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Review Article

The president's GHI: were women served?

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Abstract: In 2009, President Obama announced the launch of the *Global Health Initiative* (GHI), a six-year (FY2009-FY2014) $63 billion effort designed to unify and coordinate all facets of the global health portfolio of the United States. Since its very inception, the GHI was steadfast in its rhetorical support for the welfare of women and in its stated focus on women, girls and gender equality. The limited amount of gender-disaggregated data that is publicly available all but precludes a meaningful determination of the dollar amounts committed to women's health within various GHI programs. Until such time that the GHI (and successor programs) can gather and release such information, establishing whether or not women were being served cannot be fully and completely ascertained.

Keywords: Global health, public policy, women's health

On May 5th, 2009, President Obama announced the launch of the *Global Health Initiative* (GHI), a six year (FY2009-FY2014) $63 billion effort designed to unify and coordinate all facets of the global health portfolio of the United States [1, 2]. As such, the GHI was designed to integrate the President's Emergency Program For AIDS Relief (PEPFAR), the President's Malaria Initiative (PMI), as well as ongoing efforts to combat tuberculosis (TB), vanquish neglected tropical diseases (NTD), promote maternal, newborn and child health (MNCH), promulgate family planning and reproductive health (FP/RH), and advance health system strengthening [3].

Predominantly focused on reducing the global burden of communicable diseases, the GHI targeted the scourge of HIV/AIDS, malaria, TB, and the NTDs. In this context, the GHI played a key role in realizing Millennium Development Goal (MDG) 6, which was established to combat HIV/AIDS, malaria and other diseases. In addition, the GHI fostered MNCH, FP/RH, and nutrition programs. In so doing, the GHI was also promoting MDGs 4 to Reduce Child Mortality and 5 to Improve Maternal Health [1]. Predominantly bilateral in focus (85 percent of the FY2012 budget), the GHI nevertheless remained committed to multilateral efforts such as the Global Fund to fight AIDS, TB and Malaria [3]. At its peak, the GHI was operational in 74 low-and middle-income countries across five continents amongst which the African continent features most prominently [4, 5]. All told, the GHI constituted the largest single worldwide contributor the global health arena [2].

Focus on women, girls, and gender equality

There can be little questioning the fact that the global health leadership of the US was, and remains committed to, improving the lot of women worldwide by adopting women-and girls-centered approaches [6]. This commitment has been most clearly articulated by former Secretary of State Clinton when enunciating that "... investing in the health of women, adolescents and girls is not only the right thing to do; it is also the smart thing to do. That is why we are integrating women's issues as key elements of our foreign policy agenda and in, especially, our GHI" [11]. Former Secretary Sebelius stated, "Under President Obama, we're putting a new focus on women's health--at home and abroad" [7]. In the words of President Obama, "countries are more peaceful and prosperous when women are accorded full and equal rights and opportunity. When those rights and opportunities are denied, countries lag behind" [6].

At the level of the GHI, the commitment to the wellbeing of women and girls was equally palpable. This commitment was most clearly articulated in GHI's leading document, the *US Government GHI Strategy Document* and the seven Core Principles, nine global health Program Areas, and eight high-level Goals thereof. In this context, the very first Core Principle of the GHI committed to a "focus on women, girls and gender equality" [3]. In addition, a total of two of nine global health Program Areas of the GHI enunciated explicit goals with women in mind [3]. For its part, the MNCH Program Area of the GHI pledged to "reduce maternal mortality by 30 percent" and "reduce under-five mortality rates by 35 percent" [8]. Similarly, the FP/RH Program Area of the GHI committed to "prevent 54 million unintended pregnancies" [9]. This latter goal was to be accomplished by "reaching a modern contraceptive prevalence rate of 35 percent across assisted countries and reducing from 24 to 20 percent the proportion of women aged 18-24 who have their first birth before age 18" [9].

