

Global health initiatives and the combat of HIV/AIDS on the African continent: a scoping review

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Abstract *The aim is to identify, in the literature, the influence of Global Health Initiatives (GHI) on the HIV combat in Africa. A scoping review was carried out in March 2023 in the Web of Science Core Collection, Medical Literature Analysis and Retrieval System Online, Scopus, Excerpta Medica Data-base and Google Scholar databases. It included original articles published in English, Portuguese, Spanish and French that dealt specifically with the influence of GHI on this endeavour. 25 studies published between 2009 and 2019 were selected. The analysis resulted in two thematic categories: Contributions of GHI in combating the HIV epidemic; and Limitations of GHI in combating it. Despite the contributions that led to improvements in HIV indicators, based on the strengthening of local health systems and the work of NGOs and religious organisations, the GHI have limitations, which are related to factors that include or depend on the type of budget, the extent to which the proposed actions can be developed in line with the health needs of the population, and the reality of each health service.*

Key words Global Health Initiatives, HIV, Africa, Global Health Strategies, Health Systems

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Introduction

Global Health Initiatives (GHI) were created in the 2000s to increase priority interventions and help underdeveloped countries in the race to achieve the Millennium Development Goals (MDG). Such initiatives have brought together different public and private entities – multi- and bilateral agencies, such as non-governmental (NGOs) and international organisations with/without profit, pharmaceutical equipment industry, and health provisions, with the aim of contributing to improvement of the health systems and services of these countries to combat the diseases most impactful on public health^{1,2}. Most of these countries have unstable, deficient health systems to cater for the needs of their inhabitants, due to a set of factors ranging across scarce or poorly used financial resources, precarious living conditions, increased risk factors and prevailing diseases. Such conditions impact public health, and foster a fertile field for dependence on international support, crucial for both the development and improvement of the living and health conditions of their inhabitants^{1,2}.

At the end of the first decade of the millennium, the most prominent GHI led health care, defining the agenda of global health policies and reducing the role of the World Health Organisation (WHO) and the World Bank². Four GHI stand out in global health: the Global Fund to Combat Acquired Immunodeficiency Syndrome, Tuberculosis and Malaria (global/GFATM fund); The Global Alliance for Vaccines and Immunisation (GAV); The Emergency Plan of the President of the USA for the Relief of AIDS (PEPFAR); and the World Bank International AIDS Program². In 2009, there were over 100 GHI covering 27 health areas.

These four initiatives are present in all Portuguese-speaking African countries (PALOPS), although they have diverse situations in terms of the funds attributed, the number of GHI and the number of years of the activities: in Mozambique and Angola, PEPFAR was present (2004-2009), GAVI (2001-2003), the Global Fund (2004-2005) and the World Bank (Multi-Country AIDS Programme - MAP, (2003-2011) and (2004-2011) in Cape Verde, the Global Fund (since 2010), and the World Bank (since 2002); in Guinea-Bissau, GAVI (since 2004), the Global Fund (since 2004) and the World Bank (MAP - 2004-2008); in Sao Tome and Principe, GAVI (since 2001) and the Global Fund (since 2005)³.

The epidemiological profile of most African countries is characterised by infectious diseases, especially malaria, tuberculosis and the human

immunodeficiency virus (HIV). Regarding HIV, the continent, especially the sub-Saharan region, has stood out as the location most affected by this grievance. Since its inception, it has had higher rates of morbidity and mortality due to causes related to AIDS, concentrating more than two thirds of the world's population living with HIV in the year 2020⁴.

It is estimated that two African regions (eastern and southern) had more than half (54%) of all people living with HIV in the world in 2020; two thirds (67%) of all infected children lived in this area. The epidemic has spread to almost every country in the region, and South Africa concentrates the largest number of people living with HIV in the world – 7.5 million people, and Eswatini presents the highest prevalence in the world (27%). The North Africa region recorded a 25% increase in new HIV infections between 2010 and 2019, without alteration in the mortality rates, and with 38% access to antiretroviral therapy (ART), the lowest of all world regions in 2020. In pregnant women, the ART coverage in the Western and Central Africa was 62% in 2016 and 58% in 2019, exposing a decrease in coverage in recent years⁴. This reality contrasts with the global scale, which, in recent years, has recorded an improvement in the indicators regarding the combat of this disease.

There are different perspectives of the GHI influence in Africa. For some authors, in general, they constitute a setback because most of the global health resources are aimed at vertical interventions, giving little importance to social determinants or dealing with health inequalities⁵. Generally, GHI are developed in offices in wealthy countries, considering western culture, to be implemented in low-income regions with different cultures and world views, ignoring the knowledge of the people who live in the realities they will intervene⁶.

