The US Global Health Initiative: where does it stand?

In May, 2009, shortly after taking office, President Barack Obama announced the Global Health Initiative (GHI), which was to be a 6-year (2009–14), US$63 billion effort to refocus US global health activities by developing the first comprehensive US Government global health strategy.[1] The GHI was conceived as a "whole of government approach"[2] to act as an umbrella over existing US global health programmes—most notably, the President's Emergency Plan for AIDS Relief. As President Obama said at the time, "We cannot simply confront individual preventable illnesses in isolation. The world is interconnected, and that demands an integrated approach to global health."[1]

The GHI represents the bulk of the US global health budget[3] and bilateral activities in more than 80 countries;[4] alongside HIV/AIDS it encompasses programmes for tuberculosis, malaria, maternal and child health, family planning and reproductive health, nutrition, and neglected tropical diseases. Historically, these programmes had operated in overlapping but distinct sets of countries by programme area[5] and the GHI proposed to consider them as a unified whole. Seven cross-cutting principles were established to guide the GHI and ambitious targets were set by programme area.[2]

4 years into the GHI, where does it stand? The picture is one of both successes and challenges. Of the $63 billion originally proposed, only 55% ($35 billion) has actually been appropriated, leaving the GHI with a substantial funding gap (figure).[3] This funding gap dampened initial excitement about the GHI and its ambitious targets. At the same time, however, the GHI has pushed for stronger coordination by establishing an Executive Director at the US Department of State, who reports to the Secretary of State and an interagency Operations Committee, and developing an overarching government strategy with country-specific plans.[2,6] The GHI does seem to have consolidated services and reduced parallel systems in some countries.[7] In our analysis of the GHI's implementation of its women, girls, and gender equality principle in 15 countries, we found that the initiative has indeed prompted some countries to step up their efforts in this area, and provided a supportive platform to those that had already begun to do so.[8]

Yet the GHI faces hurdles, including its leadership structure at the State Department that lacks statutory or budget authority to coordinate across agencies and programmes. Later this year, pending achievement of certain benchmarks, the GHI coordination function will move to USAID but without PEPFAR, its "cornerstone"[2] programme.[9] PEPFAR, which accounts for more than 70% of the GHI's budget[3] will, per statute, remain at the US Department of State. Over and above these challenges, another structural barrier to integration is that Congress typically designates funding streams for specific global health programmes individually.

So is the GHI's approach right for the US? History and context are important here. The ideas that underpin the GHI were part of a growing global health conversation that questioned whether vertical programmes, with PEPFAR often cited as the most prominent example, were the best way to achieve a sustainable global health response. This conversation pointed to the potential downsides of siloed health programmes: their singular focus could be wasteful, miss opportunities to build stronger infrastructure, and ultimately not achieve optimal health outcomes for people in low-income and middle-income countries who face much more than one disease threat or health challenge.[10,11] These concerns were certainly relevant for the US, given that its approach was largely vertical and there were numerous agencies, programmes, and initiatives involved in global health without any overarching strategy or coordinating mechanism.[12]

But the GHI faced another obstacle. Its roll-out coincided with the global economic crisis that has altered fundamentally the fiscal environment in Washington.

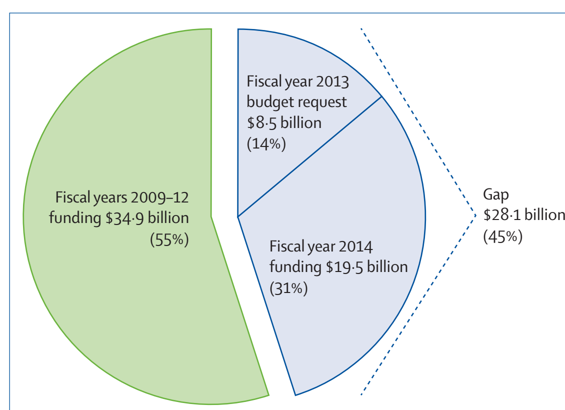

***Figure:* The Global Health Initiative's funding gap**
Total proposed for fiscal years 2009–14 US$63 billion.

The $63 billion intended for the GHI was based on projections set at a time of increasing funding for global health. Although funding for global health has fared relatively well, it has already begun to flatten and the US Administration's Fiscal Year 2013 budget for the first time requests less GHI funding than the previous year, including $0·5 billion less for HIV/AIDS through PEPFAR.[3] Ironically in light of the economic outlook over the next decade, an integrated approach may be more vital than ever, although looming cuts could perversely cause programmes and constituencies to retreat to defending their own vulnerable territory.

