

Health in Africa and the Role of International Organizations

For Africa, international health financial organizations, such as the United Nations (UN) through the World Health Organization, and bi-lateral assistance programs represent a curse and a blessing simultaneously. While they provide needed assistance and help meet the health needs of Africans, they make the continent dependent on hand-outs, unwittingly encouraging unscrupulous leaders not to generate or make national resources available to the people. Worse even, foreign assistance leaves a vacuum when it is depleted or, for various reasons, withdrawn. Foreign funds are also easily prone to misuse by leaders and unscrupulous high and middle level civil servants. Furthermore, as is the case with the IMF, assistance has always come with strings attached, forcing Africa to rely on international generosity to meet the health needs the West deems a priority for the continent. These conditions often imply at times that the donors know best what is good for Africans. While not denying the usefulness and the need for international assistance, the author argues that the use of financial assistance must be completely transparent to prevent misuse and abuse, not condescending, and always respectful of Africa's sovereignty. In this context, world leaders must also note that the globalizing trend is often one-sided, unidirectional—from North to South—always exploitative in nature and accompanied by a cultural baggage that corrupts the youth, unwittingly promotes violence, sex, decadent practices, and unhealthy behaviors, such as the consumption of fast foods and tobacco, bad diets

and alcohol abuse, thus contributing to non-communicable diseases, such as liver and stomach cancers, now dubbed by the UN as Africa's second disease burden.

THE WORLD HEALTH ORGANIZATION (WHO)

Very few experts can deny the vital role the WHO has played in the elimination or eradication and containment of infectious diseases and the awareness it has created globally about the risks of chronic or non-communicable diseases, especially during the last decade. The concept and origins of the WHO are quite interesting. The UN, of which WHO is one of its most important agencies, came into official existence on October 24, 1945, in San Francisco, when 50 of its members signed the Atlantic Charter. The creation of such an organization had been already agreed upon by President Franklyn D. Roosevelt (one of the most important spokesmen of the new international body), Joseph Stalin, and Winston Churchill. The most critical mission of the UN was to perverse world peace and security in the Post-World War II era by avoiding at all cost the mistakes that led to the previous world conflicts. For those who have followed the course of history, the UN was remotely related to the Quadruple Alliance (Austria, Prussia, England, and Russia) announced at the Congress of Vienna following the Napoleonic wars and French emperor Napoleon's final defeat at Waterloo in 1815. The aim of the Alliance was to maintain the status quo disturbed by the two Napoleons' ventures and ensuring that, if one of the four powers were to be threatened, the threat applied to the other three, forcing all members to fight together against the enemy. More recently, the principles embraced by the UN also incorporated those espoused by the League of Nations contained within the 1918 Treaty of Versailles, following the defeat of Germany in World War I, even though the US refused to sign it because of internal politics: Woodrow Wilson, the major proponent of the Leagues of Nations, which was to endorse "open covenants of peace openly arrived at," failed to have the endorsement of his own country, but the remaining members of the League, led by Georges Clemenceau of France and Lloyd George of England, signed the treaty and tried to enforce it immediately. Wilson was an idealist who envisioned a world without wars, in which only diplomacy would be the solution for international conflict.

However, because of its weak nature, the disdain Adolph Hitler showed for its existence, and the appeasement policy particularly followed by

Neville Chamberlain, Prime Minister of England, during the 1930s, the League of Nations had been rendered virtually dysfunctional by 1939. The UN was deemed to be the successor, incorporating relatively much stronger clauses and structures that would preserve world peace. To a great extent, this has happened. It stands to reason that, if an organization is strong and respected by the international community, the same can be expected of its components and its various agencies. Most experts would agree that this was the intent whose results could be seen through the creation of the WHO, which, according to many “is the world’s leading health organization, because, over the years, it has had ‘a far-reaching impact on the status of international public health’” (Ling 2002: 1). WHO components include the World Health Assembly (WHA), the Executive Board, and the Secretariat. Meeting with the 193 member states’ ministers of health or their delegates once a year to discuss a policy agenda, the WHA is the decision-making or legislative body on the state of global health and recommends action that addresses problems that affect people all over the globe. This body also approves the WHO budget, with each member state having an equal vote on the “direction” of the organization. Headquartered in Geneva, the WHO Secretariat is headed by a Director-General who is nominated by the Board and then elected by the WHA.

The Director-General is assisted by and shares responsibilities with the six regional Directors, who are selected by their respective regional offices. The regional offices are headquartered in Copenhagen for the European Region, Cairo for the Eastern Mediterranean Region, New Delhi for the Asian Region, Manila for the Western Pacific Region, Harare for the African Region, and Washington, D.C., for the American Region or the Americas, with the regional Directors choosing the WHO representatives at the “country level for their respective regions.” The final approval of the appointments is given by the headquarters, which means that the regional offices enjoy considerable autonomy, a structure that has led some to claim that there are many WHOs, given that the regional directors can virtually operate independently (Ling 2002). The number of the member country’s offices has varied. But in 2001, 141 WHO country offices were operating, the total number of WHO staff reaching 3,800 that year. As can be easily detected, the WHO “is the only agency of the UN system with such a decentralized structure” (Ling 2002: 1).

The mission of the UN was very general at first, focusing on international peace and security through common action, as noted earlier, and did not encompass active and deep involvement in global health, health

education, and environmental monitoring. With time, however, the need arose to do precisely that: monitoring and surveillance of disease, announcing strategies and guidelines on health, and providing financial resources for the development of vaccines and the holding of immunization campaigns especially directed towards the health of women and children. However, the spread of infectious diseases and the continued outbreaks of disease epidemics, especially in the developing world, were seen as serious threats to human survival. These conditions were aggravated by changes in travel and communication that enhanced the spread of epidemics across the globe, which convinced the world community that a special agency was needed to fill the serious vacuum in the area of health. The WHO would also guide its mission according to the principles embraced by the UN, namely, promoting human rights, working towards social and economic development, protecting the environment at all cost, and assisting member states globally when disasters hit, such as famine, hunger, flooding, earthquake, an epidemic, and a refugee situation following armed conflict.

The idea of a world health organization came into being after three well-known respected physicians, Szeming Sze of China, Karl Evang of Norway, and Geraldo de Paula Souza of Brazil proposed in 1945 the establishment of “a single health organization that would address the health needs of the world’s people.” Their joint declaration regarding such an organization was eventually approved by the world body when it adopted the resolution in 1946. It was thus that the WHO came into existence along with several other agencies within the UN framework, including the Food and Agriculture Organization (FAO) (1945), the International Civil Aviation (ICAO) (1947), the International Labor Organization (ILO) (1946), the International Maritime Organization (IMO) (1948), the International Monetary Fund (IMF) (1945), the International Telecommunication Union (ITU) (1947), the United Nations Education Scientific and Cultural Organization (UNESCO) (1946), the Universal Postal Union (UPU) (1947), the World Bank Group (WBG) (1945), the World Meteorological Organization (WMO) (1974), the Atomic Energy Agency (IAEA) (1957), the United Nations Industrial Development Organization (UNIDO) (1967), the World Food Program (WFP) (1963), the World Tourism Organization (UNWTO) (1974), the World Intellectual Property Organization (WIPO) (1974), and the International Fund for Agricultural Development (IFAD) (1977). As one commentator noted, at its founding, WHO was not intended to provide health services

but rather be a coordinating body for global health policy implemented by national and international health agencies (Johnson 2011: 1). In fact, its original mission was ambiguous as it was designed for “the attainment by all people of the highest possible level of health, listing thereafter some 22 “wide-range functions, of which the first was to ‘act as the directing and coordinating authority on international health work’” (Clift 2013: 6).

Thus, until 1969, the role of the WHO, contained in its original mission, was confined to fighting a few infectious diseases, such as cholera, small-pox, yellow fever, guinea worm disease, onchocerciasis, and the six most common infectious diseases, particularly affecting children—diphtheria, tetanus, pertussis (whooping cough), measles, tuberculosis and poliomyelitis—and plague, and the reporting requirement, which “ultimately failed to generate compliance by WHO member countries” (Johnson 2011). The original focus continued to expand, however, so that by 2005, WHO member states were asked “not only [to] report but also to prevent and control any disease that presents a significant harm to humans, and surveillance for pandemics,” covering infectious diseases. Thus, the WHO mission even by 2002, had expanded exponentially, and included (Ling 2002):

establishing and maintaining administrative and technical services in member countries, such as epidemiological and statistics services; stimulating the eradication of diseases; improving nutrition, housing, sanitation, working conditions and other aspects of environmental hygiene; promoting cooperation among scientific and professional groups; proposing international conventions and agreements on human matters; conducting research; developing international standards for food; and informing public opinion among all people on matters of health.

It was the WHO that gave us the now renowned definition of health, proudly quoted by health professionals, which declared health as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity and the enjoyment of the highest attainable standard of health as a fundamental human right,” for which governments had the “...responsibility to provide ‘adequate health and social measures.’” Today, the WHO is deeply involved in matters of health and poverty, maternal and infant mortality, health disparities and inequalities, globalization and health, tourism (including medical), patients’ rights in medical innovation, health worker migration, safety guidelines for genetically engineered foods, adaptation to climate change, and all other

issues that in 2005 it classified as social determinants of health. The latter has been a major shift from 1948, the time when some had described the agency's mission as restricted to providing "technical consultancy to national health ministries and international agencies, promoting the best practices to combat the worst diseases" (Bollyky 2012). Currently, the issue of chronic or non-communicable diseases, or lifestyle diseases, such as cancers, diabetes, respiratory and cardiovascular diseases, vehicular injuries, crime, and corruption, tobacco use, and drug trafficking, which are growing at an alarming rate in the developing world and have become the leading causes of death and disability almost everywhere in the world, are a part of the WHO's overarching responsibility. This demands application of "evidence-based ideas, and global surveillance, technical assistance, and international coordination that can support countries' effective and sustained implementation" (Bollyky 2012).