In this context, the purpose of GHI and their presence in African countries, the epidemiological situation of HIV in these regions and the criticism from some authors of these initiatives, seeks to map scientific production about the influence of GHI in HIV combat on the continent. It is understood that this mapping can serve as the basis for social actors, researchers and national and international policy formulators to explore different aspects of the role of GHI in Africa, especially in combating HIV, as well as to stimulate reflections about the influence of these initiatives.

This research seeks to answer the following question: what is the state-of-the-art of the influence of GHI in the fight against HIV in Afri-

ca? Thus, the objective was outlined, namely to identify, in the literature, the influence of GHI in the fight against HIV in Africa.

Method

Outline of the study

This is a scoping review, according to the assumptions of the Joanna Briggs Institute (JBI) - Methodology for JBI Scoping Review⁷, which consists of a systematised, exploratory approach, which aims to identify relevant scientific production in a particular area of knowledge. The research protocol was registered with the Open Science Framework (osf.io/xu2ps), and this study was conducted in the following steps: definition and alignment of the objectives and the research question; delimitation of the inclusion criteria; devising and planning of the search strategy and the selection of studies; identification of the relevant studies; selection of the primary studies; data extraction; data mapping; and, summarisation of the results.

The studies included were listed from the acronym PCC: P - Population: global health specialists, public health administrators, health professionals and researchers focusing on HIV/AIDS; C - Concept: GHI that influence HIV combat; and, C - Context: African countries where GHI operate. The guiding question devised for this review was: what is the state-of-the-art of the influence of GHI in the battle against HIV in Africa?

Eligibility criteria

Inclusion criteria: original articles published in English, Portuguese, Spanish and French that specifically dealt with the influence of GHI in the fight against HIV in Africa. No time limit was defined, aiming to include as many studies as possible. Those excluded were: studies that did not answer the central research question, duplicate studies, review studies, articles not available in full, theoretical articles, dissertations, theses and books.

Data collection

The data were gathered in March 2023 from the database, Web of Science Core Collection/Clarivate Analytics (WoS), Medical Literature Analysis and Retrieval System Online (MEDLINE/PubMed), Scopus (Elsevier), and Excerpt-

ta Media Data-base (EMBASE). Subsequently, there was an extension to the metadata search tool, Google Academic.

The research team defined the search strategy considering the Descriptors in Health Sciences (DeCS) and/or Medical Subject Headings (MeSH). Boolean AND and/or OR operators were used, respecting the peculiarities and characteristics of each database. The English combinations were: "Global health initiatives" AND HIV AND Africa. In Google Academic, the same search strategy was used.

The selection of studies took place in three consecutive steps: 1. Title reading, which should contain the terms Global Health Initiatives and/or HIV/AIDS; 2. Abstract reading; and, 3. Reading of the article in full. Two reviewers assessed the complete versions of the selected articles, considering the inclusion and exclusion criteria, which resulted in the final sample for the study. The detailed search/selection of studies can be found in the supplementary material available at: <https://doi.org/10.48331/scielodata.s2tnkt>.

For the systematisation of the information, the researchers devised a means of data extraction for those containing the sections: author, year of publication, country, periodical, approach and main results. Figure 1, according to the PRISMA Extension for Scoping Reviews (Prisma ScR)⁸ methodology, presents the systematisation of the search process, exclusion and selection of studies for inclusion found through their identification, analysis and eligibility.

Data analysis and treatment

The data analysis was performed based on the definition and organisation of a numerical, categorical synthesis. The first presented the characterisation of the selected studies; and the second included sorting into thematic categories according to the findings related to the influence of GHI in combating HIV in Africa.

Results

The process of identification, analysis, eligibility and inclusion of studies according to PRISMA is presented in Figure 1.

Of the 418 articles identified, 326 were excluded because of duplication. In the selection stage, 92 were eligible for reading in full, of these, 25 were included in the scoping review. The article publication period spanned from 2009 to 2019, and 17 (68%) were published in the first