Above and beyond the preceding considerations, the GHI took specific steps to address gender discrimination and the socio-cultural barriers, which stand in the way of women's health. In particular, note is made of the *Supplemental Guidance on Women, Girls and Gender Equality Principle* the key objective of which was to assist countries in integrating women, girls and gender into their country strategies [10]. As such, this policy document called for the inclusion of three tasks in each and every GHI country strategy: a gender analysis; a woman, girls, and gender equality narrative; and a measurement and evaluation component [10]. Specifically, this document called for the GHI to collect "sex- and age-disaggregated data as well as health statistics to monitor progress and evaluate effectiveness of programs on women, girls and gender equality and health" [11]. Importantly, the focus of the GHI on gender equality extended well beyond supplemental guidance. Indeed, the GHI strove to implement the focus on gender equality by attempting to rectify gender imbalances related to health, promoting female empowerment, and improving community health outcomes [10].

Multiple GHI programs were attempting to mainstream gender-or assess the different implications which current policies may have on both genders - through their annual program-specific operational plans. For example, PEPFAR created a *Gender Technical Working Group* to assess gender issues and what potential role they might play in reducing vulnerability of women and men to HIV infection [12]. The recent evaluation of PEPFAR by the Institute of Medicine dedicated a section to PEPFAR's gender focused programs and recommended the development of precise objectives with desired outcomes within the gender-focused efforts [13]. Finally, as a natural extension of the gender equality imperative, GHI programs launched a concerted effort to address gender-based violence [14].

In this communication, we review the overall efforts undertaken by the GHI and the Program Areas thereof in support of the welfare of women. In this context, special efforts have been made to identify sex-disaggregated data. In the absence of such, sparing use has been made of qualified estimates and qualitative observations whenever available.

Investments in family planning/reproductive health (FP/RH)

One billion citizens of the world live in countries wherein women give birth to an average of 4.9 children during their lifetime [15]. Left unattended, these birth rates will effectively double the population of countries such as Afghanistan and Uganda within the next 30 years [16]. This reality has not gone unrecognized. As stated by former Secretary of State Clinton "millions of women and young people in developing countries don't have access to information to plan their family. They don't have health services and modern methods of contraception" [17]. It follows that the need in contraceptive services far exceeds current offerings. Indeed, at the time of this writing, an estimated total of 215 million women world-wide lack access to all important family planning services [15]. It is this context and these realities which underpin the commitment of the GHI to FP/RH and more specifically, to preventing "... 54 million unintended pregnancies" [9].

Funding for Family Planning and Reproductive health for a given year (FY2012) provided 31.6 million women and couples with contraceptive supplies and services, prevented 9.4 million

unintended pregnancies, helped avert 4 million (3 million unsafe) abortions, saved 22,000 maternal lives-and in so doing spared 96,000 children the otherwise all too common loss of their birth mother [18].

Access to family planning services has been associated with improved maternal, child and family health, reduced infant, maternal and child mortality, reduced prevalence of unsafe abortions, and enhanced social, economic, and environmental standing for women, their families, and their communities [19]. As of 2011, over 25 million women in 54 developing countries were being served by the GHI through its FP/RH programs [20]. Interventions include but were not limited to counseling, contraception provision, post-abortion care, as well as screening/testing for HIV and other STDs [21].

The funding of FP/RH through the GHI has seen substantial increments. In FY2008, the year preceding the launch of the GHI, the annual FP/RH budget stood at $391 million. In FY2009, its very first year of existence, the FP/RH program of the GHI saw its enacted annual budget rise to $455 million. Additional increments followed suit to yield an enacted annual budget high of $524 million by FY2014. As such, the latter budget represents a $137 million (37 percent) increment in funding relative to the FY2008 allocation [22].

Investments in maternal, newborn and child health (MNCH)

Around the world, 800 women die every day due to preventable causes related to pregnancy or childbirth [23]. Regrettably, the majority (99 percent) of maternal deaths transpire in low-and middle-income countries [24]. Equally disturbing, for every 1,000 babies born around the world, 37 of them will die before their first birthday [8]. As such, newborn deaths account for as many as 41 percent of all deaths of children under five years of age [25]. The objective of the MNCH Program Area of the GHI was to reverse these substantial global burdens. Indeed, in countries served, the GHI pledged to reduce maternal mortality by 30 percent and under-five infant mortality by 35 percent [8, 26].