The WHO receives financial contributions from UN members that pay according to their GDP. Unfortunately, politics have been a distractive and, at times, destructive force within the WHO itself, particularly on the issue of dues. We are often reminded, as someone dramatically put it, that, "The poor countries [have] said 'we cannot afford to do anything. The middle income countries [have] said 'we do not like the rich guys telling us what to do.' And the rich countries [have] said 'we have our own polities, why should we listen to WHO?' So, all the policy outcomes were eliminated" (Johnson 2011: 4). Politics in the WHO are also centered on the power of the big Western nations that try to control the agenda and the strategies which are often forced on the less powerful nations, while exerting pressure to ensure that the WHO does not place too much emphasis on people's rights to health. As renowned epidemiologist Laurie Garrett wrote, there is the impression that a rich country, "like the US, uses its funding leverage to continually pressure the WHO to steer clear of 'macroeconomics and trade issues that it says are outside its scope, and to avoid such terminology as 'the right to health'" (see Johnson 2011).

Thus, when SARS became pandemic and the Western pharmaceuticals asked to have samples of the avian flu to manufacture drugs, the Chinese claimed "biological sovereignty" and refused to honor the request, alleging that the West would produce vaccines that would benefit only its people, while the Chinese themselves would be unable afford to buy them. International politics also caused China to block Taiwan's membership of the WHO. Unfortunately, the WHO could not do anything in the face of the avian flu because it can only share the protocols but cannot force any

member state to comply with its requests, even though it knew that China was not at the time in a position to develop a vaccine against the flu. This is the reason why many experts wished “international health regulations would give the WHO more leverage during the transnational emergencies” (Johnson 2011). Several developing countries would most likely side with China’s attitude because quite often Western pharmaceuticals focus on drugs or vaccines that will benefit primarily the West—ones that result in financial profit—just as is the case with the attempts at finding a vaccine for HIV/AIDS in Africa, where the West has been testing the HIV sub-type B when the predominant strain in East Africa is HIV sub-type C. The reason is that, if they discover the vaccine for the African strain, this would not be as lucrative because it would not serve the interests of the West, which would therefore not buy it.

A growing number of professionals believe that it is time for the WHO to make changes in the mission given to it by the UN over 60 years ago and claim that it has not adapted itself to the global health needs and the effective operations of a system in the twenty-first century. On the budget, it is clear that the WHO is being overtaken by many philanthropic organizations that do not depend on member state donors, including the Bill and Melinda Gates Foundation, USAID, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and even PEPFAR provided by the US. These shortcomings are aggravated by the inefficiency and timidity in the use of the funds allocated for health across the globe. Indeed, instead of increasing, the WHO’s budget has been shrinking dramatically since 2008. From 1990 to 2012, the overall level of global aid seems to have increased four-fold, reaching \$22 billion annually, while that of the agency remained \$1 billion, and continued to decline or remained static thereafter (Bollyky 2012). Indeed, 80% of the WHO budget comes from private and public donations and not from member states’ dues.

It is estimated that the 2014 budget was less than \$4 billion, less than the \$6 billion allocated by the US to the Center for Disease Control (CDC), forcing the agency to begin relying on donations from government and private institutions. For example, the UN sought to raise some \$600 million in emergency funds to battle the Ebola virus outbreak for its most important agency. Critics also say that the WHO is over-reaching and at times gets involved in issues of health that can be best handled by regional officers and professional personnel of the member states themselves, who can manage their own services, and be partners, and not merely patrons in the WHO’s efforts to improve global health and eradicate disease.

In Bollyky's opinion, the developing world needs only technical support and data on the best global practices so they can perform more effectively locally. The operative words are "reliance on local leadership" that ensures that "technical professionals resident in the various members states take over most operations and administer the budget, which is often used to pay unnecessary staff that is constantly traveling. This would save the few scarce resources it musters. The budget reduction that began in 2008 resulted in the loss of 35% of the agency's personnel.

The inability of the WHO to come quickly to the rescue of the outbreak of the affected people during the Ebola virus in parts of West Africa in 2014 shows the agency's inefficiency, its weak global surveillance, and it is unwise allocation of resources that should be used to train volunteers, strengthen local personnel, and stop relying so much on *Medecins Sans Frontieres* (MSF)(also known as *Doctors Without Borders*). The agency should also focus on its ability to engage in scaling up emergency measures that might have save the lives of thousands of people. Ebola, one the most deadly virus the world has ever seen, can be contained, as was the case several times since its first outbreak in 1976. The Communications Director of MSF, Jason Cone, has noted that the inability of the agency to contain the outbreak during a period of six months indicates the existence of a "huge vacuum in leadership" that it cannot fill, compelling, as well, President of MSF Joanne Liu to confess at the time that the world was losing the battle to contain the outbreak and, therefore, could not coordinate the international response (Gaist 2014: 1). The interjection of politics, as mentioned earlier, does not help the WHO image either. Its hiring practices across the globe have been criticized for cronyism and unethical practices that seem to favor friends and those who are inclined to accept unprofessional demands to advance their careers, even though most of these charges are often based on hearsay and innuendo. The British would like to see the WHO given the mandate of simply "preparing a strategy for global health governance," while others suggest that the Secretariat in Geneva take over control over WHO's "resources for health programs" (Johnson 2011: 6).

However, thanks to the WHO, we now have guidelines on food safety, started as early as 1960, and proper nutrition strategies for children and mothers (see the work of FAO/WHO *Codex Alimentarius* Commission), which has become one of the priorities of global health; and the provision and availability of essential drugs has become another important priority in every corner of the world. The quick containment of SARS, a major target

of the WHO and the Western world, despite the refusal of the Chinese to share samples of the virus at first, has been a triumph of the most respected UN agency (Water 2005). Also to be remembered is the flu pandemic H1N1—the first one in 40 years in 2009—which showed the critical role the WHO has played over the years. Prevention of vertical transmission of HIV to the fetus and the announcement of clear guidelines on the merits of baby breastfeeding constitute one of the most successful projects undertaken by the WHO. The fight against HIV/AIDS, TB, and malaria, called the “Big Three” in Africa, is being won, though slowly, but people are now able to live with HIV for decades because of new therapies, proving that having HIV is no longer a death sentence.

Recently, the WHO and its partners, such as the World Bank, have been focusing their attention on non-communicable diseases, the silent killers, while warning member states of the deadly consequences of motor vehicle and motorcycle crashes, which are caused by drunk driving, drug use, fatigue, and poor road infrastructure. Significantly, the WHO’s turn towards mental disorders as serious illnesses is a move in the right direction, given that Africans have so far paid very little attention to the problem. Included in the arena tackled by the WHO are oral hygiene, veterinary science, occupational safety, special care for the elderly, and the fight against tobacco use, particularly among minors (see Oluwafemi 2014: 27). The various free publications and information one can obtain from the organization’s headquarters, such as its *Bulletin*, and the many reports that can be freely downloaded from the Internet are a major source of health education and information. Rather than decrease its influence and its health service, as suggested by some, WHO has proven to be the most trustworthy agency of the UN, and should therefore be given enforcement power to ensure that our planet is protected not only from the spread of disease but also from corrupt individuals, including state leaders, who misuse the funds allocated for the improvement of the health of their people and endanger the safety and survival of the entire globe.

Returning for a while to the problems WHO has encountered over the years, but particularly now that resources are fewer and the developing world begins to feel emancipated and able to manage its own health systems, we might summarize what the Centre on Global Health Security Working Group papers (2013) have noted regarding changes that are needed to make the agency operate more effectively. After chronicling the history and development of the agency, the Center stresses that the major challenge for WHO has come from the World Bank’s involvement

in the health sector “on a large scale” during the 1980s and the proliferation of a number of health initiatives thereafter, which placed in jeopardy the agency’s authority in directing and coordinating health issues at hand, given that some of the new actors have a larger budget than this UN organization. The WHO also found itself challenged by the emerging new and old diseases, coupled with the alarming increase in non-communicable diseases and the impending threats of more epidemics, which underscored its weaknesses and its inability to act more effectively as the Ebola virus proved in Africa. These developments raised more questions about its future, especially in reference to its structures and operations. What is acknowledged, though, is that the WHO succeeded in placing center-stage the proposition that health was a human right and that social issues that cause or contribute to health inequalities should constitute a serious concern for all member states.

A major criticism, however, has been that the WHO makes “top down” and “vertical” decisions regarding “disease-specific campaigns,” detracting it from developing “horizontally integrated health service” (Cliff 2013: 24). In addition, as Cliff writes, “The challenge to WHO lay in competition in the sphere of policy where World Bank thinking, grounded in macroeconomics and neo-liberal ideas, was a sophisticated response to WHO’s position grounded in the thinking of health professionals as exemplified by “Health for All,” all of which contributed to a clash of philosophy and therapeutics as approaches to health. Finally, though praising the constitutionally framed structure, critics point to the agency’s actual function, which, according to them, “is wrought with serious and complex problems of constitutional, political, managerial, and programmatic nature.” The comment is applied in practice to the agency’s interaction with the regional offices, the “centerpiece of “One WHO.” This aspect has received mixed reviews from those who criticize the agency’s management style and the nature of relations on the ground. Although some of the criticism may have some merit, it is often based on personal opinion couched in subjective information. Indeed, it would be a miracle, if an organization of such import and longevity as the WHO, which has to deal on a daily basis with issues of global relations and budget matters, particularly in time of want and recession, were not criticized for one reason or another. Criticizing is cheap but providing convincing solutions, based on the best practices available, is not an easy task. However, this is not to deny the reality that an organization that does not adjust to changing times cannot survive.