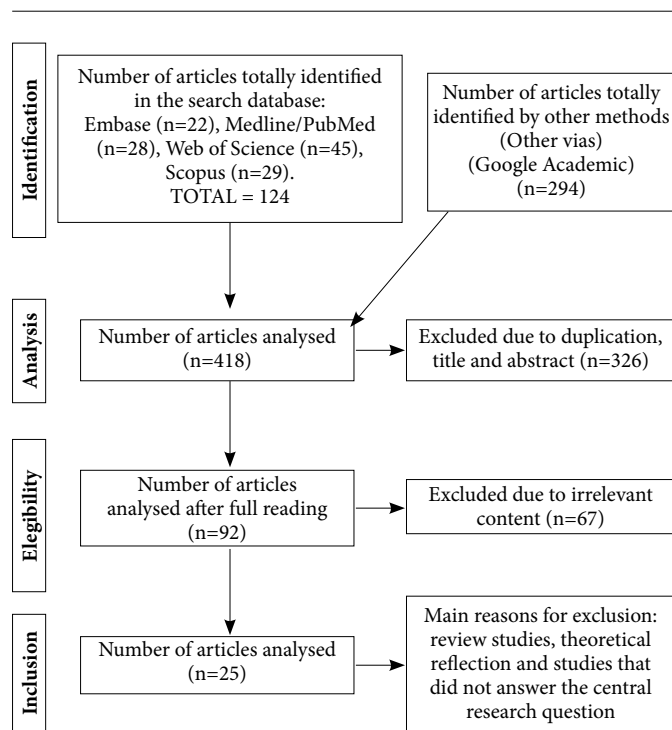


Figure 1. Flowchart of the study selection process according to the PRISMA recommendations⁸. Porto Alegre-RS, Brazil, 2023.

Source: Authors.

six years (2009-2014), in which 2010 and 2011 were outstanding with four studies each year. As for the place where the studies were conducted, the majority, 16 (64%) occurred in one country, and the others in more than one. Chart 1 presents the characterisation of the studies, with Zambia, Uganda and South Africa the countries possessing the largest number (six or more). Regarding the methodological approach, 14 (56%) were qualitative, six (24%) mixed and five (20%) quantitative.

Regarding categorical synthesis, the findings of the articles were organised into two thematic categories and four subcategories, as presented in Chart 2: 1) Contributions from GHI in combating the HIV epidemic; 1.1 Indicators of HIV and other diseases and strengthening of local health systems; 1.2 Fighting the HIV Epidemic by Civil Society Organisations (CSOs), such as local NGOs, religious and community organisations, and Chart 3: 2) Limitations of GHI in combating the HIV epidemic, repercussions for Health Systems; 2.1 Local health systems; 2.2 Leadership training for policy co-ordination,

human and material resource administration; and Finance and sustainability of the actions.

Discussion

It can be inferred that the increase in papers on the influence of GHI in the fight against HIV in Africa is related to the high prevalence of HIV, to the worst socioeconomic scenarios, as well as the greater difficulty of local administrators in articulating successful responses, which require the devising of policies potentially capable of reducing inequalities and defending human rights, both determinants for combating the HIV epidemic^{34,35}.

Regarding the first category – GHI contributions to combating the HIV epidemic –, related actions are highlighted that modified the indicators of the disease and the strengthening of local health systems^{11,13,14,16,17,19,23,26,29,32}. Among them, PEPFAR activities contributed to the increase in life expectancy, to reduced incidence and mortality by HIV and tuberculosis in the sub-Saharan region¹¹, and investments from the Global Fund were decisive in stabilizing the HIV epidemic in Ghana¹³, a country that has achieved progress in terms of the MDG. Data from the Global Report of the United Nations Joint HIV/AIDS (UNAIDS) Program, published in 2023, pointed to investment in the expansion of the ARVT in this region, which collaborated so that eight sub-Saharan countries came close to reaching the proposed 95% goals for 2025³⁶. According to the report, improvements in the scenario were mainly due to the development of strong political leaders, whose evidence-based HIV plans and actions were able to consider confrontation of the inequalities³⁴. On the other hand, a study by the International Society against AIDS, in which an international commission of experts assessed the future of the response to HIV from a more integrated view of health promotion, stressed that the increase in diagnosis and ARVT, although they had had an impact by reducing disease deaths, they were not enough to put an end to the epidemic in general. It is necessary to invest in aspects related to the primary prevention of the transmission of the virus, through initiatives that can guarantee basic human rights, as well as the strengthening of civil society organisation³⁷.

In this context, the rapid expansion of prevention, testing, counselling and treatment actions^{13,32}, Investment in Human Resources training in Health^{12,13,23,24,29,32}, and the strength-

Chart 1. Characterisation of the articles according to author, year of publication, country where study occurred, periodical, approach. Porto Alegre-RS, Brazil, 2023.