With an eye towards making a real difference, elements of the GHI strategy include but were not limited to developing, introducing and scaling up "high impact" interventions, strengthening health systems, preventing malnutrition in mothers, newborn, and infants, and promoting vaccination [27]. In the words of the GHI leadership "we have to make sure women count and that they are counted" [28].

Through the GHI, the funding for MNCH programs has increased progressively over the last several years. In FY2008, the year preceding the launch of the GHI, the annual MNCH budget stood at $449 million. By FY2014, the corresponding enacted budget rose to a total of $705 million, which represented a $256 million (57 percent) increment relative to FY2008 funding levels [29].

Investments in HIV/AIDS

The HIV epidemic has had a profound and indeed disproportionate impact on women worldwide. Former Secretary Sebelius, stated that combating HIV/AIDS in women and ending mother-to-child transmission of HIV constituted top policy priorities for the Obama administration [30]. Women represent half of all adults living with HIV worldwide [31]. HIV remains the leading cause of death among women of childbearing age [30]. The feminization of the pandemic has proven particularly striking in Sub-Saharan Africa wherein 13.6 million women (81 percent of the cognate global cohort) accounted for 58 percent of those affected [32]. It follows that HIV/AIDS remains the leading global cause of death among women of reproductive age (age 15-49 years). Finally, note must be made of the plight of young (15-24 year old) women who constitute a particularly high-risk group. Globally, these young women are twice as likely to become infected with HIV [33].

The variables involved in the discrepant affliction of women with HIV are biological, socio-economic, and cultural in nature. On biologic grounds alone, women are twice as vulnerable as their male partners as gauged by the per-act transmission probability. The increased vulnerability of women to the acquisition of HIV is also attributable to critical socio-economic and cultural variables. Root causes include but are not limited to abusive and violent relationships as well as to transactional survival or cross-generational sex. Anchored in gender inequity and social class structures, the compromised pos-

ture of women in male-dominated cultures is further accentuated by limited educational and employment opportunities. Stated differently, many women lack the social or economic power required to negotiate safe sex with their male partners. Curtailed access to health care (e.g. female and male condoms) likely plays a significant role as well.

The GHI aimed to combat the HIV/AIDS epidemic through a variety of PEPFAR-sponsored programs. To address the feminization of the epidemic, the GHI also strove to maintain gender equality through women- and girls- centered approaches. In this context, the GHI sought to reduce gender based violence and coercion, engage men and boys on norms and behaviors, and increase the access of women and girls to income and productive resources [34].

The FY2014 Budget for the HIV/AIDS component of the GHI consolidated all of the bilateral and multilateral activities of the US in the global HIV/AIDS arena. Overall, funding for HIV/AIDS decreased from a FY2008 high of $5 billion to $4.86 billion in the enacted FY2014 Budget, thereby all but approximating FY2008 funding levels [35].

Investments in malaria, TB and NTDs

Malaria, endemic in more than 100 countries, constitutes a preventable and treatable disease associated with high mortality and morbidity rates especially in resource-constrained regions such as Africa. Pregnant women are at a particularly high risk until they develop protective immune responses to "pregnancy malaria" over the course of multiple gestations. At present, up to 200,000 annual newborn deaths are attributable malaria in pregnancy [36, 37].

The PMI aims to achieve a "mortality rate near zero for all preventable deaths and a 75 percent reduction in the malaria burden" [38]. The PMI engages in health system strengthening, the leveraging thereof for the integration of MNCH programs and to understanding, gender-related vulnerability to malaria. In so doing, the PMI identifies pregnant women as the primary adult target group. However, it was been found that the "data on malaria is often not sex-disaggregated" [39]. In FY2008, the GHI funding for Malaria stood at $521 million. By contrast, the enacted FY2014 Budget stood at $844 million [40]. This represents a $323 million (62 percent) increase over FY2008 funding levels [41].

