Global Health Initiative and Aids Effectiveness in Africa Health System

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Abstract

This paper critically examines global health initiative and aid effectiveness in Africa health system. The advent of global health initiatives (GHIs) has changed the landscape and architecture of health financing in low and middle income countries, particularly in Africa. GHIs arose as a funding mechanism out of the need to advocate, mobilize and hasten funding, for some key health problems facing the globe. More than 100 GHIs have been created over the last 20 years with the aim of assisting countries to achieve their health goals. GHIs mainly focus on disease conditions that affect poor countries, saving many lives. Global Health Initiative becomes veritable owing to the fact that Infectious diseases and pandemics have always been a priority in international development, and this prioritization is justifiable to some extent because their control is a regional or even global public good that would be underfinanced by national governments. The research relies mainly on secondary sources of data. The research recommend that Global Aid/Funds should design differentiated strategy for each recipient country. Aid destined for fragile states needs to be implemented with quite different modalities than aid to well-governed countries. African countries should have a, continues partnerships with other donors, such as the private sector and civil society organizations. This will most effectively leverage donor contributions to global health. Global Health Initiatives should as a matter of necessary alignment. By so doing access to funding would not be so restrictive and cumbersome.

Keywords: Global Health Initiative, Africa, Aid, Health, Health System

Introduction

With the world having experienced endemic and pandemic and still having the ravaging spread of diseases globally, much more needs to be done on a global scale in terms of holistic intervention to reverse the trends. Hammer (2002) states that Global Health Initiatives ("GHIs") have ushered in revolutionary changes in the international public health architecture. In the late 1990s, we were busy fighting over the price of essential AIDS drugs, without serious visions of implementing clinically effective HIV/AIDS treatment worldwide. Today, groups such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), the President's Emergency Plan for AIDS Relief ("PEPFAR"), the Gates Foundation and the Global Alliance for Vaccines and Immunizations ("GAVI"), Roll Back Malaria Global Partnership (RBM), Stop TB Partnership(Stop TB), Global Alliance for Improved Nutrition(GAIN), Global Polio Eradication Initiative (GPEI), United States Agency for International Development(USAID) have initiated a wide range of public health programs across the planet that are starting to meaningfully link the global, national to the local. These groups are the sources of finances for global aid. They do this via consideration of some approaches. Vertical approaches, i.e. the targeting of specific diseases and limited interventions to achieve results in a priority area, and horizontal approaches that strengthen health systems.

The advent of global health initiatives (GHIs) has changed the landscape and architecture of health financing in low and middle income countries, particularly in Africa (WHO,2008). GHIs arose as a funding mechanism out of the need to advocate, mobilize and hasten funding, for some key health problems facing the globe. More than 100 GHIs have been created over the last 20 years with the aim of assisting countries to achieve their health outcomes. GHIs have mainly targeted disease conditions that affect poor countries, saving many lives (Cachill et al, 2003). Global Health Initiative becomes veritable owing to the fact that Infectious diseases and pandemics have always been a priority in international development, and this prioritization is justifiable to some extent because their control is a regional or even global public good that would be underfinanced by national governments.

Africa is a destination for health and medical care. This is occasioned by the dearth in health systems development. In terms of

the geographical distribution, Africa is the biggest recipient of development assistance for health. According to van der Hoeven (2000) only countries in Africa and some in Central America and Asia have a higher percentage of aid. Kates et al. (2011) approximately 40 percent of total aid for health went to the continent in 2009. This growth was driven predominantly by HIV/AIDS, which accounted for almost half of the total increase in aid for health between 2002 and 2009. Spending increases for malaria, the health workforce, basic health and medical care, and reproductive health each account for roughly 10 percent of the increase. Overall, 39.5 percent of aid for health went to HIV/AIDS in 2009.

Despite significant progress over the 20th century, there are large unmet health needs in developing countries. To fill this gap, substantial financing will be needed to improve national health systems and access to health services. While this is primarily a responsibility of national governments donors are not well placed to finance the large recurring costs of health interventions development assistance for health does play an important role, in particular in the fight against communicable diseases.