Author	Year/Country	Periodical	Approach
Cailhol <i>et al.</i> ⁹	2019 Burundi	Globalization and Health	Qualitative
Zakumumpa <i>et al.</i> ¹⁰	2017 Uganda	BMC Health Services Research	Mixed Methods
Cohen <i>et al.</i> ¹¹	2013 sub-Saharan Africa	JAIDS Journal of Acquired Immune Deficiency Syndromes	Quantitative
Cailhol <i>et al.</i> ¹²	2013 Angola, Burundi, Lesoto, Mozambique and South Africa	Globalization and Health	Mixed Methods
Atun <i>et al.</i> ¹³	2011 Ghana	JAIDS Journal of Acquired Immune Deficiency Syndromes	Mixed Methods
Jobson <i>et al.</i> ¹⁴	2017 South Africa	Globalization and Health	Qualitative.
Hushie ¹⁵	2019 Ghana	African Journal of AIDS	Qualitative
Lohman <i>et al.</i> ¹⁶	2017 Uganda	International Journal of Health Policy and Management	Mixed Methods
Azuine <i>et al.</i> ¹⁷	2014 Ethiopia, Kenya, Tanzania, Malawi, Zimbabwe, Mozambique, Ruanda, South Africa, Uganda, Zambia, Burkina Faso and Mali	International Journal of MCH and AIDS	Quantitative
Brugha <i>et al.</i> ¹⁸	2010 Malawi and Zambia	Human Resources for Health	Quantitative
Bendavid <i>et al.</i> ¹⁹	2012 Ethiopia, Kenya, Mozambique, Namibia, Nigeria, Ruanda, Tanzania, Uganda and Zambia	National Institute of Health	Mixed Methods
Chima and Homedes ²⁰	2015 Nigeria	Journal of Global Health	Qualitative
Grignon <i>et al.</i> ²¹	2014 Botswana	Dovepress	Qualitative
Kenworthy ²²	2014 Lesoto	Global Public Health	Qualitative
Rasschaert <i>et al.</i> ²³	2011 Ethiopia and Malawi	Journal of the International AIDS	Quantitative
Bisika <i>et al.</i> ²⁴	2009 South Africa	The Lancet	Qualitative
Chima and Franzini ²⁵	2015 Nigeria	The Royal Society of Tropical Medicine	Quantitative
Matsubayashi <i>et al.</i> ²⁶	2011 Uganda	BMC International Health and Human Rights	Mixed Methods
Hanefeld ²⁷	2010 Zambia and South Africa	AIDS Care	Qualitative
Parsons <i>et al.</i> ²⁸	2010 South Africa	Sabinet African Journals	Qualitative
Craveiro and Dussault ²⁹	2016 Angola	Global Public Health	Qualitative
Hellevik ³⁰	2012 Tanzania	International Review of Administrative Sciences	Qualitative
Edström and MacGregor ³¹	2010 Kenya, Malawi and Zambia	Global Health Governance	Qualitative
Cohn <i>et al.</i> ³²	2011 Kenya, Malawi, Uganda and Zambia	Global Public Health	Qualitative
Hanefeld and Musheke ³³	2009 Zambia	Human Resources for Health	Qualitative

Source: Authors.

ening of infrastructure, support for multisectoral responses to achieve national and international goals to maintain the quality of the HIV services¹³, cited as important contributions of the GHI in Uganda²⁶, meet the proposed needs to reinforce the response to the epidemic, using a more global approach³⁷.

GHI contributions were also identified as important in the fight against the HIV epidemic, along with the actions of the CSOs, such as local NGOs, religious organisations and community organisations^{15,20,31,32}. It should be not-

ed that, specifically in Nigeria²⁰, GHI focus on HIV strengthened the role of non-State actors in health care. In Kenya, Malawi, Uganda and Zambia, the main contributions to civil society occurred in the definition of priorities, implementation of programs and monitoring of GHI (PEPFAR and GFATM) activities (PEPFAR) activities³², unlike other countries. A study by the University of New Hampshire, which analysed limitations and potentialities of local and international NGOs, international donors, religious organisations and multilateral representatives,

Chart 2. GHI contributions to combat the HIV epidemic. Porto Alegre-RS, Brazil, 2023.