TB remains a leading worldwide scourge. Poverty, overcrowding, and other diseases such as HIV all promote the spread of TB. Indeed, HIV and TB often co-exist. TB constitutes the third leading cause of death for women worldwide. A gender-driven delay in treatment is attributable to factors such as stigma, low socio-economic status, and lack of education [42]. The GHI pledged to "continuing the treatment of a minimum of 2.6 million new sputum smear-positive cases and 57,200 multidrug-resistant cases thereby effecting a 50 percent reduction in TB deaths and disease burden relative to the 1990 baseline" [43]. Regrettably, budgetary information as to the allocation of funds for the treatment of TB-afflicted women is not or has not been made available for public viewing on relevant websites or in reports to congress. Overall funding for the TB component of the GHI has increased from $177 million in FY2009 to $236 million in FY2014, an increase of 33 percent over five years.

Finally, note must be made of the efforts of the GHI to address the NTDs and the more than 1 billion people so afflicted [44]. In general, NTDs affect the poorest and most marginalized populations. It follows that women and children are disproportionately affected [45]. Unfortunately, a sex-disaggregated breakdown of the budgetary information detailing the spending by the GHI on NTD-afflicted women is not or has not been made available for public viewing. Overall spending on NTDs has increased measurably under the GHI from $15 million in FY2008, to $25 million in FY2009, and to a high of $89 million in FY2012. However, the FY2014 outlay was limited to $100 million, an increase of 560% relative to FY2008 levels [46].

Transparency/Need for data

In his first days in office, President Obama signed a memorandum on *Transparency and Open Government* thereby highlighting the commitment of the United States Government (USG) to achieving an "unprecedented level of openness in government" [47]. Former Secretary of State Clinton in turn suggested that one "can't just rely on moral arguments as important and compelling as they might be. We have

to make a rigorous case, backed up with solid evidence and data" [48]. Measuring impact is key in identifying future investments. This type of measurement would by necessity require routine reporting measures and coordination of monitoring plans [49]. Collecting aid data and the transparent reporting thereof is indispensible.

In this vein, some steps have been taken towards assuring better data collection and open reporting. PEPFAR recently released a preliminary report titled "*Expenditure Analysis Initiative*" which examines evidence-based decision-making and transparency. However, this report is limited to providing the expenditure analysis for six of the 58 countries wherein PEPFAR operates. Moreover, this pilot report does not include raw data. Instead, the reader is provided with a "curetted sample" which by many accounts makes it "difficult to draw any concrete conclusions from the data" [50]. The lack of data results in uncertainties as to the efficacy of existing programs and the viability of future ones. As for GHI programs other than PEPFAR, budgetary information, including spending data is difficult to find, except at a cursory level that is also available from relevant programmatic websites or from the federal budget.

In a sign of progress, the US has recently joined the *International Aid Transparency Initiative*. Still, the US has yet to participate and contribute in a meaningful manner. In addition, the USG is attempting to broadly capture foreign aid spending information through the *Foreign Assistance Dashboard*. USAID, for its part, has in effect updated this dashboard to include ¾ of its FY2013 transactional data [51]. Should this commitment to data collection and sharing yield credible, sex-disaggregated health data, it will allow for an examination of the effectiveness of programs and the appropriate use of resources [52].

The above notwithstanding, there remains a significant need in a central clearing house of foreign assistance budgetary information. In a sign of progress in this arena, a Bipartisan *Foreign Aid Transparency and Accountability Act of 2013* (HR 2638) bill has been introduced along with similarly named Senate bill (S1271). This bill seeks to require all of the governmental agencies involved in foreign assistance to evaluate their activities and post their results to the aforementioned *Foreign Assistance Dashboard* on a quarterly basis [53, 54]. As such, these recent developments highlight the continued vocal commitment to transparency on the part of the USG in the face of lack of data and/or the incomplete sharing thereof.

As it stands, sex-disaggregated indicators are increasingly being reported to the OGAC on a country-to-country basis (e.g. Benin [9]). However, it would appear that sex-disaggregated data were not collated centrally for the purpose of annual reporting by PEPFAR to Congress. Indeed, a specific report on gender-based violence programs can only be produced upon request. In other words, while data is available for use by country programs and by implementing partners, program-wide information is not collated, is not reported to Congress, and is not available to the public. PEPFAR acknowledges this shortcoming. To address this deficiency "PEPFAR is supporting efforts to increase monitoring and evaluation of the impact of cross-cutting gender activities" [55].