The 2014 Ebola outbreak has also brought attention to the role of the global health architecture in managing negative externalities. The outbreak has been used as a starting point for assessing the current state of the architecture and for crafting new proposals. For many, the Ebola crisis has been a turning point not just regarding reform of the WHO, but also for assessing leadership and coordination failures in the entire global health system (Gostin & Friedman,2015). The epidemic demonstrated that in fragile states with weak healthcare systems, preventable health hazards can escalate, given densely populated cities, frequent human and animal interchange, and rapid air travel. The international resources and attention generated by the outbreak provide an opportunity for global health leaders to help strengthen national public health capacities and to address shortcomings in the implementation of global frameworks (Edelstein, Heymann & Angelides, 2015).The most recent outbreak of COVID19 has also posed another challenge to health system in Africa. The pandemic has now become a serious threat to health care development in the continent. The vaccine for the treatment came from the west to Africa inform of foreign aid been promoted by WHO. This is due to poor health care system in the continent.

According to WHO (2020) the early experience in countries with large-scale community transmission (China, Iran, Italy and Spain) shows that COVID-19 requires unprecedented mobilization of health systems. With the phenomenal incidences of COVID-19 in Africa, it requires a robust healthcare system to cater for the present cases and eventualities of any exponential spike .Six key building blocks of national health systems can be identified health system financing, a health workforce of sufficient size and quality, access to drugs and other essential supplies, reliable health information systems, service delivery and governance (WHO 2007). Low income countries and their development partners have to direct their efforts at all these levels, ensuring for example that their policies do not undermine the retention of public health workers or access to affordable drugs at the international level, or render the governance structure of the health system more complicated.

Conceptual Clarification

Global Health Initiative (GHI)

Global Health Initiatives (GHIs) are humanitarian initiatives that raise and disburse additional funds for infectious diseases– such as AIDS, tuberculosis, and malaria– for immunization and now COVID19 for strengthening health systems in developing countries(Shiffman& Smith, 2007). Examples of GHIs are Global Alliance for Vaccines and Immunization (GAVI), the Global Fund to Fight AIDS, Tuberculosis, and Malaria, President's Malaria Initiative, Polio Eradication, Stop TB, and PEPFAR) etc. Universal access to health is the guiding principle and health equity among nations and for all people is the major objective of global health. Global health initiatives were established to tackle increasing global health threats, reduce disparities within communities and between nations and contribute to a world where people live healthier, safer and longer lives. The global health initiatives collaborative work in the needy nations covers several areas: AIDS, tuberculosis and malaria, immunization programmes, maternal and child health, tobacco use, human resources, emerging diseases (communicable and non-communicable), nutrition, health promotion and health system strengthening.

GHI supports the following goals and targets:

HIV/AIDS: PEPFAR will: (1) support the prevention of more than 12 million new HIV infections; (2) provide direct support for more

than 4 million people on treatment; and (3) support care for more than 12 million people, including 5 million orphans and vulnerable children.

Malaria: Reduce the burden of malaria by 50 percent for 450 million people, representing 70 percent of the at-risk population in Africa. This effort will include the expansion of malaria efforts into Nigeria and the Democratic Republic of Congo.

Tuberculosis (TB): Save approximately 1.3 million lives by reducing TB prevalence by 50 percent. This will involve treating 2.6 million new TB cases and 57,200 multi-drug resistant (MDR) cases of TB.

COVID19; this is the latest disease ravaging the world in general which has killed millions of people globally despite the discovery of the vaccines .

Maternal Health: Save approximately 360,000 women's lives by reducing maternal mortality by 30 percent across assisted countries.

Child Health: Save approximately 3 million children's lives, including 1.5 million newborns, by reducing under-5 mortality rates by 35 percent across assisted countries.

Nutrition: Reduce child under nutrition by 30 percent across assisted food insecure countries in conjunction with the President's Feed the Future Initiative.