Subcategories	Description of the findings
Indicators of HIV and other diseases, and strengthening of local health systems	Studies ^{11,13,14,16,17,19,23,26,29,32} point out that GHI actions were effective in health and/or combat of the HIV epidemic in African countries, specifically in Angola, Botswana, Ethiopia, Kenya, Tanzania, Malawi, Zimbabwe, Mozambique, Rwanda, South Africa, Uganda, Zambia, Burkina Faso, Mali, Ivory Coast, Namibia, Nigeria and Rwanda. In Ghana ¹³ , Global Fund investments represented a substantial portion of the HIV program budget, which allowed the country to stabilize its HIV epidemic and progress in the reach of health-related Millenium Development Goals (MDG). Some studies indicate that the GHI actions, which are usually directed toward the promotion (availability and access) of antiretroviral treatment services, resulted in rapid expansion of prevention, testing, counselling and treatment of HIV ^{13,32} ; an increase in Human Resources in Health and/or training of workers involved in HIV programs ^{12,13,23,24,29,32} ; as well as strengthening infrastructure and supporting multisectoral responses to meet (national and international) goals, maintaining the quality of HIV services ¹³ . The study ¹¹ stressed that PEPFAR activities showed statistically significant associations in proximal health systems strengthening indicators directly related to HIV, specifically regarding increased life expectancy ($P=0.003$) and reduction in incidence, prevalence and mortality by tuberculosis ($P=0.0001$). In Uganda ²⁶ , in addition to actions in combating HIV, there was a significant increase in coverage in other areas not linked to HIV/AIDS, such as laboratory tests (1.19, CI95%: 0.25-2.14) and diagnostics (0.34, CI95%: 0.05-0.64) of tuberculosis, paediatric assistance, including immunisation (52.43, CI95%: 32.42-74.43), laboratory tests of malaria (1.21, CI95%: 0.67-1.75), its diagnosis (7.10, CI95%: 0.73-13.46) and diagnosis of skin diseases (4.92, CI95%: 2.19-7.65).
Combat of the HIV epidemic by CSOs such as local NGOs, religious and community organisations	CSOs (local NGOs, religious organisations and community organisations) have obtained recognised HIV-fighting actions in several countries ^{15,20,31,32} . In Nigeria ²⁰ , GHI focused on HIV strengthened the role of non-State actors in health care ³² . In Kenya, Malawi, Uganda and Zambia there were contributions to civil society, especially in relation to the definition of priorities, implementation programs and monitoring of GHI (PEPFAR and GFATM) activities. Such contributions included the development of partnership between the group of community health agents of Shibuye (a region in Kenya) with the local government to develop a surveillance program designed to help widows and orphans protect their property rights. This aspect tends to reduce health risks through an approach that includes human rights, contributing to reduction of the vulnerability of these groups and lower risk of contracting HIV by transactional sex or sexual violence. It is noteworthy, however, that identification of the most acute, emerging needs of vulnerable populations was only possible due to the proximity of the CSOs with the target communities, which provided stimulation to rapid GHI responses ³² .

Source: Authors.

Chart 3. Limitations of the GHI in combating the HIV epidemic, repercussions for Health Systems. Porto Alegre-RS, Brazil, 2023.

Subcategories	Description of the Findings
Local Health Systems	Studies^{9,20,24,32} conducted in South Africa, Nigeria, Burundi, Kenya, Malawi, Uganda and Zambia pointed out that the entry of GHI in these countries had contributed to the creation of systems parallel to local health systems, whose complex interinstitutional relations make it difficult to co-ordinate HIV actions³². Another aspect that influenced local health systems²⁴ were the divergences presented in reports on similar programs, or even different statistical data about equivalent issues, presented in international forums held by the same agencies that implemented projects in South Africa. A study in Ghana¹³ pointed out that about 150 administrators, supported by Global Fund HIV subsidies, sent data on Antiretroviral Therapy (ARVT) and treatment of opportunistic infections directly to the Ghana National AIDS Control Program. Also, although this centralised system guaranteed reports in a timely manner, it impaired data integration within the district system, hindering local decision-making¹³.
Leadership training for co-ordination of policies and administration of human resources and materials related to HIV combat.	Research conducted in Angola²⁹ points out that regional level administrators are unaware of how GHI work. In Nigeria, Burundi and Tanzania, for example, studies^{9,20,30} have pointed out the existence of weak political direction (unprepared administrators, insufficient and poorly structured policies), lack of leadership and vision on the part of administrators. A study³¹ conducted in Kenya, Zambia and Malawi, with national government actors, donors and civil society sectors, pointed out, on the one hand, the defence of greater co-ordination through investment in the State, through “basic financing” or budget support. On the other, they suggested support through different non-governmental structures and sectors. Predictably, many government informants tended to defend the first option, but several donors (World Bank AIDS program, the Global Fund and PEPFAR) expressed profound concern about the ability of governments to manage large-scale finance efficiently or equitably. In Burundi⁹, the co-ordination of HIV combat actions was strongly centralised at the Ministry of Health, although all interveners feared loss of power to other development fields, such as access to GHI resources. In the cases of Kenya and Zambia, there was documentation of inefficiency and corruption by government agencies, whereas non-governmental agents with experience of financing structures were more successful, facilitating greater community access³¹. Studies have emphasised that, despite the importance of CSOs as opportunities for civil society participation in the determination of priorities, such participation is still limited^{31,32}. In Malawi³¹, a national representative of the people living with HIV (PLHIV) reported that he had no voice at meetings, and the scheduling, close to the occurrence, did not allow preparation of the agenda of this segment. In the case of Kenya, there was a loss of autonomy of the SCOs for GHI to the detriment of the maintenance of finance received³¹. Unlike Burundi⁹, in South Africa²⁴, much of the GHI finance was channelled through the South African Medical Research Council or NGOs, not the National Health Department. For NGOs and the provincial government, no approval of the National Department of Health is required, so external donors work directly with the NGOs whenever possible²⁴. Regarding human resources, studies^{16,18,20,21,24,27,29,32,33} in Angola, South Africa, Nigeria, Malawi, Kenya, Uganda and Zambia revealed an increase in the work load of health professionals in the public sector, as well as migration of these to the private sector through positions funded by GHI. Corroborating this reality, a study²⁴ conducted in South Africa, in which six of the nine tuberculosis/HIV co-ordinators, trained by the National Health Department in 2006, left the Department three years later. This turnover hinders the administration and implementation of projects, thus leading to additional time to train new employees. Some donors trained people to work in the administration of tuberculosis and HIV action, but these later entered the private sector. Although GHI-funded projects pay the same salaries as the public sector, migration on the agenda was motivated by high net value, due to lower deductions and poor working conditions in the public sector²⁴. A study²⁰ in Nigeria on interaction between HIV and GHI and the health system found that these initiatives did not invest in the production of new health professionals and the allocation of qualified people. In South Africa²⁸, the distribution and availability of human resources for the provision of ARVT services was affected, mainly due to dependence on a model oriented by the doctors for beginning the ARVT, despite the scarcity of these professionals in the public sector. Nevertheless, the government did not approve the agreement for nurses to prescribe the start of ARV treatment²⁴.