THE PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF (PEPFAR)

In 2003, President George W. Bush committed the largest amount of funding ever, which he announced at the 2003 State of the Union Address, to enable Africa to cope with the issue of HIV/AIDS for the following five years. He called it the President's Emergency Plan for AIDS Relief (PEPFAR) and it was worth \$48 billion for the period 2003–2008. This assistance was reauthorized by Congress in 2009 through 2013 and was designed to prevent some 12 million new infections, treat 3 million people suffering from AIDS, and provide care to 12 million people, including 5 million orphans and vulnerable children. The reauthorized funding could change or switch the original priorities but required the recipient agencies or governments to eventually make the programs strong and self-sustaining and develop durable strong partnerships. Thus, on May 25, 2003, the US Congress passed the legislation called “The US Leadership against AIDS, Tuberculosis, and Malaria Act” (P.L.108–25, 2003), authorizing \$15 billion over a five-year period, which would be managed by the Office of the Global AIDS Coordinator (OGAC).

OGAC would also coordinate US Government-supported HIV/AIDS programs in developing countries. According to the legislation, the Executive Branch was to come up with and implement a “comprehensive, integrated, five-year strategy to combat HIV/AIDS that strengthens the capacity of the United States to be an effective leader in the international campaign against AIDS (P.L. 108–25, 2003). Following were PEPFAR's priorities:

1. 55% funding for treatment or people with HIV/AIDS
2. 20% of funding for HIV prevention, of which 33% had to be spent on abstinence-until-marriage programs
3. 15% for palliative care of people with HIV/AIDS and
4. 10% to support orphans and vulnerable children.

The percentages have varied from year to year and have stipulated how much could be spent, for example, for the purchase of antiretroviral pharmaceuticals, which amounted to 75% for the period 2006–2008. The function of the OGAC was delineated by Congress, and included its “direct oversight and responsibility for programs in 15 focused countries to achieve the 2/7/10 targets. Recipient countries in Africa were Botswana,

Cote d'Ivoire, Ethiopia, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, and Zambia. OGAC would also provide funding overseas generally to all bilateral or regional offices, although the management of these programs would largely remain with the technical agencies managing US government foreign assistance, such as USAID, NIH, CDC, and embassies. OGAC was to manage and distribute US government contribution to the Global Fund to Fight AIDS, Tuberculosis and Malaria. Even though the President had requested \$1 billion only for the Global Fund for five years, Congress approved a higher amount.

PEPFAR results have not been disappointing, if figures are to be believed. As of September 2013, PEPFAR supported the health treatment of 6.7 million people, and 17 million others cared for humanitarian reasons, including some 5 million orphans and vulnerable children. In 2013, antiretroviral prophylaxis from the anticipated continued funding was administered 780,000 HIV-positive pregnant women and, as a result, some 240,000 children were born without HIV. Under new guidelines for countries receiving PEPFAR aimed at establishing Country Operations Plans to “document annual investments and anticipated results,” which are then reviewed by OGAC and, if compliant, they would become part of the annual PEPFAR Operational Plan. In the full year 2014, \$6.7 billion were approved for PEPFAR, an increase of almost \$240 million or 40% over 2013, “the highest level of funding since 2010” (KFF Analysis, FY 2012, US Congress Law No. 112–25, August 2, 2011). For 2015, President Obama requested \$6.4 billion, a decrease of 5% or \$350 million over 2014, the lowest since 2009. The 2014 PEPFAR appropriated \$6.7 billion, 72% or \$4.9 billion for HIV, 3% or \$326 for TB, and \$1.65 billion for the Global Fund. PEPFAR funds are turned over to the US Department of State (\$5.7 billion in FY 2014) and then allocated to the various agencies, including the \$1.65 billion to the Global Fund, USAID, (\$366 million), NIH (\$376million in FY 2014), CDC (\$128 million in FY 2014), and \$8 million to the DOD. Most of the approved bilateral program funding in countries is for care and treatment, about 46% (in FY 2011), followed by prevention or 29% of the funds.

PEPFAR has certainly been one of the greatest humanitarian gifts the US has ever given to Africa, and the Africans are extremely grateful to America, to the extent that George W. Bush, one of the most disliked US presidents, has become an instant hero on the continent, and it has continued to be so even with Obama, a black President, in the White House. The commitment was cemented by the August 4–6, 2014 Summit called

by President Obama in Washington, D.C. The United States' ultimate goal, as President Obama put it on July 28, 2014, is to ensure that the programs are sustainable and empower "governments themselves to begin to set up public health infrastructures and networks and clinicians and specialists so that it becomes self-sufficient. So [he continued] we're making progress." The President also noted that, over the past 20 years, HIV in Africa has been cut by half and TB and malaria deaths were reduced by 40% and 30%, respectively. "The rate of reduction of maternal deaths at birth was 50%, while 50 million children's lives were saved. The dramatic success of PEPFAR gave Secretary of State Hillary Clinton the hope in 2011 that the world would now embrace the goal of "creating an Aids free generation," which was followed, in 2012, by her "blueprint for achieving the goal" (See PEPFAR, *Fact Sheet* 2011, 2012).

The Henry J. Kaiser Family Foundation, aligned with PEPFAR, expresses the following critique of the initiative and its implementation in Africa and elsewhere. Noting that PEPFAR was heralded as "one of the most significant and successful global health initiatives undertaken," the Foundation believes that this longitudinal US Government project must take several actions (2013):

1. Continue to support the shift from an emergency response to a sustained, country-led model
2. Move toward a more outcomes-based system to assess impact, including the challenge of attributing results in the field directly to PEPFAR support
3. Coordinate PEPFAR with other US global health investments and applying lessons learned from PEPFAR more broadly
4. Strike the appropriate balance in funding and programming between HIV treatment, prevention, and care; between bilateral HIV programs and the Global Fund; and between HIV and other parts of the global health portfolio, and
5. Implement the PEPFAR blueprint and achieve the vision of an AIDS Free Generation, particularly within a challenging US and global fiscal climate.

Even though PEPFAR does not approach disease vertically as narrowly as some other international funders, in which the local technicians and professionals have little say, it is still a top to bottom program in the establishment and allocation of funds, and, as such, it has received some

criticism. What must exist is a balance between independent local control (which, however, can result in misuse of funds and corruption), and direct participation of people in setting priorities and realistic strategies based on a country's economic conditions and the state of its infrastructure. Furthermore, since its inception, PEPFAR has continued to put much more emphasis on treatment rather than on prevention, which appears to go counter to the accepted prescriptions of the Alma-Ata Declaration.

In addition, it is worth remembering that PEPFAR does not support only African health initiatives but that of some 31 countries of focus, even though Africa gets the bulk of the funds. Finally, with the introduction of the Global Fund and the distribution of funds through several agencies of the US government, PEPFAR is a mammoth "institution" that is difficult to understand and implement fairly to satisfy both the domestic funder and the funded country or government, complicating the need to make it more rational and more realistic in view of the differing local conditions. All agencies involved have their own objectives and strategies, which render the responsibilities of the recipient countries more complex. As one looks at the official outcomes of PEPFAR, one is not provided with the details related to screening and testing, the rule that mandates abstinence-until-marriage, free distribution of condoms, and the funder's veiled requirement that all African males be circumcised to apparently end HIV transmission from sexual activity with uncircumcised men. This reflects the Congress disdain for the use of condoms as an unchristian practice, thus attaching religious ideologies to the provision of health care. The same applies to abstinence-only-until-marriage, with the still unsubstantiated claim that it reduces sexual activity, especially among the young. Studies in the US itself have proven that, no matter what you tell young men and women, even at the point of forcing them to sign a pledge, the mandate does not work, as proven by many broken pledges made by high school kids or even children from religiously fanatic households.

A major study published in 2007 by the Sexuality and Information and Education Council of the US concluded emphatically that:

Over the past 25 years, Congress has spent over \$1.5 billion on abstinence-only-until-marriage programs, yet no study in a professional peer-reviewed journal has found these programs to be broadly effective. Scientific evidence simply does not support an abstinence-only-until-marriage approach. In April 2007 [says the study], a federally funded evaluation of Title V abstinence-only-until-marriage programs was released. The study, conducted

by Mathematica Policy Research Inc. on behalf of the U.S. Department of Health and Human Services, found that abstinence-only-until-marriage programs are ineffective. Of the more than 700 federally funded abstinence-only-until-marriage programs, the evaluation looked at only four programs. These programs were handpicked to show positive results and they still failed. (Trenholm 2007)

Other studies, such as one released in early November 2007 by the National Campaign to Prevent Teen and Unplanned Pregnancy, *Emerging Answers 2007*, authored by Dr. Douglas Kirby (called “a leading sexual health researcher”) discussing what programs work in preventing teen pregnancy and sexually transmitted diseases, including HIV, came to the same disappointing conclusion. *Douglas Kirby’s* report was, of course, no consolation to the proponents of the “*abstinence-only-until-marriage programs.*” This study concluded by noting that:

At present, there does not exist any strong evidence that an abstinence program delays the initiation of sex, hastens the return to abstinence, or reduces the number of sexual partners. In addition, there is strong evidence from multiple randomized trials demonstrating that some abstinence programs chosen for evaluation because they were believed to be promising actually had no impact on teen sexual behavior. (Kirby 2007)

Tara Culp-Presser, of the Center for American Progress Fund, Think Progress, also points out that:

According to a [new study](#) conducted by researchers at the University of Washington, men who take virginity pledges may struggle with long-lasting issues with sex, even after they’re married. The participants in the study—all conservative evangelicals who joined an abstinence support group in their late teens or early 20s, before they got married—remained confused about what constitutes a healthy sexual relationship and how to broach the topic with their wives. Some of them confessed that they wish their church pastors had done a better job preparing them for navigating this aspect of marriage. (Culp-Presser 2014: 1)

Thus, several researchers and activists have criticized the waste of resources when federal or private grants aimed at enforcing or persuading the youngsters not to engage in sex before marriage. As for Africa, African youngsters are known to be actively engaged in sex, especially in the urban

areas, just as is the case in the US. Furthermore, there have been studies in countries such as Uganda, where high school students are more afraid of getting pregnant than contracting an HIV infection because of the consequences: Pregnant students are not only being chastised and even expelled from the households but also forced to drop out of school if they show signs of pregnancy, the latter being a terrible outcome of a mistake given the thirst for education on the continent. Even though laws about forcing students to leave school are changing, they are not changing fast enough, and family traditions tend to continue even when it is to the detriment of the household and the future of a child.