Family Planning and Reproductive Health: Prevent 54 million unintended pregnancies. This will be accomplished by reaching a modern contraceptive prevalence rate of 35 percent across assisted countries, reflecting an average 2 percentage point increase annually, and reducing to 20 percent the number of first births by women under 18.

Neglected Tropical Diseases (NTDs): Reduce the prevalence of 7 NTDs by 50 percent among 70 percent of the affected population, contributing to: (1) the elimination of onchocerciasis in Latin America by 2016; (2) the elimination of lymphatic filariasis globally by 2017; and (3) the elimination of leprosy (Implementation of the Global Health Initiative: Consultation Document, n.d.).

Health System and Aid

The World Health Organization defines health systems as follows: A health system consists of all organizations, people and actions whose

primary intent is to promote, restore or maintain health. This includes efforts to influence determinants of health as well as more direct health-improving activities. A health system is, therefore, more than the pyramid of publicly owned facilities that deliver personal health services. It includes, for example, a mother caring for a sick child at home; private providers; behaviour change programmes; vector-control campaigns; health insurance organizations; occupational health and safety legislation. It includes inter-sectorial action by health staff, for example, encouraging the ministry of education to promote female education, a well-known determinant of better health. The health system comprises all organizations, institutions and resources that produce actions whose primary purpose is to improve health. The health care system refers to the institutions, people and resources involved in delivering health care to individuals (World Health Report,2000).

WHO Framework of Action (2007)spells out six building blocks of a health system: Good health services are those which deliver effective, safe, quality personal and non-personal health interventions to those that need them, when and where needed, with minimum waste of resources. A well-performing health workforce is one that works in ways that are responsive, fair and efficient to achieve the best health outcomes possible, given available resources and circumstances (i.e. there are sufficient staff, fairly distributed; they are competent, responsive and productive).A well-functioning health information system is one that ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health system performance and health status. A well-functioning health system ensures equitable access to essential medical products, vaccines and technologies of assured quality, safety, efficacy and cost-effectiveness, and their scientifically sound and cost-effective use. A good health financing system raises adequate funds for health, in ways that ensure people can use needed services, and are protected from financial catastrophe or impoverishment associated with having to pay for them. It provides incentives for providers and users to be efficient. Leadership and governance involves ensuring strategic policy frameworks exist and are combined with effective oversight, coalition building, regulation, attention to system-design and accountability. However, health system is the sum total of health affairs, level and quality of hospital

and hospital equipment, numeric strength of hospitals and medical personnel as against per capita; the availability of health care service to the people in a given territory.

AID according to Merriam Webster Dictionary(1828) aid is to provide with what is useful or necessary in achieving an end, to give assistance, the act of helping someone, tangible means of assistance (such a something by which assistance is given).Lancaster (2007) defines *foreign aid* as "a voluntary transfer of public resources, from a government to another independent government, to an NGO, or to an international organization (such as the World Bank or the UN Development Program) with at least a 25 percent grant element, one goal of which is to better the human condition in the country receiving the aid.

Theoretical Framework

This paper is positioned within the system theory. System theory is largely accredited to the Austrian scholar, Karl Ludwig von Berdalanffy in the 1930s which was described and has since become known as General systems theory, the concept that systems cannot be reduced to a series of parts functioning in isolation, but in order to understand the interrelations between these parts.

The main ideas of the system theory are integration of parts of a system in problem solving and that problem cannot be solving as well if it is considered in isolation from components parts that make up the system. A system approach improves health by considering the multiple elements involved in caring for patients and multiple factors influencing health. A system approach can help with the design and integration of people within Global Health Care domain, processes of health care development and effectiveness, health care policies and organisations to promote better, effective and efficient health at lower cost.