it continues

Chart 3. Limitations of the GHI in combating the HIV epidemic, repercussions for Health Systems. Porto Alegre-RS, Brazil, 2023.

Subcategories	Description of the Findings
Finance and sustainability of isolated actions	Donor financing for HIV has increased dependence on foreign aid ^{20,27} , compromising the sustainability of actions ^{20,27,28,29,33} , due to emphasis on short-term objectives and neglect of long-term effects on the programs ²⁷ . In Ghana ¹³ , reproductive and child health actions and interventions directed to neglected tropical diseases, received less attention to the detriment of the prioritisation of actions for HIV. In Nigeria ²⁵ , there was an increase of \$1 per capita for HIV associated with a an 8% to 31% decline in the likelihood of receiving vaccines. A study in Lesoto ²² documented that the donors and NGOs promote strategies, which are viewed (by national and international society) as a moral practice in the global health efforts, even without privileging participatory activities. In Zambia, GHI also channelled their finance through different non-State actors, such as NGOs and other CSOs ²⁷ . However, a study ³² conducted in Kenya, Malawi, Uganda and Zambia pointed out that, on several occasions, opportunistic NGOs, which lacked competence or a history of providing services in a certain district, were financed. These changed their missions according to funding priorities and had no significant training or experience in local communities ³² . This sort of finance limited supervision at the national level ^{24,27} and raised questions about the country's political and economic priorities. Furthermore, it removed the sovereignty of the State; the health and care that are part of the classical function of a nation-state and national governments. The GHI represent a "control mechanism" in global governance, where actors not only determine the content of policy, but also shape their implementation processes, and, in some cases, completely ignore the State ²⁷ . In the case of Kenya, Malawi, Uganda and Zambia ^{31,32} , GHI did not reflect the health priorities of these countries and determined investment in their priorities within these structures.

Source: Authors.

pointed out that the principal obstacles in the search for better approaches to HIV – such as insufficient technical and administrative capacity, workloads and overloads, lack of a favourable environment, and the stigma associated with local groups working with marginalised populations – which will only be overcome with the development of programs aimed at enhancing the action of CSOs³⁸. What the report of this research indicates is that obtaining resources efficiently, effectively and responsibly from multilateral partners is that it is still a challenge to achieve a sustained local response. A study that assessed the role of religious organisations in facing HIV in Zambia corroborates that the development of community initiatives, aimed at providing education services to needy families and orphans due to the disease, emerge as potential strategies for the development of sustainable community relations³⁹.

From this perspective, this review identified that, in a region of Kenya³², the proximity of CSOs with the target communities provided encouragement for rapid GHI responses from innovative programming based on human rights. Such programming made it possible to grant aid to widows and orphans for protection of their property rights, which is positively re-

lated to HIV prevention, as vulnerable homeless groups are at greater risk of contracting HIV by transactional sex or sexual violence. Such aid is essential in view of certain global events, especially since 2018, that emerged as trends that redefined the historical, political and social scenario, such as the weakening of democracy, the increase in xenophobia and authoritarianism, factors that might worsen the spread of diseases in these vulnerable groups³⁵.

Furthermore, in relation to the action of the CSOs, it is noteworthy that the term, action is understood differently according to global differences, and that the best benefits will be from those who reach the highest degree of interaction among the social sphere, the family and the State. A study in Ghana pointed out that the confrontation of HIV depends on the quality of partnerships between the State and civil society, and not only the CSOs alone⁴⁰. It needs to be considered that, although the performance of CSOs is identified as important for better responses in the fight against the disease, some local interventions continue to be developed in a disarticulated way in relation to the financial flows of the main donor agencies and national strategies⁴¹. There are, therefore, problems that some authors call the "finance funnel" by which

NGOs receive most of the donor support, that is without proper transfer. The difficulty of access to funding by informal religious OCs is a considerable problem, as they have developed activities in parallel to programs performed by large congregations, as well as initiatives motivated by members of the community inspired solely by faith.