Core to this examination of GHI's commitment to women, and the lack of sex-disaggregated data provided is the question: why? Why is gender-disaggregated data not available to the public? We postulate that even though it is emphasized it is not mandated, and the cost of reporting and sharing this data exceeds the resources available. Looking more deeply, the answer is complicated at each step of the reporting process. Day to day, the federal government, government agencies, and country based organizations providing resources struggle with their mission of providing quality care to those in need. The division between those on the ground, and those in Washington is rather stark at times. Sitting in hospital in Kenya with very limited resources to assist the mothers and children in desperate need is in sharp opposition to the conversations taking place in the gilded halls of our capitol building. At times, one could imagine those providing direct services with the financial help of the GHI feel more connected to their patients than endless reams of GHI paperwork. Despite this, gender disaggregation is reported to a fair degree at the agency, and even federal level. After research, it seems the true disconnect seems to be within providing that information to the public. This, it seems, is based upon a lack of

resources to do so. The real answer to this problem is simple but hard to do: reallocate resources to facilitate the reporting, and open sharing, of sex-disaggregated data.

At the onset of the GHI there was strong efforts undertaken by the GHI and the Program Areas thereof in support of the welfare of women. However, there were limited metrics established to track the success of this support in the way of data. We propose a simple solution: tracking the sex (male or female) of each patient who utilizes services funded by GHI. This information should then be tracked by each agency, and made publically available by an easily accessible Internet database.

As noted before, GHI's own *Supplemental Guidance on Women Girls and Gender Equality* requires that the GHI to collect "sex- and age-disaggregated data" [56]. Evidence of the implementation of this imperative has yet to be reflected in country operational plans. As such, these observations highlight an important disconnect between the stated need for sex-disaggregated data on the one hand and the collection and public distribution thereof on the other. Regrettably, what cannot be measured cannot be tracked, or improved upon. There is thus an urgent need for the USG to prove that the action and the attendant resources are commensurate with the sound bites. To be truly invested in the fate and health of women on the receiving end means having robust funding for the data analysis of what works and what does not.

Summary

Since its very inception, the GHI was steadfast in its rhetorical support for the welfare of women and in its stated focus on women, girls and gender equality. In this context, President Obama, former Secretary of State Clinton, former Secretary of HHS Sebelius, and USAID Administrator Shah repeatedly reaffirmed the all-important contribution of women's health to building strong, successful, and peaceful communities. Former OGAC Goosby for his part committed to "intensive focus on advancing and protecting the rights and health of women and girls" [57]. The Department of State even issued supplemental guidance calling for the GHI to collect "sex- and age-disaggregated data as well as health statistics to monitor progress and evaluate effectiveness of programs on women, girls and gender equality and health" [11]. At the conclusion of GHI's 6-year arc, what evidence exists to document progress in this all-important arena?

Assessment of recent appropriation trends leave little doubt as to the fact that distinct elements of the GHI budget was dedicated to the welfare of women and girls. Indeed, budget allotments to areas one would commonly associate with women health-FP/RH and MNCH-have increased 37 and 57 percent, respectively over the FY2008 to FY2014 interval. That said, outlays for the FP/RH and MNCH programs constitute only a small (6.2 and 6.8 percent respectively) element of the total GHI budget. Far less is known as to what portion of the HIV/AIDS, Malaria, TB, and NTD budgets was dedicated to girls, women, and gender equality. Indeed, the limited amount of sex-disaggregated data that is publicly available all but precludes a meaningful determination of the dollar amounts committed to women's health within various GHI programs. Even less sex-disaggregated information is available as to the contribution of the GHI to health outcomes and to the welfare of women as established by ongoing maintenance and evaluation. While a positive GHI contribution can certainly be assumed, documentation is left wanting. This relative deficiency is particularly applicable to budgetary and programmatic sex-disaggregated data. Until such time that the GHI, and successor programs, can gather and release such information, establishing whether or not women were being served cannot be fully and completely ascertained. In the words of Dr. Margaret Chan, Director-General of the WHO: "What gets measured gets done. Timely, reliable and accessible health information is critical for improving health outcomes for women …" [58]. The GHI deserves no less.

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