This theory applies that global health initiative and aid is a system comprising of various interrelated and interdependent components of global health collaboration with several areas coverage from global health financing ,tuberculosis and malaria, immunization programmes, maternal and child health ,HIV and AID programme, promotion and health system in order to achieve global health objectives of holistic intervention to reverse the trends of spread of disease globally, reduce disparities within communities and

between nations contribute to a world where people live healthier, safer and longer lives.These components cannot be carried out insolation because of their interrelatedness and interconnection for strengthening health system not only in developing countries but to achieve universal access to health and health equity among nations.

Global Health Initiative and Aid Intervention

Africa is confronted by a heavy burden of communicable and non-communicable diseases. Cost effective interventions that can prevent the disease burden exist but coverage is too low due to health systems weaknesses (Kirigia& Barry, 2008). The diseases pose great challenges in Africa considering the state of leadership and governance; health workforce; medical products, vaccines and technologies; information; financing; and services delivery.

According to the Organization for Economic Co-operation and Development (2008) the health sector has become a major recipient of development assistance from just over US$ 6 billion in 1999 to US$ 13.4 billion in 2005. The bulk of this increase can be credited to disease-targeted programmes and new global health partnerships, such as the GAVI Alliance (formerly the Global Alliance for Vaccines and Immunization) and the Global Fund to fight AIDS, Tuberculosis and Malaria. By August 2008, the Global Fund had approved grant agreements worth over US$ 11 billion with 136 countries, becoming the most important single agency for health assistance in terms of numbers of country partners and diversity of recipients (Bannati & Moatt,2008).

Various experts report large gaps between actual funding and internationally agreed health goals: for Africa alone, it has been estimated that to reach the health-related Millennium Development Goals, annual external public financing for health assistance may need to reach some US$ 25–30 billion by 2010 (MDG, Africa Steering Group, 2008). Since demand explicitly expressed by countries tends to align with increased absorptive capacities and effective health needs, these gaps will translate from hypothetical scenarios to practical challenges for the international donor community and domestic governments. In response to the 2008 Round 8 of the Global Fund, 97 countries have asked for a total of US$ 6.4 billion in fresh grants, nearly three times as much as in previous rounds(Global Fund, 2008).

While the majority of total health expenditures in most developing countries are funded through households' out-of-pocket payments at the point of consumption (i.e. the most regressive and inequitable financing mechanism), global health initiatives contribute to reducing this burden by subsidizing access to essential medicines. Abolition of user-fees and cost recovery policies have been proven to increase access for people on very low incomes and to facilitate adherence and success of treatment, as clearly shown by data from HIV care programmes (Nabyonge, et al, 2005). In Rwanda, the Global Fund has supported the expansion of community health insurance coverage for 3.3 million people on low-incomes, including approximately 300 000 people living with HIV/AIDS and 150 000 orphans. About one-third of expenditures supported by the Global Fund are already devoted to upgrading health-care infrastructures and to training and capacity building for health-care personnel. Both GAVI and the Global Fund now offer specific mechanisms for funding health systems using "cross-cutting" solutions. Moreover, by reducing mortality among health-care personnel, by reducing the incidence of infectious diseases through prevention interventions and by limiting hospitalization rates for appropriately treated individuals, disease-targeted programmes allow better use of the scarce resources for health systems, 2012).

In a swift response to COVID-19 pandemic, commitments to strengthening public health infrastructure was adduced. On 4 May 2020, heads of government, institutions and industry pledged USD $7.4 billion (of the USD $8 billion goal) to ensure equitable access to new tools for COVID-19 globally. The funding will support the Access to COVID-19 Tools Accelerator, which will help develop new global health technology solutions to test, treat and protect people, and prevent the disease from spreading(OCHA,2020). Thereafter, several donors pledged new funding to Gavi, one of the partners of the Global Polio Eradication Initiative (GPEI), ahead of its upcoming replenishment in June 2020. This funding will not only help vaccinate hundreds of millions of children against diseases such as polio, but also ensure that immunization delivery systems are sustained through the pandemic.

State of Health System in Africa

Health for all is considered both a basic human right and essential for social and economic development. Health is central to human happiness, and it contributes to growth and development as healthy populations are more productive, live longer and save more. Member states of the World Health Organization have long recognized the importance of health for all and have committed to providing universal access to health services without causing hardship for individuals when paying for these services (WHO 2010).