The issue of circumcision is still being debated, even though the US has embraced the policy of forcing many African countries to hold mass circumcision operations among the elderly and among societies that never practiced it. On the final results of the policy, the jury is still out despite the few studies conducted during the mid-2000s suggesting that circumcisions would prevent by 60% the transmission of HIV from man to woman or from man to man. This researcher witnessed the gathering of dozens of children between the ages of four and 12, Christian, Muslim, and traditional in religion, being brought to a hospital in Uganda to be taught the merits and advantages of male circumcision. Lectures were followed by the actual circumcisions sponsored by USAID. Some of the children who had undergone the “Western baptized ritual” could hardly walk to the vehicle that took them back to their parents’ home. The not-for-profit Circumcision Research Center in the US under the direction of psychologist and educator Ronald Goldman disputes virtually all the claims made by the studies regarding the protective operations. Its Director is convinced that the studies done in Africa are flawed, cannot be valid, he says, because the facts tell us the contrary and that African children in one area of the world, such as Africa, should not be equated with those in other areas, such as the US, given the cultural differences and the socio-economic environment.

First, the Center notes that the difference between ethnomedical circumcision in Africa and the Western medical surgery in terms of complications is minor—35% to 18% respectively—meaning that both are unnecessary and, at times, life-threatening or disabling. He also makes the point that heterosexual transmission of HIV in Africa is often done through contaminated injections and surgical procedures, while the “effect of circumcision on the rate of heterosexual transmitted HIV could not actually be determined” in the studies (see Azevedo et al. 2014: 248–249). Important as well is the fact that the studies conducted did not take into account the age and time when those transmitting the infection were considered. Indeed, it

does make a difference when the studies involve younger or older persons, and most of the participants have been young people. Recent studies, he claims, have not shown differences between those practicing circumcision and those not practicing it.

The organizers of the studies and the mass circumcisions, dubbed voluntary, fail to mention that in the 13 countries of interest, eight had a higher rate of infection among circumcised men compared to non-circumcised individuals. The claim of the effectiveness of circumcision also creates a false idea in many men and women that an operation prevents HIV transmission and it therefore encourages unprotected and increased sexual activity, while condoms, less expensive and less invasive than surgery, have proven to be 99% effective. He mentions the fact that the various so-called “scientific” and “objective” studies tend not to consider the role of culture and that surgery in African Western-medical facilities increases the chances of HIV infection through the use of contaminated or non-sterilized tools. Goldman also convincingly argues that circumcision causes immense pain in infants, to the point that some faint and many develop post-traumatic stress as they reach the age of six years. They may also experience reduced sexual pleasure, since the prepuce has been removed, which is there to “protect the gland and enhance feeling in the sex act.” Finally, he notes that most of the proponents of massive male circumcision are themselves circumcised and are Jews or Americans. Goldman then writes, “For American society, circumcision is a solution in search of a problem, a social custom disguised as a medical issue,” adding, “Beware of culturally-based studies on circumcision posing as a science, and take your *whole baby* home” (researcher’s emphasis) (Goldman 1997).

Thus, against the objection of societies that do not circumcise their children or adults, Kenya performed more than 230 “voluntary” circumcisions between November 2008 and December 2010, seemingly reaching 60% of previously non-circumcised males in the Nyanza Province, while Tanzania claims to have circumcised 30,000 men and boys by 2011. However, less than one-third of the goals had been reached by 2014 due to people’s resistance. Some clinical studies had to be abandoned because of the small size of the participants, many of whom believed that they would get the HIV virus if they participated in the clinical trials, while others feared the stigma that came from participation in them. Rumor was that those who were a part of the studies would become infected. The massive scale up of circumcision campaigns in such countries as Tanzania and Kenya have encountered resistance from the population, and therefore, the millions of quotas set had not been reached by 2015.

The seeming flawed nature of mass circumcisions being carried out in Africa, especially East Africa, and South Africa, has also been convincingly presented by detailed studies published in 2014 by Michael Garenne and his colleagues. First of all, they say, the WHO/UNAIDS endorsement of the practice to prevent infection in 2007 has ethical and scientific flaws, namely, forcing people, including grown men, to be circumcised against their own will and their culture, whether they understood or note the benefits of the so-called medical male circumcision (MMC). African medical facilities are, moreover, incapable of reaching the goal of circumcising virtually all males not only due to their weak infrastructure and sustainability “under sufficiently safe, hygienic conditions” (Garenne et al. 2014: 199) but also due to many other factors, such as lack of facilities and national funding. The problems the researchers had to confront from the start included confounders on how to determine the efficacy of the measures on newly circumcised persons and “delay to decreasing incidence; and global level of efficacy.” When based on geographic and ecological studies, the conclusions were not unanimous but contradictory.

After examining study after study, Garenne and his colleagues asked this question: “Is medical male circumcision, then, a new avatar in the male circumcision saga—a new form of power abuse, exercised by an informal alliance of international organizations, funding agencies, and various lobbies of scientists and political activists? Proponents have supported this measure of ‘prophylaxis,’ justifying it with scientific evidence’ presented as absolute proof by the “gold standard”” (Garenne et al. 2013: 204). The authors also note how quiet the media has been in the face of contrary evidence and the critical importance of taking a stand against “genital integrity and human rights.” Interestingly, the studies have focused so far on Southern Africa. Finally, Garenne et al. got to the meat of this precipitously adopted MMC strategy by pointing out that:

First, it will not have any major population impact, nor will it curb the course of HIV epidemics, as many studies cited in this chapter demonstrate. Second, it diverts human and financial resources into a single strategy that could be better used in other more effective strategies. Most African countries, for instance, lack physicians and nurses who are so badly needed to provide HAART treatments and other kinds of care; these countries also lack finances for their health care systems. In such a context, using scarce resources for a strategy that is unlikely to have a major population-level impact is questionable. Third, because circumcision has deep social, cultural, and emotional implications, MMC cannot be imposed on men; individuals must

freely choose circumcision, so that population coverage will likely be below. Fourth, MMC on a large scale may have deleterious unintended consequences, ranging from infection to mild or moderate mutilations; these consequences are often disregarded in cost/benefits analyses. Fifth, MMC and HIV control strategy may encourage more dangerous practices. (Garenne et al. 2013: 197–198)

Perhaps, they speculate, circumcising boys before the age of the first sexual intercourse is a better practice, as it gives them the right to choose whether or not to be circumcised, but they also add that parents and others would fight the strategy as a violation of children’s human rights. On circumcision, Bouhdiba relies on a study done in Uganda among 6,800 respondents who seemed to have found that only 7% of the circumcised were HIV positive contrasted to 16% of the non-circumcised. Of course, these studies conducted in East Africa, are still in dispute.

THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA (GFATM)

One of the most humanitarian ideas the Western World and Japan have come up with is the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). In January 2000, whatever the true motives were, the G8 met in a conference in Okinawa and conceived and agreed to the formation of this organization to wipe out AIDS, tuberculosis and malaria off the face of the earth. It is the most noble idea not only due to the hugeness of its chest funds but also to the goal and the unique way the Fund was to be organized and administered to countries of the developing world in particular. The exciting generous idea was accepted without reticence in 2001 by the UN and its Secretary—General, Kofi Annan, who saw it as a winning proposition that would help Africa in particular where the three infectious diseases were most devastating. Subsequently, in 2002, he himself contributed \$100,000 out of his own pocket to the fund. GFATM is a multi-billion dollar international “financing mechanism” aiming at making the globe better for everyone in health including reduction of poverty. The organization describes itself as one that is designed to:

Attract, manage and disburse additional resources through a new public-private partnership that will make a sustainable and significant contribution to the reduction of infections, illnesses and deaths, thereby mitigating

the impact caused by HIV/AIDS, Tuberculosis and Malaria in countries in need and contributing to poverty reduction as a part of the Millennium Development Goals. (PDF-The Global Fund, *Framework Document 2000*)

As the idea spread among the wealthy as well as poor nations, the founders and funders agreed to provide funds that would benefit some 36 and other less fortunate countries of the world. The structure of the organization is in general terms simple. It is made up of a Secretariat whose offices are located in always strategic and safe Geneva, Switzerland, which carries out the day-to-day operations of GFATM. It is funded by public and private organizations, businesses, foundations, individuals such as the UN Secretary-General, interested communities, and any philanthropic organization. The decisions on grants to countries are made by an international Board of Directors composed of 20 voting and eight non-voting members, which is assisted by a Technical Review Panel that uses its expertise to advise about which countries and which proposals merit funding. The Board is assisted by three Board Committees that have “decision making, advisory, and oversight functions.”

