It is not diversification of funder *risk*, because the underlying driver, the small set of institutions that supply both, is the same. The labels on a balance sheet can show two funders where the exposure is one.

SECTION 5

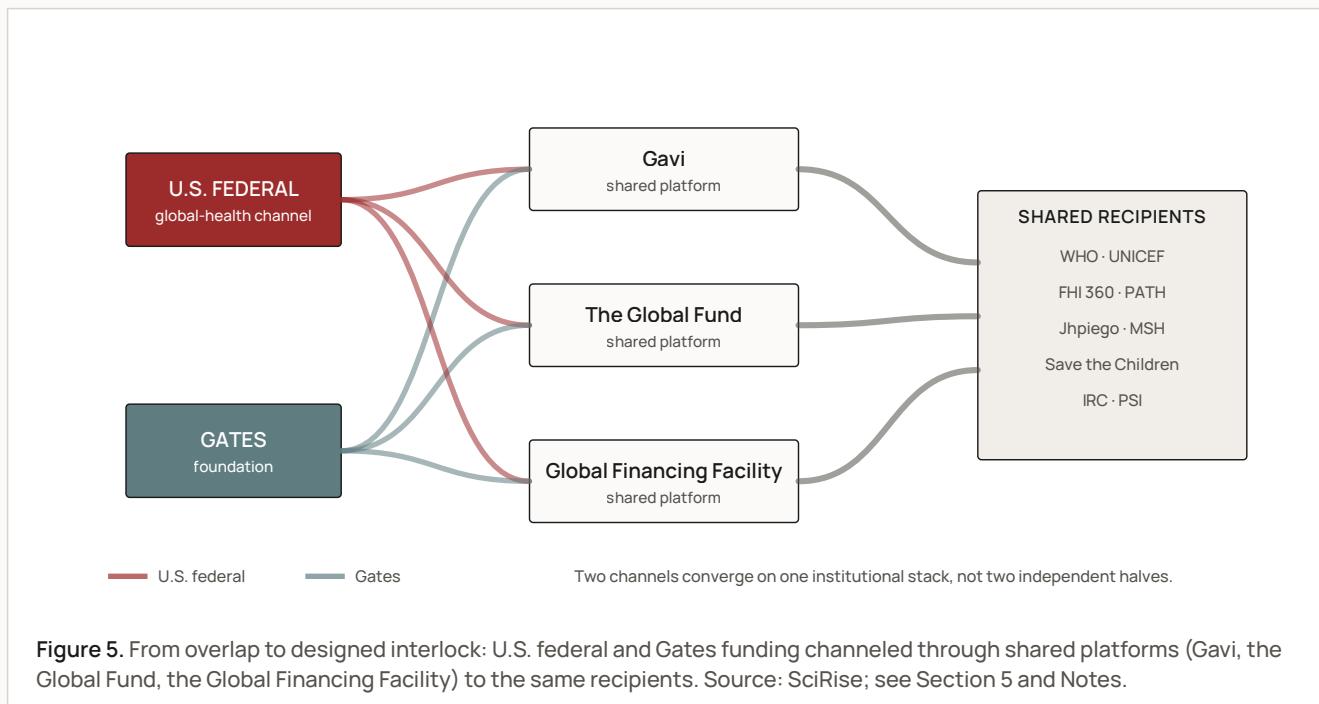
The overlap was partly designed

The shared recipients in the table above are not a coincidence of two funders independently favoring the same organizations. For two decades, major parts of U.S. global-health policy and Gates philanthropy were built to run through the same institutions. The overlap is in part an artifact of how the field was financed on purpose.

The clearest cases are the multilateral platforms at the top of the recipient list. Gavi was launched on a five-year, \$750 million pledge from the Gates Foundation in 1999, and the United States has been one of its six original donor governments since 2001, raising its annual contribution from \$48 million then to \$300 million in 2024.⁴ The Global Fund was structured from the start to pull public and private money toward the same grants: U.S. law caps the federal contribution at no more than a third of the fund's total, a ceiling written to force other donors in, and successive administrations have offered a dollar for every two from other donors (a recurring match across administrations, not a one-term policy). The Gates Foundation has been a Global Fund partner since 2002, has contributed \$3.92 billion to date, and sits on its board and committees.⁵ Public and private money was not arriving at these institutions independently. It was aimed there by design.