Regarding the second category – the limitations of GHI in combating the HIV epidemic, repercussions on health systems, the creation of parallel systems and weak local health systems were identified^{9,13,20,24,32} in countries like South Africa, Nigeria, Burundi, Kenya, Malawi, Uganda and Zambia, mainly due to the effects of complex interinstitutional relations in the monitoring and assessment of actions related to HIV. The divergences in information presented in reports that analysed the same epidemiological scenario in South Africa²⁴, and the sending of data on HIV, ARVT and opportunistic infections from the Global Fund to the National AIDS Control Program in Ghana¹³ impaired the integration of data in the district system and consequent decision-making. A review that analysed the interaction between GHI and local health systems pointed out that their inoperability were the result of decades of neglect and insufficient investment in public health, allied to or the consequence of a scenario composed of economic crises and a consequent increase in poverty and inequality⁴². On the other hand, another study that sought to understand the priorities, governance, harmonisation and alignment of GHI in Africa stressed that the structure of those who generate the actions are generally distant from the countries in which they will be operationalised, thus contributing to the inability of local governments to monitor their resources. Indeed, often the decisions regarding their allocation is defined by the interests of donors, without considering local health priorities⁴³.

Another aspect noticed was the problem of Human Resources. In Angola, South Africa, Nigeria, Malawi, Kenya, Uganda and Zambia^{16,18,20,21,24,27,29,32,33}, an increase in the workload of health professionals in the public sector was identified, leading to staff migration to the private sector to GHI-funded positions, which, combined with high turnover and poor working conditions of the public sector²⁴, it made it difficult to administrate and implement new projects. It is also noteworthy that, in Nigeria²⁰, it was found that GHI did not invest significantly in the recruitment of new health professionals. It is also necessary to consider the issue of

nursing skills in combating the HIV epidemic, because, in South Africa, ARVT is still oriented from a central medical model²⁴, despite the scarcity of doctors in the public sector. In this regard, it is noteworthy that the globalisation process, which has accelerated since the 1990s, has contributed significantly to the migration of health professionals. This fact, associated with the growth of the HIV epidemic, has weakened the technical capacity of countries that already had a fragile local health system⁴².

Despite the significant increase in financial resources to address HIV, tuberculosis and malaria, investment in human resources⁴⁴ is still an obstacle. Since the need for human resources permeates the five strategies proposed by the WHO to confront HIV, more professionals are required to increase diagnoses, maximize disease prevention actions, and accelerate the expansion of treatment and care for people with HIV/AIDS and their specificities. As well as expanding health systems and investment in strategic information to guide the effectiveness of actions, it is urgent to define the priorities focused on the formation and availability of qualified human resources, mainly in the most vulnerable regions, such as sub-Saharan Africa⁴⁵.

Difficulties in the formation of leadership for co-ordination of HIV combat policies emerges as one of the limitations of GHI, since its performance does not match the local reality of their governments²⁹. This ignorance of the reality of each country contributes to the existence of uncertain policies, lack of leadership and vision by the Ministries of Health in Nigeria, Burundi and Tanzania^{9,20,30}. In this sense, a study³¹ in Kenya, Zambia and Malawi involving national level government actors, donors and sectors of civil society, highlighted the divergence between local administrators and those of GHI, that is, while some count on the State, such as its “basic finance” or budget support, others prefer support through different structures and sectors (including non-governmental sectors). This generates concern on the part of the GHI components to rely on the governments’ ability to handle large amounts efficiently or equitably. Certainly, these aspects differ according to each country. For example, in Burundi⁹, the option in maintaining centralised co-ordination at the Ministry of Health incurs a risk of loss of access to GHI from those more minutely distributed to the SCOs. In the case of Kenya and Zambia³¹, inefficiency arising from possible corruption on the part of government agencies was highlighted. Nevertheless, there are successful experienc-

es in financial structuring along with NGOs, due to the access of stakeholders at the community level.

It is noteworthy that the WHO is undergoing a reform that aims to make its actions more effective, transparent and efficient. One of the main problems faced is that the lack of “regular budget funds” (fixed, regular contributions from member countries consistent with the wealth of each) makes it difficult to form leadership in policy co-ordination and resource administration for HIV. This is because most of the resources are voluntary contributions, called “extra-budget funds”⁴⁶. A review study that explored the economic impact State actions had in addressing TB stressed that countries with good governance had lower, stable HIV rates. Good governance, in turn, includes transparency in its action to reduce disease discrimination, as well as protection and well-being of vulnerable groups⁴⁷.