In terms of health care, governments of African nations face a number of challenges, including lack of funds and poor infrastructure. This is compounded by epidemics, poverty and the brain drain of homegrown doctors moving abroad, in search of higher wages and a better standard of living.

The vulnerability of our public health systems in Africa at large to limited economic resources cannot be overemphasized. For instance, funding for essential public health functions has been in chronic decline. Also, the system is characterized by human resources shortage, and diverted resources also significantly impacted the provision for emerging COVID-19 pandemic –related care(Randall, 1999). An estimated 3.5 million untreated cases of malaria and 10,623 additional deaths from HIV/AIDS, tuberculosis, and malaria during the period of March 2014–March 2015 were an indirect result of the diversion of health resources" (Huber, Finelli & Stevens,2018). However, Africa has experienced confronting infectious diseases, including the Ebola epidemic in West Africa in 2014-2016.

Africa initiative aim at promoting Health Care System

Many African countries have made improvements in health security since that outbreak, including the establishment of the Africa Centres for Disease Control and Prevention. Aetna International (n.d.) gives a brief account of health care quality in some African countries, namely: Nigeria, Kenya, Zimbabwe and South Africa.

Nigeria

While Nigeria has a public health service financed through a national insurance scheme, newcomers to the country might want to consider their own private medical insurance, use private health care facilities,

and make sure they are covered for repatriation (in the event of death) or medical evacuation to another better-equipped country, if necessary. Public health care is improving, but it faces a number of difficulties including a low ratio of doctors at only 1 per 2,000 inhabitants (low on a global scale but higher than most of its African neighbours) and an infrastructure struggling to cope.

The country spends 3.7% of its GDP on health care: a figure well below global average but on par with many of the countries around it. Although it has a network of multi-discipline hospitals, mainly in the more urban areas, doctors complain of low pay. Despite only being ranked at 187 on the World Health Organization's (WHO) league tables (World health report published in 2000) for the overall effectiveness of its health care system, a number of initiatives are improving life for inhabitants including family planning and immunization programmes, and the country's prospects continue to change as its economy grows to become one of the largest in Africa. The Federal Government has established center for Disease Control. (NCDC) headed by Director General to promote health care delivery in the country.

South Africa

There is an excellent level of care to be found at the private hospitals in the major cities and around the game parks in South Africa, so much so, that it's not uncommon for patients to be flown in for treatment from other countries. This is against a backdrop of a poor standard of public health care and one of the shortest average life expectancies on the planet it's fair to say that South Africa has more than its fair share of challenges.

As a whole, the country spends nearly 9% of its GDP on health care (on par with countries like Spain and Malta) but the doctor to population ratio is just under 1 to 1000, well below the world average. As public facilities can be poorly equipped, overcrowded, and waiting times long, comprehensive private medical insurance is worth thinking about for anyone looking to relocate to South Africa.

Kenya

With spending on health care just 5.7% of GDP, low by global standards, it is higher than that of some neighboring countries like Sudan and Ethiopia. There is one doctor per 5,000 inhabitants and

there can be huge variation in standards of care across geographical areas, private and public facilities, and the type of treatment available. The best private hospitals are to be found in the larger cities such as Nairobi and Mombasa, offering the kind of provision akin to that available in developed countries for many conditions.

Foreign nationals are able to join the national health insurance scheme (which is compulsory for civil service staff), but most have their own private insurance, often arranged through an employer. Consider having insurance in place to cover evacuation or repatriation, and set cash aside in case any payments need to be made up front.

Zimbabwe

Foreign nationals seeking to live and work in Zimbabwe might want to ensure they have adequate private medical insurance to cover private treatment and evacuation to somewhere with additional facilities, if necessary. The availability of staff, beds, technology, and pharmaceuticals is unreliable in hospitals and, although the government has promised to improve the health of the nation as a whole, many foreign nationals will find that provision is underfunded and varies in standard. Have access to enough cash to cover emergency care, as many private clinics will not treat patients until they have paid up front. With just 1 doctor per 10,000 people the country's health care system is ranked as 155th out of 191 in the world by the World Health Organization.