The pattern runs below the big platforms too, and it predates any single administration. In 2006, under the Bush administration, Gates put \$46.7 million into neglected-tropical-disease work, with one grant earmarked to co-fund a USAID-run program across five African countries.⁶ In 2011, USAID's first Grand Challenge, Saving Lives at Birth, launched as a joint fund with Gates, Norway, Grand Challenges Canada, and the World Bank, at least \$50 million over five years, and the next year Gates routed \$3 million back through USAID to seed the following round.⁷ The Global Financing Facility, launched in 2015, opened with \$214 million in pooled commitments from Gates, the United States, Canada, and Japan, for a set of countries that included the Democratic Republic of the Congo.⁸ USAID's own auditors described the agency's model in these terms, as a co-investor and convener that mobilized outside money rather than acting alone.⁹

This is what makes the concentration more than a tally. In many of the field's flagship platforms, the two channels were not merely landing on the same organizations; they were engineered to. That interlock was an efficiency while both pillars stood: much of the flagship public money was built to attract private money, and the platforms that delivered were funded from both sides at once. It becomes a liability when one side withdraws. A field assembled as a single co-financed stack does not fall back into two independent halves when the federal leg is cut, because the private side cannot simply occupy a structure that was built around the public side being there. None of this means the two funders move together. They plainly did not this year, with Gates ramping up as the federal channel fell. It means that when they do move apart, the organizations built on both feel it as one shock, not two that offset.



SECTION 6

Where the cut lands on the ground

That shock is easiest to see in one place. Aggregate percentages understate what a delivery cut means. Measured by where the work is performed rather than where the recipient is headquartered, the federal global-health money reaching the ground in specific countries can be tracked directly.

In the **Democratic Republic of the Congo and Uganda**, global-health funding delivered in-country fell from a combined **\$664 million (FY2024) to \$225 million (FY2025), about 66%**. The epidemic, infectious-disease, and health-systems slice of that work, the capacity an outbreak response draws on, fell from **\$287 million to \$167 million**, and is running at **\$39 million** so far in FY2026.