The Board is led by a Chairman, currently Mr. Norbert Hauser, according to its Website. The Executive Director, Mark Dybul was appointed in 2012 following the resignation of its General Manager Mr. Gabriel Jaramillo. The Vice-Chairmanship position is occupied by Mr. Mphu Ramatlapend, the Minister of Health and Social Welfare of the Kingdom of Lesotho, who was elected in 2011. The Board’s decisions are made by consensus. However, if consensus cannot be obtained, a three-third majority vote carries the day. Regional representatives of the developing countries and governments on the Board are based on the WHO 6 Regions, with Africa having one extra representative: Eastern and Southern Africa (Union of the Comoros), West and Central Africa (Ghana), Western Pacific Region (China), South East Asia (Nepal), Eastern Europe and Central Asia (Moldovia), and Latin America and Caribbean (Mexico). Civil society and the private sector have five representatives: the so-called NGO Developed Country (International HIV/AIDS Alliance): NGO Developing Country (African Council of AIDS Service Organizations (AFRICASO), private foundations (the Bill and Melinda Gates Foundation), the private sector (Anglo-American plc), and representatives of communities living with HIV/AIDS, TB and Malaria (Foundation for Professional Treatment). Non-voting members are represented by the Board Chair, Board Vice-Chair, WHO, UNAIDS, Partners representative

(Stop TB Secretariat), Trustee of the Global Fund (World Bank), Director of the Global Fund, and a Swiss citizen (in compliance with Swiss law). In general, the structure has worked well, as members realize that they are representing countries and important constituents, who have entrusted them with an onus but noble responsibility on behalf of the less fortunate of our globe. What is more unique with the organization, which is virtually not the case in any global financial organization, grants and other types of assistance are provided to countries and public and private organizations or individuals with no strings attached. For the Fund, its most important operation is to ensure that the “the money given out in grants actually reaches the people who need it.”

In the first phase of the GFATM, 2002–2015, the organization has received some \$30.7 billion in pledges from 54 governments and others, of which 33% came from the US, the largest contributor to the Fund. In 2009, the US contributed \$1.05 billion for fiscal year 2010, which was the largest sum ever pledged by Washington since the beginning of the organization. Whenever funds are running low, the GFATM meets to assess the situation and urges members to contribute further to meet the needs of the people the organization has pledged to assist, which is known as “Replenishment.” The third Replenishment solicitation (2011–2013) brought in \$11.7 billion, the largest amount ever promised to the Fund. The fourth Replenishment, held in Washington on December 2, 2013, for the period 2014–2016, generated pledges of \$12.0 billion from 25 countries, and from the European Commission, corporations, faith-based organizations, and private foundations.

Private sector partnerships also exist, including RED initiated by singer Bono in the UK in January 2006 and in the US in October of that year, which raised \$180 million targeting specific members sponsored by the Fund. Fundraising events, as was the case with the Real Madrid Match held in 2002—which secured \$112,487—have also taken place to boost the GFATM’s treasury (The Global Fund 2012). The magnitude of the generosity on the part of several rich countries and some corporations is clearly shown below for the period 2011–2013. The US: \$4 billion; France: \$1.48 billion; Germany: \$822 million; Japan: \$800 million, and Chevron Corporation: \$25 million. Switzerland pledged a three-year donation of \$300 million (2011); Bill and Melinda Gates Foundation: \$750 million (2012); the same Foundation and the Tahir Foundation announced on October, 2013, that each would contribute \$130 million to fight AIDS, tuberculosis and malaria. Admirably, this Foundation has

provided the largest financial assistance of any private foundation to the Global Fund to support “efforts to diagnose, treat, and prevent AIDS, TB and malaria, leading causes of death and disability in Indonesia.”

The average yearly amount of funds dispensed by the Global Fund has been about \$1.0 billion in support of programs led and run by local experts in more than 140 countries on the globe (RED, Global Fund 2014). There have also been instances when debtor countries’ loan payments have been forgiven completely if they promised to invest the funds saved in the Global Fund health programs, as was the case with Indonesia, Pakistan, and Cote d’Ivoire that were indebted to Germany and Australia. For a long time, the Global Fund was confused with the WHO, as the latter, until January 1, 2009, provided the staff and administrative services. Furthermore, because both are based in Geneva, people could not differentiate them easily. Since then, however, the GFATM has been completely autonomous and separate from the WHO, even though both do work together towards the elimination of the diseases targeted by the Fund.

Like any organization, GFATM has had its own problems, which have hampered periodically the smooth running of its operations and the unhindered implementation of its goal. GFATM insists that the transitional money mechanism matches the one supported by UNAIDS, that is:

1. Treatment care and support
2. PMTCT
3. Condom promotion
4. Male circumcision
5. Behavioral change and communication and
6. Services for key populations.

The appearance that the Fund was favoring the distribution of condoms rather than urging abstinence-only-until-marriage and that abortions and prostitution might be funded compelled George W. Bush to start PEPFAR discussed earlier. However, GFATM accepts the premise that antiretroviral therapy should continue to be accessible to those who are already receiving treatment from other sources, if needed. Since 2002, antiretroviral treatment funds have been accessible to 3.3 million people and PMTCT (prevention of mother-to-child transmission) provided to 1.3 million HIV-positive pregnant women. Incidentally, no member of the G20 is eligible to receive any funds from the organization to which it contributes, except South Africa. Despite these minor problems, there is

no doubt that the Fund will continue to exist and improve the health of people globally for some time to come, as the major donors have shown no intention of stopping the contributions. It is therefore up to the receiving countries to ensure that the funds are used wisely and as promised because the better the health of their populations, the higher the economic and social returns.

THE BILL & MELINDA GATES FOUNDATION (BMGF)

Bill gates and wife Melinda are the two of the wealthiest people on earth. As known, their fortune has come from their Microsoft software business, which made Bill Gates the *guru* of the computer world. However, taught from early childhood by his parents to be generous and helpful to other human beings, especially the poor, the sick, and the helpless, Bill decided to distance himself from his own Microsoft business and dedicate his life to helping others. The idea of a foundation that would help him achieve his philanthropic goals matured during the late 1990s and, by 2002, he had established it, pouring millions and even billions of dollars into it as an endowment. At first, his endowment was known as the William H. Foundation but then it added the name of his wife, Melinda French, who had also been raised with the same philanthropic principles as her husband. During the period 1994–1999, the Foundation had a chest of \$94 million, but this was just the beginning of a major philanthropic organization which, by the year 2000, would eventually surpass the budget of the WHO.

In 2001, the Foundation opened another global seat in Seattle, Washington, with the goal of facilitating the strongest partnerships with other philanthropic organizations, civic societies, businesses, and foundations, and public and private volunteers, who had similar humanistic goals. While in 2004, Bill Gates launched a branch office on HIV/AIDS prevention in India, in 2005, he turned his attention to malaria and announced a donation of \$258 million to develop a malaria vaccine, new prevention drugs, and innovative mosquito eradication strategies. By 2006, Bill Gates had made up his mind about what he thought the world needed, that is, a clear focus on global health and global development. In 2007, investing first \$200 million, Bill Gates and wife formed a partnership with Rotary International, an organization whose major aim was to eradicate polio from the globe, while opening an office on global health in China. In Africa, where resources are geared towards the most devastating diseases,

such as malaria and HIV/AIDS, Gates created offices in three capitals: Addis Ababa, Ethiopia; Abuja, Nigeria; and Johannesburg, South Africa.

In addition, along with the Rockefeller Foundation, Bill Gates and wife launched the Alliance for a Green Revolution in Africa to assist Africans, especially women, who were unable to begin or sustain a small business or an economic scheme that would help improve their conditions, given that banks were virtually closed to them. Luckily for the Foundation and the beneficiaries, both from the developing and developed world, like the US, including billionaire Warren Buffet, also a most generous individual, befriended Bill Gates, and pledged \$10 million out of his personal fortune of \$62 billion. With a global base of operations in Seattle, Bill Gates removed himself from the daily operation of Microsoft, assumed the position of Co-Chair of the Foundation, and began learning directly from the sick, the poor, and the disadvantaged themselves, especially children and women, through his own travels throughout the world. On a trip to India, for example, where he administered in person polio vaccine to children, Gates left a gift of \$100 million through the Bill and Melinda Gates Foundation Children's Vaccine Program.

Concerned with lack of vaccines in parts of the world, Bill Gates hired known epidemiologist Dr. William H. Forge as his Senior Advisor and joined the Global Alliance for Vaccines and Immunizations (GAVI), besides other global health organizations, policy-makers, donors, and researchers, and was on board with the Millennium Development Goals (MDGs) accepted by most of the world in September 2000, which would reduce their poverty and the disease burden, especially HIV/AIDS, tuberculosis, and malaria, in places like Africa where diseases have had the highest death toll. In 2010, the Foundation opened an office in London with the purpose of assisting European and African partners and grantees that had similar objectives. In 2012, Bill Gates declared that his Foundation had pledged to fund the immunization of more than 250 million "of the world's poorest children "against life-threatening" infectious diseases, because, when he and his wife decided to venture into global health, their focus was on infectious diseases, especially those that affect children. As the Foundation's website notes:

Guided by the belief that every life has equal value, the Bill & Melinda Foundation aspires to help all people lead a healthy life, productive lives. We are dedicated to discovering and disseminating innovative approaches to addressing extreme poverty and poor health in developing countries and

improving the US education system. Because our financial resources, while significant, represent a small fraction of what's needed to address these challenges, we work in partnership with governments, the private sector, and other donors and organizations to achieve the greatest possible impact (www.gatesfoundation.org).