Many of the difficulties of several sub-Saharan African countries, in which practically two thirds of the prevalence of HIV/AIDS are concentrated, include a lack of leadership for co-ordination of more robust policies, and relate precisely to the expansion of the SCOs and NGO, which more and more fill the gaps where local governments do not act. Even though in South Africa these groups are responsible for the transfer of financial resources, and, despite all the criticism of their benefits and losses, the 25% reduction in the incidence of HIV in 22 African countries, from 1990 and 2009, is recognised as a strong element that would justify maintaining their interventions, even if these, to some extent, contribute to the lack of political leadership at the local level⁴⁸.

Although studies have found that donor financing for HIV combat has increased dependence on foreign aid^{20,27} and that most of the support was not sustainable, some research points out problems related to the financing period^{20,27-29,33}, whose need to measure the impacts of GHI prioritised short-term objectives to the detriment of evaluating the long-term effects of programs²⁷. In this sense, the prioritisation of actions in combating HIV has led to adverse effects on other areas that needed investments, such as reproductive health, child health and confrontation of neglected tropical diseases¹³. This aspect is related to the current reform the WHO is undergoing and the increase in financial resources through public-private partnerships, which are increasingly configured as the principal suppliers of resources to tackle HIV⁴⁶.

Nigeria, for example, had negative effects on immunisation services²⁵. A study in Lesoto²² draws attention to the difficulties of developing strategies with participatory approaches capable of formulating equitable policies, mainly due to the fact that NGO resources, besides being provided vertically, are not directed according to the needs of the communities of the beneficiary States of Africa²². Misalignment between program budgets and the financial commitments of the member States, unpredictability, lack of financial transparency and resource administration efficiency are pointed out as factors that make it difficult to sustain the actions⁴⁶.

In a way, the process of globalisation in health strengthens the idea that it is possible to find common solutions to global health problems, including HIV. However, it turns out that, even in the face of increasing financial resources for populations in more vulnerable areas, the historical disabilities of health systems in the poorest countries generate funnels in the distribution and use of these funds⁴⁹. The high rates of HIV infection and prevalence worldwide, even in the face of high budgetary investments, corroborates that success in dealing with the epidemic demands a direct focus on social, environmental, behavioural, as well as human rights issues⁴⁹. In general, it is noteworthy that financing and the form of resource allocation are fundamental aspects that influence GHI action. It was observed that the major approaches have not changed over the years, but there has been evolution in terms of finance involving the decisions of donors, which are determinant in the development of less vertical, more comprehensive action, increasingly close to local policies. The literature review showed that one of the strategies used by GHI to achieve sustainability for the action is the greater involvement of the private sector, co-finance by the countries that will receive the intervention, as well as the inclusion of the SCOs⁴³.

Final considerations

The influence of GHI in combating HIV in Africa identified in the literature analysed refers to both contributions and limitations. Regarding contributions, it was identified that GHI investments represented a substantial portion of the program budget, which allowed countries to make progress and stabilize the epidemic by strengthening infrastructure and support for multisectoral responses to achieve goals (na-

tional and international), improvement of the quality of services, increased Human Resources in Health and/or training of workers involved in the programs, greater access to diagnosis and treatment for HIV/AIDS and investment in the participation of CSOs by local NGOs, religious organisations and communities.

Such directions reverberated in strengthening HIV services, especially regarding increased life expectancy, improved tuberculosis indicators and SCO participation in relation to the definition of priorities, implementation of programs and monitoring of GHI activities.

Among the limitations identified, outstanding is the creation of systems parallel to the local health systems, whose complex interinstitutional relations make it difficult to co-ordinate actions related to HIV, lead to non-sharing of data with local administrators, loss of autonomy for governments and CSOs for the GHI to the detriment of maintaining the finance received, increasing dependence on foreign aid, worsening the workload of health professionals in the public sector, as well as their migration to the private sector through the offer of GHI-funded positions.

This study's findings raise reflection on the traps found in the forms of channelling resources. If, on the one hand, government resources can cause inefficiency in administration and corruption in government institutions, on the other, SCOs and NGOs can foster opportunistic NGOs through verticalisation of health actions, where GHI ignore the health needs of countries and invest in their priorities within these structures, removing the State sovereignty. Health and care are part of the classical function of nation-state and national governments.

In the race to meet the Goals of the United Nations HIV/AIDS (UNAIDS) Program, for the year 2025 and 2030, as well as for health improvement of the local population, this study becomes relevant to understanding the influence GHI in combating HIV in Africa, and is available for social actors, researchers and national and international policy formulators to exploit different aspects of the role of GHI in Africa, especially in combating HIV, as well as to stimulate reflections on the influence of these initiatives on each of the countries studied.

Collaborations

All authors participated actively in the construction of this study and approved its final version.

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