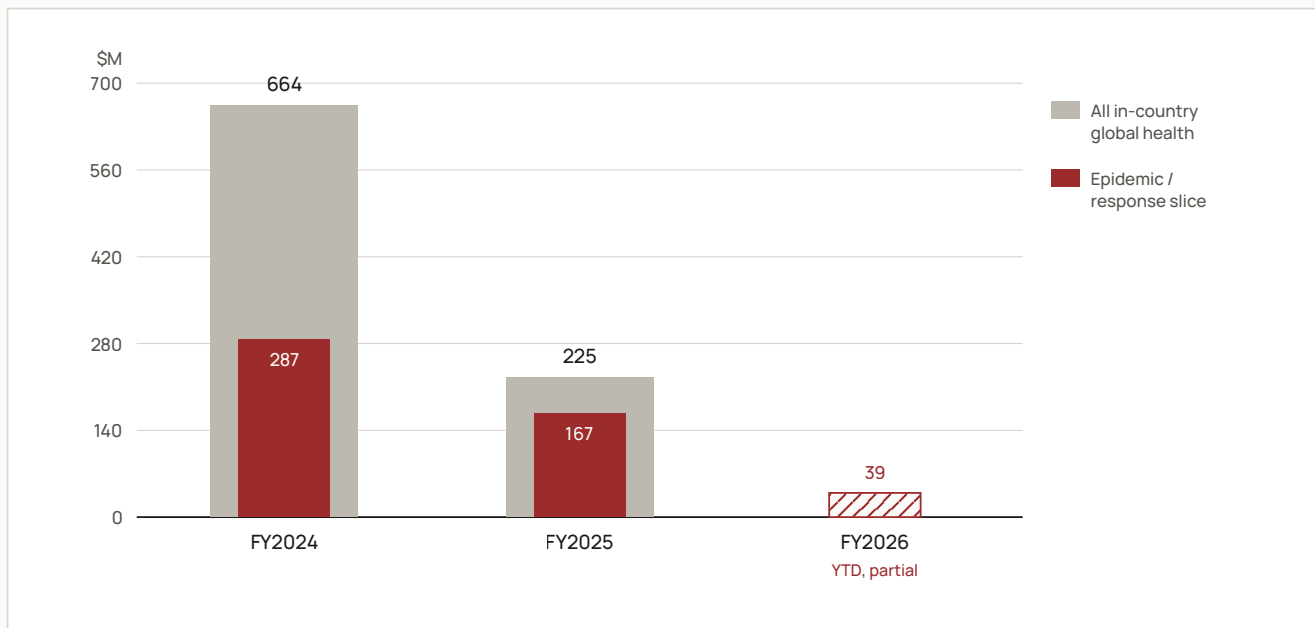


Figure 6. In-country global-health funding in DRC and Uganda, FY2024 to FY2026 (\$M). FY2026 is year-to-date and partial. The FY2026 value shown is the epidemic / response slice only; the full in-country FY2026 total is not shown. Source: SciRise analysis of federal award records.

These are the two countries now facing an **Ebola outbreak**, which the World Health Organization declared a public health emergency of international concern on 17 May 2026 (Bundibugyo virus, for which there is no licensed vaccine or specific treatment).¹⁰ The relationship is correlation, not causation: U.S. funding decisions did not cause the outbreak, which is an independent epidemiological event. The finding is not that funding cuts drove transmission. It is that the funding base for detection and response in exactly these two countries contracted in the same places before response capacity was tested. For a decision-maker, the consequence is not abstract. The capacity to detect and contain is not rebuilt at the speed an outbreak moves, and the funding base that built it has contracted where it is now most needed.

Place-of-performance coverage is a floor: awards to U.S.-based organizations performing work abroad are not always coded to the destination country, so the in-country figures understate the true delivery. The FY2026 figure is partial and lagged.

IMPLICATIONS

What this means for your decision

The reflex in a contracting environment is to ask whether there is enough money in the field. That is the wrong question here. The field's central vulnerability is not its size. It is that both of its funding pillars are, separately, a single concentrated source: one foundation that accounts for three-quarters of private giving and has set a date to close, and one federal channel that was the larger of the two and has fallen by more than half. They are not a balanced base. They are two concentrated bets on the same organizations, and one has already been cut.

For a funder or an investor assessing an organization in this field, the diligence question is not "does it have public and private support." It is "do its public and private dollars rest on the same concentrated base, and how much of the larger, public leg has it already lost." For an operator, the same logic points inward: support that reads as diversified across funder type may still rest on one dominant risk source.

And the cut is not falling evenly. It is falling on delivery, on multilateral platforms, and on in-country capacity, the parts of the field that do the work, while sparing for-profit implementers and the domestic research base. The clearest illustration of what that means is on the ground in the two countries now facing an outbreak, where the capacity to respond was drawn down in the year before it was needed. That is the stake a decision-maker is weighing: not a smaller field, but a field whose support has concentrated, contracted, and pulled back fastest from exactly the work that is hardest to rebuild and most exposed when it fails.

SCOPE

What this report does not claim

- It measures U.S. funding only. Non-U.S. funders (the Wellcome Trust, European and Gulf donors) do not file with the IRS and are not in the foundation figure; bilateral aid from other governments is not in the federal figure.
- The two channels are **purpose-classified and shown side by side, never summed**. They are an order-of-magnitude comparison, not a combined total.
- The federal figures cover the **foreign-assistance and global-health universe**, not all federal spending. They reconcile to USAspending within 0.2% for USAID and State, but totals for domestically-oriented agencies (HHS, NSF) are partial by design and are not quoted as totals here.
- Global health is defined as health activity **in and for other countries**. Domestic U.S. health (Ryan White, NIH domestic research, U.S. maternal-health block grants) is excluded by design. The "international plus U.S. research" sensitivity shows what including the U.S. research base would add.
- The foundation figure uses each funder's **latest complete filed tax year**, predominantly 2023–2024. It is an observed floor that will revise upward as later filings complete (see Methodology).
- The FY2026 federal figures are a **partial-year floor**, reported only on a same-period basis and never as a settled level.