Among other notable grants, by 2015, the Foundation had distributed \$1.5 billion to the GAVI, \$456 million to PATH Malaria Vaccine Initiative, \$355 million to Rotary International against polio, \$24 million for Consultative Group to Assist the Poor, and \$1.7 billion to the United Negro College Fund. At that time, the mammoth Foundation employed some 1,211 people, had a Trust Endowment of \$40.0 billion, and a total of \$30.1 billion in grant payments. In 2013, grant payments totaled \$3.6 billion, up from \$3.4 billion in 2012 (Bill & Melinda Gates Foundation 2014). Buffet's contribution installments have grown over the years, as shown below (Table 5.1):

In terms of structure, the Foundation is led by a Chief Executive officer, Susan Desmond-Hellman, as of April 2014, who determines the priorities, monitors the outcomes, works closely with the Foundation's partners, and has four program areas: Global Development Division; Global Health Division; US Division; and the Division of Global Policy & Advocacy. Each Division has its own Director. The BMGF is overseen by three trustees, who hold most of the power: Bill Gates, Melinda Gates, and Warren Buffet, but it has also a Scientific Committee made up of a group of renowned experts from outside the Foundation, who make independent assessments of the strategies and serve as the evaluative team.

Table 5.1 Warren Buffet's gifts to BMGF (2006–2013)

<i>Year</i>	<i>Installment</i>	<i>Amount of gift (billion)</i>
2006	1st	\$1.6
2007	2nd	\$1.76
2008	3rd	\$1.8
2009	4th	\$1.25
2010	5th	\$1.6
2011	6th	\$1.5
2012	7th	\$1.5
2013	8th	\$2.0

JOINT UNITED NATIONS PROGRAM ON HIV/AIDS (UNAIDS)

Since 1986, immediately following the discovery of HIV, the UN entrusted the WHO with the mission to coordinate global activities to fight its spread through sharing information, monitoring the spread, surveillance, sharpening understanding of the causes, and gauging the overall impact on the health of people throughout the world. However, the task was monumental, and, by the 1990s, the agency was overwhelmed with the responsibilities, time, and energy the mission required. Thus, in 1993, members of the WHO's World Health Assembly (WHA) recommended that the task be entrusted to a new agency of the UN, which would work with other UN agencies to take over its responsibility. Subsequently, the named agencies and the Economic and Social Council of UN agreed with the recommendation. In January 1996, the six cosponsors, UNICEF, UNDP, UNFPA, WHO, and the World Bank, were joined by UNDCP in April 1999 to create UNAIDS. This alliance was strengthened by collaboration and partnerships with its other agencies, national governments, the media, corporations, faith-based and community-based organizations, corporations, "regional and country networks of people living with HIV/AIDS, and NGOs. UNAIDS Secretariat is headquartered in Geneva, Switzerland. Its Charter contains the following clearly delineated aims:

1. Preventing the spread of HIV
2. Providing care and support for those infected and affected by the disease
3. Reducing the vulnerability of individuals and communities to HIV/AIDS and
4. Easing the socioeconomic and human impact of the epidemic

UNAIDS understands the need to continue to fight against HIV/AIDS as it continued to spread during the 1990s and 2000s, a reality that necessitates the expansion of two strategies: Improving the quality and "scope" of ongoing prevention, care, support and impact-alleviation efforts; and combining such efforts "with actions that tackle the societal factors that increase people's vulnerability" (United Nations Special Session on HIV/AIDS 2001: 2), such as poverty, impact of migration, inferior status of women, and the many existing social inequalities. As the WHO has stressed over the decades, "injustice over the state of health

goes beyond simple inequalities to determinants of health to access to resources necessary to improve health or to maintain it or to the results of good health” (WHO 2009). It appears that leaders in Africa are finally realizing these interwoven realities and that it is the confluence of many factors that brings good health, as Yaya and Mackossot put it in their work (2010: 60): “C’est la conjonction des progrès médicaux, des ressources économiques mises au service du développement humain, de l’efficacité des politiques de santé, de l’évolution du statut de la femme, des habitudes de vie, qui expliquent les améliorations de l’état de santé relevées au secours du dernier siècle.” In other words, leaders must understand that it was the combination of medical advances, economic resources available to people, effective policies, the *evolution of women’s status*, and life styles that revolutionized health over the last century.

On the national level, more specifically in the developing world, working in tandem with its six cosponsors, UNAIDS is assisted by Theme Groups on HIV/AIDS led, in most countries, by a Country Program Advisor, sharing information, planning and monitoring coordinated action among themselves and their partners, including joint financing HIV/AIDS activities, to assist governments they represent on strategic plans. Currently, more than 130 Theme Groups exist in more than 155 countries. Despite its wide global presence, UNAIDS employs only some 160 professional and support staff, and functions mostly through assistance from UN member countries, the reason why it has a modest budget of \$70 million a year, of which one-tenth is earmarked for the International Partnership Against AIDS in Africa (IPPA). In 2014, the UNAIDS budget was smaller than the one the agency enjoyed in the 1996–1997 biennium, which was \$120 million, of which 51% were used for country support, 29% for policy, strategy, and research, 11.5% for program administration, and 8.5% for program direction, external relations, and advocacy (UNAIDS 2014: 3). It must be stressed that UNAIDS is not a funding agency, though it does support certain activities and most of the funds come from the US, the Netherlands, Norway, Japan, the UK, and Sweden. For better coordination, UNAIDS has set up in-country teams of staff that are headquartered in West and Central Africa (Abidjan), Southern and East Africa (Pretoria), South-East Asia (Bangkok), Europe, and the Americas. Their primary role is providing and fostering “technical collaboration.”

In terms of the daily operation, UNAIDS decisions are made by a Program Coordinating Board made up of 22 representatives from across the globe and of the seven cosponsors, who meet twice or three times

a year. For fairer representation, there are also five more (non-voting) members reserved for non-governmental organizations, including those representing the HIV community. Since 2014, the agency was led by African Executive Director Michel Sidibe. The UNAIDS headquarters in Geneva has five departments: The Office of the Executive Director, the Department of Country Support, the Department of Policy, Strategy, and Research, the Department of External Relations, and the Department of Program Administration, which, intent on seeing that its four functions—policy and planning for international best practice, technical collaboration, advocacy, and coordination—are executed according to the goals and policies of the organization. As UNAIDS notes, “this makes the only UN institution to have non-governmental organization participation on its governing board” (United Nations Special Session 2001: 2). It is important to stress, however, that 40% of UNAIDS staff is female. Overall, at the global level, UNAIDS is the AIDS program of its six cosponsoring organizations, and engages in the following activities:

1. Program development and coordination
2. Advocacy and working with decision-makers
3. Global program monitoring
4. Global HIV/AIDS surveillance
5. Information networking
6. Resource mobilization and
7. Networking with non-governmental organizations, community based organizations and people living with HIV.

To fulfill this role, UNAIDS has its own personnel in the regional offices of the WHO (Manila, Washington, Copenhagen, and Brazzaville), and UNICEF and UNDP in New York, and cosponsors staff from UNICEF, UNDP, and UNFPA have been posted to its headquarters in Geneva (UNAIDS, *Facts about UNAIDS 2014*: 9).

How effective has UNAIDS been since 1986? The 2011 Report of UNAIDS on AIDS is encouraging but the battle has not been won yet. TB is still the leading cause of death among people with HIV/AIDS in the world, but, unfortunately for Africa, 80% of the people living with HIV/AIDS and TB are in Sub-Saharan Africa. The report adds that, in some parts of the African Region, 82% of them live with a TB condition. Annual deaths from AIDS-related causes decreased worldwide from a peak of 2.3 million in 2005 to an estimated 1.7 million in 2011, and the accelerated access to treatment has had its greatest impact in Sub-Saharan Africa,

where an estimated 550,000 (or 31%) fewer people died from AIDS-related causes in 2011 than in 2005 when the number of deaths peaked (UNAIDS 2012: 24). Because of increased access to HIV treatment, the number of people dying annually from AIDS-related causes fell from its peak of 1.8 million in 2005 to 1.2 million in 2011, with most of the deaths occurring in Southern Africa. However, in North Africa (and the Middle East in general) the number of people dying of AIDS rose from 14,000 in 2001 to 25,000 in 2011 (UNAIDS 2012: 24).

In 2011, the UN unanimously agreed on a Political Declaration on HIV and AIDS whose goal was to be achieved by the international community in 2015, including having 15 million people with HIV under treatment, and preventing new infections among children by that date, while at the same time halving sexual HIV transmission among drug users. The successes are visible: In 2011, 1.4 million people were receiving more antiretroviral treatment in low- and middle-income countries than the previous year (UNAIDS 2012: 19). The UNAIDS Report further notes that “The most dramatic progress has been in Sub-Saharan Africa, where treatment coverage increased by 19% between 2010 and 2011. In addition, at least 745,000 people were receiving antiretroviral therapy in high-income countries.” Encouraging is also the fact that low- and middle-income countries’ resources put at their disposal a record \$8.6 billion for AIDS spending in 2011, which included such countries as Ghana, Nigeria, and South Africa. China has pledged to contribute more to offset any changes in the formula for resource allocation in the Global Fund for HIV/AIDS. This change is balanced by the hope that, by 2015, the international community will reach the UNAIDS \$22–\$24 billion request to combat AIDS.