Challenges of Meeting Health Needs in Africa

Shortfalls in financing are therefore an important, but not the only bottleneck to be addressed in order to improve health outcomes. Nonetheless, the financing gap is wide, and is reflected in extreme global inequalities in current spending on health. Low and middle income countries, which have 84 percent of the global population and 92 percent of the global disease burden, account for only 12 percent of global health spending (Schieber et al. 2006). The mobilization of additional resources will thus be crucial to address these imbalances. While this is primarily a responsibility of national governments, aid to health will undoubtedly play a part in this mobilization.

According to Schwank, (2012) funding gap is biggest in Sub-Saharan Africa, which faces additional costs of $150 billion, or 60

percent of the total. In terms of specific programmes, the spending requirements are biggest in supporting health systems (75 percent of the total additional costs), and infrastructure, transport and equipment, as well as human resources in particular, which account for 22 percent of total additional spending needs. Additional spending needs on specific diseases on the other hand are comparatively low, which reflects the current emphasis and priorities of donors on vertical interventions – that is on specific diseases or on selected interventions across countries.

Protracted social and political unrest in most grant-recipient countries (African countries) continues to be a major challenge. Insecurity in many places hampers access to social services with the health sector being the worst affected, and the loss of human capital has severely weakened health services and systems in affected countries. Furthermore, global health initiatives have created parallel systems that undermine the holistic approach for health system development, and the principles of external aid, such as ownership and harmonization, are not adequately applied.

When global health initiatives use their own monitoring and assessment systems, they increase transparency, but these systems run in parallel to national systems, which increases the workload of health professionals and does little to strengthen national systems. Regional service managers lack knowledge of global health initiatives, although they judge the effect of external funds as positive, improving health infrastructures in the public sector and drug supply systems at municipal and provincial health units, and increasing training opportunities. The main effect of global health initiatives was to increase training opportunities and the number of workers engaged in HIV or other specific disease programmes, but they have not addressed the dilemma of attraction and retention of qualified personnel in provinces because the initiatives focused on their own needs(Craveiro &Dussault, 2012).

Impact of Global Health Initiative and Aids on Africa Health Sector

As health is an important economic asset, it has been an important part in defining MDGs. Thus, over the 8 objectives, 3 focused on health: Reducing infant and child mortality; improving maternal health fight HIV/AIDS, malaria and other diseases. This particular

focus is due to the precarious global health situation, especially in developing countries such as sub-Saharan Africa. According to the World Health Organization (WHO) statistics (2014), in developing countries, 1 in 10 children dies before the age of 5, and 500,000 women die each year in child delivery or during pregnancy. In order to achieve these objectives, the international community has decided to make financial efforts in the form of ODA. Thus sub-Saharan Africa was able to benefit from external aid with a volume representing an average of 4.65% of its GDP over the period of 2000 to 2013. This aid allowed funding about 9.15% on average total health expenditure, from 6.5% in 2000 to 11.8% in 2011 (WHO, 2014). However, as the MDGs has elapsed in 2015 and the phase of SDGs emerged, health statistics show the expected results for 2015 have not been achieved fully in all regions of the world.

The impact of GHIs is reflected in both shortcomings and gains. Spicer and Walsh (2011) specify the effect of Global Health Initiative on nations' Health Systems in negative and positive terms. Negative effects focus on the non-adherence of GHIs with the Paris Principles for Aid Effectiveness, such as misalignment between GHI programmes and country policies and programmes resulting in poor co-ordination of GHI-funded and government-funded services, and duplication of reporting, monitoring and evaluation systems and funding/disbursement mechanisms. GHIs are also criticized for having undeveloped plans to strengthen country health systems' capacity, particularly human resources for health. Positive effects, often emerging more recently, include substantial scale-up of HIV and AIDS services and a widening of stakeholder participation, particularly by non-governmental organizations. Recommendations for GHIs include more meaningful engagement with the Paris Principles and a call for more analytical health policy and systems evaluations.