METHODOLOGY

How the figures are built

Federal. Source: USAspending award records (assistance and contracts), FY2022–FY2026. Global health is operationalized as health-purpose funding with an international orientation: a global-health program or CFDA (PEPFAR/Global AIDS, the President's Malaria Initiative, global TB, family planning, maternal and child health, nutrition, neglected tropical disease), or a multilateral health recipient (the Global Fund, Gavi, WHO, UNICEF, UNAIDS, PAHO), or health-purpose funding by a foreign-assistance agency or to a foreign recipient. Domestic-only health is excluded. Two measures are reported: the **international** figure (global health in and for other countries, the headline) and **international plus U.S. research** (that figure

plus U.S.-performed NIH global-disease research). Figures are obligations by fiscal year. Agency totals reconcile to USAspending's published agency obligations to within 0.2% for USAID and State. FY2026 is reported on a same-period (Oct 1 → Apr 24) basis only.

Foundation. Source: IRS Form 990 and 990-PF grant records, classified to global health by stated grant purpose under a two-tier rule: inherently-global disease terms (malaria, TB, polio, neglected tropical disease, PEPFAR) qualify regardless of recipient location; ambiguous health terms (maternal health, immunization, nutrition) qualify only with a foreign recipient or an explicit international signal. A small number of organizations whose mission is inherently global health (for example EGPAF, in pediatric HIV and AIDS) are counted on health purpose alone, since the international-signal test would otherwise exclude their core grants. To avoid an artificial decline from incomplete recent filings, each funder is represented by its **latest complete filed tax year** rather than a fixed calendar year. This is necessary because fiscal-year filers, including the largest donor-advised-fund sponsors, file their tax-year-2024 returns into late 2026; using a single calendar year would drop roughly a quarter of funders and understate the field by tens of billions of dollars across all causes.

Recipient resolution. Federal recipients are resolved by Unique Entity Identifier and EIN. The per-recipient figures in the fifteen-recipient table are built on these identifiers (UEI and EIN on the federal side, matched nonprofit and university identifiers on the foundation side), not on name matching; multilateral recipients, which have no U.S. identifier, are matched by name. Roughly 3% of foundation global-health dollars remain unmatched; the unmatched pool is dominated by multilaterals, foreign organizations, and for-profit vendors, not by missing U.S. nonprofits.

Known limitations. Foundation tax-year-2024 coverage is incomplete for fiscal-year filers (handled by the latest-complete-year basis). Recipient name-matching has residual gaps. Place-of-performance coverage is a floor. The FY2026 federal figure carries reporting lag. The DRC/Uganda finding is a correlation of funding timing with an outbreak, not a causal claim.

VALIDATION

Sources and external benchmarks

Our figures for the two channels are this report's own measurement from primary records. The external numbers below are independent benchmarks used to check them. They are not identical measures (an appropriation is not an obligation; a single-agency decline is not the whole-channel decline), so they are cited as direction-and-magnitude checks, not exact matches.

FIGURE IN THIS REPORT	VALUE	INDEPENDENT BENCHMARK	BASIS DIFFERENCE
Federal global health, FY2024 (international)	\$12.7B	KFF: ~\$12.3B U.S. global-health funding	KFF is appropriations; ours is obligations
USAID + State agency obligations, FY2024	agree to within 0.2%	USAspending agency totals	same basis (obligations)
Federal global-health channel, FY2024 → FY2025	-58%	CGD: USAID obligations -43%	ours is all agencies; CGD is USAID only
U.S. foundation global health, per year	\$4.44B	no public per-year benchmark	observed sum from IRS filings
Gates share of U.S. foundation global health	~78%	COF/Candid: Gates over three-quarters of foundation global-health giving	different period (2016–2019) and dataset; same direction