It has also been hard to "sell" integration and coordination to policy makers and the public, even if health experts recognise that such an approach is better and more cost effective than a vertical approach. Members of the US Congress generally want to let constituents know how many bednets or immunisations they have supported, not whether US global health programmes promote platforms for integrated health systems (even if those platforms are what will ultimately sustain the global health response). Our opinion polls of the US public similarly show that specificity matters in generating public support for US global health efforts.[13]

The GHI has to some extent been a victim of unfortunate timing, but it has also perhaps underestimated the governance and structural challenges of integration—challenges that fall both to the Administration and Congress. At the same time, the GHI represents a move beyond a polarising, and unresolvable, dichotomy between vertical and horizontal approaches to global health. One lesson might be the need for US global health programmes to "talk vertically" even when acting "horizontally", and to tell global health stories in a new way.[14]

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1 White House. Statement by the President on the Global Health Initiative. May 5, 2009. http://www.whitehouse.gov/the_press_office/Statement-by-the-President-on-Global-Health-Initiative (accessed May 7, 2012).
2 US Government Global Health Initiative. Strategy document. March, 2011. http://www.usaid.gov/ghi/documents/GHI_Strategy.pdf (accessed May 8, 2012).
3 Kaiser Family Foundation. US funding for the Global Health Initiative (GHI): the President's FY 2013 budget request. Feb, 2012. http://www.kff.org/globalhealth/8160.cfm (accessed May 8, 2012).
4 Kaiser Family Foundation. US Global Health Initiative. March, 2012. http://www.kff.org/globalhealth/8116.cfm (accessed May 8, 2012).
5 Kaiser Family Foundation. The US Global Health Initiative: a country analysis. Feb, 2011. http://www.kff.org/globalhealth/8140.cfm (accessed May 7, 2012).
6 Global Health Initiative. GHI in country. http://www.ghi.gov/country/index.htm (accessed May 8, 2012).
7 Donnelly J. GHI: a rough beginning. *Global Post* May 9, 2011. http://www.globalpost.com/dispatch/news/health/110428/healing-the-world (accessed May 8, 2012).
8 Kaiser Family Foundation. The women, girls, and gender equality principle of the GHI: how have USG country programs responded? (in press).
9 US Department of State. Leading through civilian power: the first quadrennial diplomacy and development review. Washington, DC: US Department of State, 2010. http://www.state.gov/s/dmr/qddr/index.htm (accessed May 8, 2012).
10 Frenk J. Reinventing primary health care: the need for systems integration. *Lancet* 2009; **374:** 170–73.
11 World Health Organization Maximizing Positive Synergies Collaborative Group. An assessment of interactions between global health initiatives and country health systems. *Lancet* 2009; **373:** 2137–69.
12 Kaiser Family Foundation. The US Government's global health policy architecture: structure, programs and funding. April, 2009. http://www.kff.org/globalhealth/7881.cfm (accessed May 7, 2012).
13 Kaiser Family Foundation. Public opinion polls on global health. http://www.kff.org/kaiserpolls/gh.cfm (accessed May 8, 2012).
14 Altman D. Pulling it together: what we know about making the case to the public for global health. May, 2012. http://www.kff.org/pullingittogether/public_case_for_global_health.cfm (accessed May 21, 2012).

Tinnitus: the end of therapeutic nihilism

See **Articles** page 1951

Tinnitus is a highly prevalent disorder. About 2% of the population are severely impaired in their quality of life because of chronic tinnitus.[1] This disorder also has great socioeconomic effects—sick leave attributable to tinnitus is related to a three-fold increased risk of receiving a disability pension.[2] Many different treatments are offered for tinnitus, but evidence for their efficacy is scarce[3] and satisfaction of patients is low.[4]

In *The Lancet*, Rilana Cima and colleagues[5] report the effectiveness of a stepped specialised care programme for tinnitus.[5] 247 patients were allocated usual care, and 245 patients were allocated specialised care, consisting of cognitive behaviour therapy enriched with elements of tinnitus retraining therapy. This report challenges and overcomes several prejudices. First and most important, the reported findings