Despite significant progress over the 20th century, there are large unmet health needs in developing countries. To fill this gap, substantial financing will be needed to improve national health systems and access to health services. While this is primarily a responsibility of national governments donors are not well placed to finance the large recurring costs of health interventions development assistance for health does play an important role, in particular in the fight against communicable diseases (Schwank, 2012).

The twentieth century has seen dramatic improvements in health. Mortality rates fell and life expectancy rose steadily and across all regions. Remarkably, the gap in life expectancy between developed and developing economies decreased at the same time. Rising health equality in the second half of the twentieth century thus stands in marked contrast with increasing global inequalities in incomes (Jamison, 2006). Nonetheless, and despite these improvements and the political commitment to health for all at the global level, most low income countries and some middle income countries still face severe constraints in providing universal access to health services. They suffer from a mismatch between the massive health's needs of their growing and often poor populations and insufficient resources to fund their health systems. This mismatch has been exacerbated in recent years by a small number of communicable diseases, most notably HIV/Aids, as well as the increasing prevalence of non-communicable diseases in developing countries. The HIV/Aids crisis in particular overburdened health systems in severely affected countries that had already been weakened by insufficient investments during the period of structural adjustment and the increased emigration of health workers (WHO 2009).

GHIs are also renowned for the part they play in raising the profile of most neglected diseases such as onchocerciasis, dengue, trachoma, tetanus and schistosomiasis. Evidence shows that GHIs have programmes for these diseases, which in the past have had a low political profile and prioritization (Caines, 2005). GHIs have three broad strategies for supporting neglected diseases: raising the profile of the diseases, improving the delivery of interventions, and donating drugs. But support for neglected diseases in developing countries is viewed as unsustainable, and the consequences can be dire where support programmes are terminated. For example, Uganda faced major problems with drug shortages for neglected diseases after the drug donation period ended (Buse & Harmer, 2007).

Easterly (2008) opines that although aid effectiveness is strongly criticized in economic literature, microeconomic results of aid tend to demonstrate its effectiveness at this scale. Aid programs for a specific sector of economy may have significant benefits for this sector without their macroeconomic effects being clearly discernible. This demonstrates the fact that foreign aid received by the developing countries for the health sector is effectual. An analysis by W. Jean

Marie Kébré which focused on the determinants of crude, infant and HIV/AIDS prevalence rates in order to assess the effect of aid on health. Built around the assumption that foreign aid has a positive direct effect on the health of populations and that the relationship between aid and health indicators is non-linear, the result suggests that aid is more effective in reducing mortality and HIV prevalence in relatively poorest countries and in those where health spending is relatively lower(Kabre, 2018). The same study concludes that 'aid from donors specializing in health sector shows that UNFPA aid improves mortality rates. Indeed, a 1% increase of UNFPA aid reduces infant mortality rate by 0.0019% and crude mortality by 0.003%. On the other hand, the impact of UNAIDS aid on HIV prevalence is negative but not significant. It should be noted that there are other donors specializing in health, but only UNFPA and UNAIDS aid provides interesting results in our regressions'.

GHIs distracted governments from coordinated efforts to strengthen health systems through distorting national priorities and through imposing donor implementation conditions. The Global Fund aims to support programmes that reflect local priorities and fit within existing country structures, but in practice the extent to which this occurred varied widely (Stillman and Bennett 2005). The Fund rejected Uganda's 2002 Round One cross-cutting systems-strengthening proposal, requiring Uganda to break it into disease-specific components (Donoghue et al. 2005). In response, the Government established a discrete project management unit, which it and its donor partners viewed in 2003 as a distortion of Uganda's policy of channeling all funds to support a coordinated national health sector strategy. Pressure from World Health Organization (WHO) consultants led to Tanzania applying for Global Fund support for an anti-retroviral treatment programme, in place of the government's priority to fund a programme on orphans and children (Starling et al. 2005). Concerns were reported about PEPFAR-imposed policy prescriptions such as disallowing grant recipients from providing counselling on abortion and promotion of abstinence-only prevention approaches (ITPC 2005). An evaluation commissioned by the US Congress reported that PEPFAR's commitment to country ownership had been undermined by its rigid budget allocations to specific control measures (Sepulveda et al. 2007). Oomman et al. (2007) report that PEPFAR's funding