While these activities take place all over the globe, UNAIDS is also urging scientists and corporations to assist in the discovery of a vaccine that might help the world end the curse of HIV/AIDS in this generation, making sure as well that the medications are varied so that drug resistance will not retrogress the momentum and the gains already made. Mr. Yayi Boni writes encouragingly in *UNAIDS Report 2012* that he was

working closely with all African leaders to develop a roadmap for shared responsibility with concrete milestones for funding, for access to medicines that must imperatively be produced locally in Africa, for enhanced regulatory harmonization and for improved governance. The roadmap will outline the roles and responsibilities of governments, regional economic communities, African institutions, people living with and affected by HIV and our development partners. (Boni, *UNAIDS Report 2012*)

If all these strategies and plans have to be enacted in Africa now, one wonders why they have been absent over the past almost 20 years and why have the heads of state and governments “not gotten their act together.” This brings us back to the issue of leadership commitment and vision that seems to be lacking or rare on the continent of Africa, while resources are being officially appropriated, at least on paper. Africa is registering little progress compared to other continents of the world that are located and found in similar geographic, economic, and political conditions. However, UNAIDS Executive Director, Michel Sidibe, is upbeat and responds to critics by noting that:

Increments of achievement that once stretched over many years are now being reached in far less time. In just 24 months, 60 percent more people have accessed lifesaving HIV treatment, with a corresponding drop in mortality. New infection rates have fallen by 50 percent or more in 25 countries—13 of them in Sub-Saharan Africa. Half of all reductions in HIV infections in the past two years have been among children; this has emboldened our conviction that achieving an AIDS-free generation is not only possible, but imminent. (UNAIDS, *Global Report 2012*: 5)

The world is watching and energized by the results, hoping that the trajectory of improvement will continue to move forward and not be slowed down by the politics of divisiveness, a culture of corruption and graft, poverty, and inequalities seen in many of our developing countries.

GLOBAL ALLIANCE FOR VACCINES AND IMMUNIZATION (GAVI)

GAVI may be identified as “a global partnership bringing together public and private sectors with the shared goal of creating equal access to vaccines for children, wherever they live” (GAVI Vaccine Alliance and Immunization 2014), improving access to “sustainable immunization services, expanding the use of all existing safe and cost-effective vaccines, and “accelerating research and development efforts on vaccines and related products specifically needed by developing countries, especially those against HIV/AIDS, malaria, and tuberculosis” (WHO, Global Alliance 2013: 3). GAVI does not simply distribute its funds to needy countries but it also requires that they contribute some of their national budget to the effort to acquire vaccines, and it expects them to increase the contribution

should their annual GDP rise, while it provides and shares its expertise, funding, and experience. Even though pledges often change or pledging countries and partners may not contribute in time or the amount promised, GAVI has an international pledge of \$8 billion for immunization for the period 2000–2017 to benefit mostly the poorest countries, of which most are found in Sub-Saharan Africa.

Between 2000 and 2005, GAVI received \$1 billion, which was a major accomplishment, given the many philanthropic organizations and countries asking for assistance to improve the health of their citizens and other human needs. The organization is optimistic that the good will and generosity of donors will continue in the future. Its major partners include the WHO, which has supported the regulation of vaccines and facilitated its use in poor countries, expanding the number of vaccinations and immunizations, while also insisting on the collection of necessary and accurate health data. UNICEF helps in the production of vaccines and ensures that developing countries are able to maintain their cold chain and enhances access. The World Bank, which initiated the International Finance Facility for Immunization, the Rockefeller Foundation, the International Federation of Pharmaceutical Manufacturers Associations, and the Bill & Melinda Gates Foundation (which gave \$750 million in the initial stage), as well as several research and public health institutions throughout the world are involved in the goals espoused by GAVI (WHO, GAVI 2014).

GAVI's achievements since its inception in January 2000, when it launched its Alliance at Davos, Switzerland, include the immunization of 400 million children worldwide, which translates into 6 million lives saved and 200 million other people immunized through vaccine campaigns. GAVI has made available some 11 life supporting vaccines in 73 of the poorest countries in the world, whose majority is found in Africa, and has waged war against diarrhea and pneumonia, considered to be the two biggest killers of children in the world. The organization has also been in the forefront toward the dramatic reduction of the price of vaccines in the developing countries, and has been instrumental in providing new vaccines quicker to the countries that need them, resulting in increased immunization rates all over the globe. GAVI also wishes the world to know that, by saving so many lives, it has contributed economically to the prevention of infectious diseases through billions of dollars over the past 14 years. Its mission continues to resonate throughout the world, where nearly still 22 million children, concentrated in the poor countries, go unvaccinated against at least six of the vaccine-preventable diseases, namely, diphtheria,

tetanus, whooping cough, Hepatitis B and *Haemophilus influenzae*, and against pneumococcal disease and rotavirus, which are the most responsible for pneumonia and diarrhea, as well as the human papilloma virus which causes cervical cancer.

Even though GAVI has been careful in not projecting the number of vaccines and children vaccinated for the near future (Global Alliance, Integrating Implementation 2014: 1), it plans to support 245 million children in countries committed to its goal, and hopes that, between 2016 and 2020, the number of people immunized may reach 300 million, representing between 5 and 6 million more lives saved. The sad part of the equation is that 3 million people die for vaccine-preventable diseases worldwide each year, half of whom are children under-five (WHO, GAVI 2014: 1). This was the major reason why the Alliance decided to establish itself, as it also realized that it is cheaper financially as well (only \$17 per child against the six child killer diseases, with a little more to cover Hepatitis B, yellow fever, and *Haemophilus influenzae* type B, recommended by the WHO in 2002) than to let children die or try to cure them. The savings can then be used wisely toward the eradication of other diseases and the reduction of poverty. Incidentally, it is estimated that the eradication of smallpox in 1977–1979, saved the world some \$275 million a year. GAVI wished to reverse the growing trend of lower immunization coverage in many countries, which fell to 74% in 1999 from 80% in 1990 and galvanize international resolve to vaccinate children nationally and regionally.

The lowest rate of immunization was concentrated in Africa, where 40% of the children are not immunized against measles, a major infant disease that every minute claims the life of a child (WHO has recommended immunization against Hepatitis B since 1993, which kills one million people a year). Even though recommendations have also been made on yellow fever, some 30,000 deaths yearly are attributed to it. Unfortunately, disparities exist between county and country, region and region, and between urban and rural areas. GAVI estimates that “a child in an industrialized country receives eleven vaccines on average, while a child from a developing country is lucky to receive half that number” (WHO, Global Alliance 2014). By the way, GAVI is not to be confused with the Global Fund for Children’s Vaccines, which is an independent financial institution created by GAVI, whose function is to raise funds for immunization in developing countries, as recommended by its Board. Unlike many organizations that spend a large amount of funds on administrative costs to the detriment of the health programs, GAVI spends 98% of its funds on vaccinations and

immunization related programs. Holland, Norway, the UK, and the US are the largest contributors to the foundation.

Just as is the case with other humanitarian organizations, GAVI has its critics. Writing in the *American Journal of the Public Health Association*, William Muraskin claims that he has found major problems with this global organization, which ought to inspire others to avoid them and introduce a system that is perfect and effective in its organizational structure, its methods of delivering service, and reliance on vaccination and immunization as the only way of saving children's lives. He points out that GAVI is a "top-down" decision-making knows-all organization that believes that its method of providing care to save lives is the best. By doing this, it undermines local support by not operating at the grass roots." Says Muraskin, "In the absence of genuine grassroots espousal, pressure is placed on global organizers to seduce participants and manipulate enthusiasm rather than actually develop it" (Muraskin 2004: 1). This critic adds the point that the organization should see its programs and agents as facilitators rather than as "movers and shakers," a function that should be left to the countries involved.

He also accuses the organization of "donor robbery," implying that because of the technical skills it needs in the service country, GAVI recruits the few local experts that are available, thus depriving the recipient nations of the most precious needed resources that might serve other critical needs. Finally, Muraskin notes that

Most in-country workers and most developing countries' governments—even their ministries of health—would not place a series of new children's vaccines at the top of their priorities without a major financial enticement. For every one familiar with conditions in the field, child immunization is only one of backbreaking press of challenges, and the introduction of new and improved children's vaccines has by no means been the most urgent... The GAVI champions immunization, and yet [continues Muraskin], its core constituents—field workers and developing countries' governments—have been unenthusiastic supporters of that goal...Although bilateral donors have been among the nations most committed to the struggle for equity for all children in the developing world, they have had doubts as to whether vaccination is the best means of achieving that goal. The same reservation alienated bilateral donors from a previous vaccine alliance, the Children's Vaccine Initiative, and made them its chief critic. (Muraskin 2004: 3)

The criticism probably has some validity as, over the years, many other organizations have behaved as if they knew better the needs of the

communities they decide to help than the nationals themselves, and have acted arrogantly and dictatorial on priorities and on how things should be run. The IMF and the World Bank are good examples.

UNITED NATIONS EDUCATIONAL, SCIENTIFIC, AND CULTURAL ORGANIZATION (UNESCO)

UNESCO is a UN agency created in 1946 to advance peace and security “by promoting collaboration among member states in the fields of education, science, and culture” and works very closely with it as one of its important branches. Unlike most UN agencies, UNESCO is not headquartered in Geneva but in Paris, and it consists of 195 member states—virtually all independent states in the world—and commands a budget of \$326 million. The budget for the two years, 2010 and 2011, whose figures are available, was \$653 million (about \$326.6 million annually). The US withdrew its membership from the agency in 2003–2005 due to the admission of the Palestinian Liberation Organization as a member of the agency, approved by a vote of 107 in favor, 4 against, and 14 abstentions in 2011. By November 23, 2011, through the end of that year, UNESCO’s budget fell by \$72 million, forcing it to slash its subsequent annual budget by 28.9% (or \$188 million) to meet its obligations. The US, whose contribution had amounted to 22% of the agency’s budget, withheld its contributions, as illustrated in the table below (Table 5.2).