External sources

- **Gates Foundation spend-down** (more than \$200 billion by 2045, close by 2045, roughly doubling annual giving): Gates Foundation, 25th-anniversary announcement, May 2025; STAT, 8 May 2025; PBS NewsHour.
- **U.S. global-health funding benchmark (~\$12.3B, FY2024):** KFF, U.S. Global Health Budget Tracker.
- **Gates concentration in U.S. foundation global health** (Gates provided over three-quarters of foundation global-health giving, and 44% of all global grant dollars, in 2016–2019): Council on Foundations and Candid, The State of Global Giving by U.S. Foundations, 2022 Edition.
- **USAID FY2025 obligations down ~43%:** Center for Global Development.
- **Federal agency obligations and reconciliation:** USAspending.gov.
- **Ebola outbreak, PHEIC declared 17 May 2026 (DRC and Uganda, Bundibugyo virus):** WHO PHEIC declaration; WHO Disease Outbreak News; CDC Health Alert Network.

Designed co-financing (Section 5)

Each of the structures below was verified against a primary source.

- **Gavi founding and U.S. role:** Gates pledged \$750 million over five years in 1999 (Gates Foundation, Nov 1999); the U.S. is an original donor government, \$48M in 2001 to \$300M in 2024 (Gavi, U.S. donor profile).
- **Global Fund 33% U.S. cap and matching logic:** statutory cap at 22 U.S.C. § 7622(d)(4)(A), enacted in the 2003 PEPFAR authorization (Cornell LII); the purpose of drawing in other donors and the recurring \$1-for-\$2 match (KFF, U.S. and the Global Fund). Gates partner since 2002, \$3.92B contributed to date, board and committee role (Global Fund, Gates Foundation profile).
- **Gates / USAID NTD co-funding, 2006:** \$46.7M in NTD grants, the Schistosomiasis Control Initiative grant earmarked to co-fund a USAID NTD project in Burkina Faso, Ghana, Mali, Niger, and Uganda (Gates Foundation, Dec 2006).
- **Saving Lives at Birth, 2011:** USAID's first Grand Challenge, a joint fund with Gates, Norway, Grand Challenges Canada, and the World Bank, at least \$50M over five years (Gates Foundation, Mar 2011); the 2012 \$3M Gates reinvestment grant to USAID (Gates committed grant OPP1037639).
- **Global Financing Facility, 2015:** \$214M in launch commitments from Gates, the U.S., Canada, and Japan, for a set of countries including DRC (World Bank, July 2015).

- **USAID as co-investor / convener, with Project Last Mile** (Coca-Cola, Gates, Global Fund, USAID): USAID OIG, Report 5-000-21-001-P, Dec 2020.

NOTES

References and citations

1. Gates Foundation, 25th-anniversary announcement, May 2025; STAT, 8 May 2025. [gatesfoundation.org](https://www.gatesfoundation.org); [statnews.com](https://www.statnews.com)
2. KFF, U.S. Global Health Budget Tracker. [kff.org](https://www.kff.org)
3. Center for Global Development, USAID FY2025 spending. [cgdev.org](https://www.cgdev.org)
4. Gates Foundation, Nov 1999; Gavi, U.S. donor profile. [gavi.org](https://www.gavi.org)
5. 22 U.S.C. § 7622 (Cornell LII); KFF, U.S. and the Global Fund; Global Fund, Gates Foundation profile. [law.cornell.edu](https://www.law.cornell.edu)
6. Gates Foundation, Dec 2006. [gatesfoundation.org](https://www.gatesfoundation.org)
7. Gates Foundation, Mar 2011; Gates committed grant OPP1037639. [gatesfoundation.org](https://www.gatesfoundation.org)
8. World Bank, July 2015. [worldbank.org](https://www.worldbank.org)
9. USAID OIG, Report 5-000-21-001-P, Dec 2020. oig.usaid.gov
10. WHO PHEIC declaration, 17 May 2026; CDC Health Alert Network. [who.int](https://www.who.int); [cdc.gov](https://www.cdc.gov)

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