allocations were remarkably consistent despite epidemiological and health systems' differences across Mozambique, Uganda and Zambia. This suggested that global earmarks and donor conditionality's were driving funding allocations regardless of countries' diseases, health needs and priorities.

GHIs do not address all the gaps in health provision. For example, very few GHIs focus on non-communicable diseases. There have also been concerns that most GHIs do not deal with certain areas that have a significant contribution to disability-adjusted life year (DALYs) losses such as maternal and reproductive health, depressive disorders, alcohol dependence and road traffic accidents, or the rising cancer incidences (Group WHOMPSC, 2009). Some of the literature argues that although technical support to countries is crucial, GHI support has not been very successful (Cruz &McPake,2011).

Some reasons for this include the unclear and lack of a structured approach to identifying the gaps, and coordinating demand and supply to the identified technical assistance needs. Technical assistance has been ad-hoc and driven by urgent and immediate needs at the country level, an approach that often is unsustainable (Storeng, 2014). According to Biesma et al. (2009) there were also unmet needs in the technical support provided by GHIs, such as in linking planning and disease prevalence, training on management and planning, cost-benefit analyses, monitoring and evaluation, and across-country application of lessons. GHIs have been blamed for selectively supporting certain groups that are easy to reach, contributing to the widening of the inequity gap. Much of the literature shows that GHIs are not completely aligned with the countries' national strategic plans and often impose preconceived ideas (Cruz &McPake, 2011).Some authors have pointed out that health aid has more effect on reducing mortality in countries with good policies and institutional quality (Mishra & Newhouse, 2009). To these determinants are added other essential variables such as access to sanitation, strict adherence to aid guide, purposeful governance access to fresh water that influence people health status.

Conclusion and Recommendations

Global Health Initiative has the opportunity to move global health to a new level of effectiveness, with a vision of long-term sustainability

led by partner countries. Seizing that opportunity requires new investments in programmes that will increase the quality of the health system in Africa. GHI has a responsibility to consider more the less developed nations in disbursement of health aid for hydra-headed diseases and in this era of Covid-19 pandemic which is globally pervasive. In the same vein, African nations (recipients) have responsibility to be accountable and transparent in utilization of funds.

The effectiveness of GHI and the Health System in Africa revolves around, availability of funds, equitable distribution of aid, commitment, collaboration of purpose, strict adherence to implementation guideline and expansion of high-performing and sustainable platforms for service delivery. With the adoption by the United Nations of the new development agenda (Sustainable Development Goals), it suggests that health promotion in Africa through increased aid is possible. International institutions specializing in health, in collaboration with national authorities, can play a central role in allocating and using aid to improve health indicators. However, aid to African nations cannot be dismissed as having no meaningful effect but at best more needs to be allocated. The paper recommends as thus:

i. The fact that Human resources alone account for half of the total spending on health in any given year and given that donors are often unwilling to fund such expenses; the majority of resources must come from domestic sources; African nations should increase budgetary allocation to health sector. If this is done donor funds will be a supplementary rather than taken as last resort.
ii. It is better for African nations to rely more on domestic funding. Hence expenditures for health are overwhelmingly of a recurrent nature, financing out of domestic budgets, which is a much more predictable and less volatile source of funding, is the preferable mode.
iii. Global Aid/Funds should design differentiated strategy for each recipient country. Aid destined for fragile states needs to be implemented with quite different modalities than aid to well-governed countries. 'One cap fits all' approach will

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