UNESCO’s activities include “literacy, media and Internet freedom, ocean management, and environmental and cultural preservation.” It often highlights the importance of historical landmarks through preservation of museums and historical sites around the globe. The agency has its own charter and administrative structure and branches throughout the world, employing some 2000 individuals from 170 countries, and holds 65 offices and institutes globally. Its organizational structure consists of the General Conference (GC), representing all member states, which

Table 5.2 US financial contributions to UNESCO in millions US dollars assessed in 2003–2012 and Voluntary Contributions

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
<i>Assessed Fees</i>	0.00	84.14	76.75	70.92	73.48	77.62	75.94	80.92	78.83	0.00
<i>Voluntary Contributions</i>	0.00	1.75	1.89	0.84	0.99	0.99	1.00	1.00	1.85	0.00

Source: Congressional Research Service 2013. Washington, D.C.

serves as the governing or decision making body. The GC meets twice a year. Decisions, like those at UNAIDS, are arrived at through consensus. UNESCO has an Executive Board of 58 member state representatives and meets twice a year just as the Executive Board charged with implementing the programs recommended by the GC. The Director-General heads UNESCO's Secretariat.

The reader should not confuse UNESCO with the United Nations International Children's Emergency Fund (UNICEF), now abbreviated as the United Nations Children's Fund, created in 1946 to protect all children following the ravages of World War II. UNICEF is headquartered in New York City. With a budget of billions, UNICEF has had good and bad days. In 2008, one of its best years, it marshaled some \$3.3 billion. To accomplish its goals, UNICEF employs a staff of 7000 people throughout most of the 189 member states, who, as the private organizations, contribute as much as they are able to. UNICEF is led by an Executive Director. While over 85% of the funds are directly used to sponsor children's programs, the remaining funds go toward the compensation of the staff. Beyond the member states and philanthropic organizations, UNICEF gets its funding through the work of Ambassadors, usually movie stars who advocate for children, children's trick-or-treat routines in October of every year, fund raising activities by famous individuals, such as famous musicians and sports players, and girl stars in movie stories. Airline passengers are accustomed to hearing flight attendants pleading for contributions to UNICEF, no matter how small their contribution might be.

UNICEF focuses primarily on the welfare of children in the developing world, on such issues as health, education, gender equality, right to adoption, freedom from poverty, safety, and protection as agreed by the international community through the 1989 Convention on the Rights of Children. In relation to the health of children, the immediate concern of this work, UNICEF's Charter makes it clear that one of its objectives is to "affirm the right of children to 'the enjoyment of the highest attainable standard of health' and to facilities for the treatment of illness and rehabilitation of health," while providing antennal care to pregnant women and neonatal disease prevention during the first four months of life (Login, UNICEF 2014). Several of the MGDs address the needs of children, and analysts expected that most countries would have achieved them by the end of 2015. Health care goals include also ensuring children have access to clean water, adequate sanitation and hygiene, advocacy, and vaccine or immunization campaigns against the six child killer diseases, and reduced

mortality. Just as is the case with many major organizations or agencies, the most recent criticism of UNICEF has centered on its policy against the international adoption of children. Despite immense pressure, the leaders of UNICEF have not changed their stance.

The dispute between UNESCO and the US centers mostly on two issues: accusations that UNESCO targets Israel in its operations and programs; and alleged “shifting the definition of human rights from the Western concept of individual rights to that of collective people’s rights” (Blanchfield and Browne 2013: 10). However, in 2003, George W. Bush announced in a speech to the UN General Assembly that UNESCO had made several meaningful reforms that enticed the US to restore its membership in the agency. Thus, the major criticism of the operations of UNESCO has come from the US, which, invariably, tries to have its own way to protect its friends through the withholding or threatening to withhold contributions, as it has done with the UN itself. However, in the case of UNESCO, the member states held their position and the US eventually had to capitulate. In 2010, a UNESCO independent external evaluation commissioned by the Executive Board and GC vaguely concluded that the agency should take five steps to adapt to the new circumstances, namely:

1. Focus: Improving the organization’s focus to address challenges consistent with its mandate
2. Field: Positioning UNESCO closer to the field to be closer to country needs, resources and partners
3. United Nations: Strengthening participation in the UN system
4. Governance: Strengthening governance mechanisms
5. Partnership: Developing a partnership strategy that improves its relationship with civil society and the private sector (see Blanchfield and Browne 2013: 8).

The call for reforms led UNESCO members to vaguely focus between 2011 and 2016 on the following three strategies: Improving talent management by “attracting and retaining talented” personnel in the agency; enhancing staff capacity; and “creating an enabling work environment, by providing the necessary internal conditions to support staff commitment and motivation.

THE WORLD BANK OR THE INTERNATIONAL BANK
FOR RECONSTRUCTION AND DEVELOPMENT (IBRD)
AND THE INTERNATIONAL MONETARY FUND (IMF)

Both the World Bank and the IMF have been agencies of the UN, and were created by the leaders of 44 countries in July 1944. The Great Powers under US leadership at the Bretton Woods Conference, New Hampshire, ensured that two most powerful financial institutions in the world be owned and operated by member states. However, the two institutions seem to be so similar in purpose, as they are seen as the “intergovernmental [twin] pillars supporting the structure of the world’s economic and financial order,” confusing many people, including the experts, about their mission. David D. Driscoll notes that “even John Maynard Keynes, a founding father of the two institutions and considered by many the most brilliant economist of the twentieth century, admitted at the inaugural meeting of the International Monetary Fund that he was confused by the names: He thought the Fund should be called a bank, and the Bank should be called a fund. Confused has reigned ever since” (Driscoll 1996: 1).

A smaller institution headquartered in Washington, D.C., with three offices in Paris, Geneva, and New York City, the IMF employs some 2300 staff members, a size three times smaller than the World Bank, made up mostly of economists and financial experts, and has no affiliates or subsidiaries like the World Bank. One of the major requirements of IMF’s loans recipients is the pledge for their “national currencies to be exchanged without restrictions for the currencies of other member countries” (Driscoll 1996: 7). By May 1996, 115 members had embraced “the monetary policy of full convertibility of their national currencies.” This number has grown ever since. On the contrary, the World Bank is a huge financial institution, with headquarters in Washington, D.C. The twin institutions focus primarily on protecting and assisting the economies of the member states with the ultimate goal of preventing global economic depression and recession as happened in October 1929, the devastating economic impact of the two World Wars, and the recession of the 1980s. The rise in oil prices and interest rates as well as the fall of prices, forced many developing countries to approach the World Bank and the IMF to borrow money, much of which was to “service a growing debt burden” (Jim Lobe 2003: 1).

Heightening the confusion, the two institutions share their libraries in Washington, D.C., and are located in the same area and building, and quite often attend the same conferences and meetings, share data, and cooperate on missions and projects supervision in the member states. Actually, when the IMF was created in 1944, its mission was to foster international economic cooperation and allow member states to borrow short-term loans “so that they could trade with other countries” to achieve a balance of payments. However, during the 1980s, the institution assumed a different mission, that of “bailing out countries” in financial crisis by providing an emergency loan package attached to its structural adjustments conditions (Global Exchange 2011). Yet, despite all similarities, the two are distinct: The World Bank, which is present in 100 countries, with an approximately staff of 10,600, is essentially an investment bank, a development institution that borrows money from investors and lends it to borrowers, while the IMF, similar to a credit union that allows members to borrow funds when needed for a particular purpose, is not a bank but “a cooperative institution” whose mission is to “maintain an orderly system of payments and receipts between nations.” Both institutions assist only member states and not individuals as foundations usually do. Yet, each has its own structure, gets funding from different sources, “assists different categories of members, and strives to achieve distinct goals through methods peculiar to itself” (Driscoll 1996: 2). The World Bank may sell bonds and notes it can lend to member governments, their agencies, and central banks. The proceeds are loaned to developing countries at some of the lowest rates, favoring the poorest as a proportion of their degree of poverty.

In sum, the World Bank is an institution that encourages and provides technical assistance to poor countries and loans for projects and “policies that will realize the countries’ [long-term] economic potential.” The World Bank is organized into five different agencies: The Integrated Bank for Reconstruction and Development, which provides assistance to middle income countries; the International Development Association, which makes free-interest loans available to the poorest countries that have a per capita income less than \$885 and provides technical assistance and policy advice; the Multilateral Investment Guarantee Agency, which protects foreign investors from losses by non-commercial risks in developing countries; and the International Center for Settlement of Investment Disputes done through mediation or arbitration between foreign investors and host countries (The World Bank Group 2013). A feature that is tempting about

the World Bank is that borrowers might have as many as 10 years before starting to pay back the loan, with little or no interest at all.

The IMF's policy has been, until recently, to provide loans on a short-term basis as an incentive for the borrowers to pay back quickly. Ideally, the Bank works very closely with developing member countries' governments and agencies, along with many multilateral organizations, as about one-half of the Bank projects are also financed by governments, multilateral financial institutions, and "export-credit agencies that directly finance the procurement of goods and services, and from private sources, such as commercial banks" (Driscoll 1996: 6). As Asad Ismi sarcastically writes, unlike the United Nations where each country has one vote, at the World Bank and the IMF, the guiding principle is one-dollar one-vote," with the US having the authority to veto any decision related to the two organizations' structure and mission, the reason being that the latter's shares in the IMF is 17% and 16.41% in the World Bank. The by-laws of the institutions require an 85% majority vote to change any of its articles. Japan is next in the number of shares owned, 6.27% in the IMF and 7.8% in the World Bank. Interestingly, highlighting the power of the US, it alone can appoint the President of the World Bank, while holding a permanent seat among its executive directors. The World Bank's Board of Directors based in Washington, D.C., has 25 executive directors, 19 from the WHO, and holds, on the average, two meetings a week to monitor the operations, assesses loans and guarantees, policies the budget and strategies, and makes decisions on borrowing and the institutions' finances (World Bank Group 2013: 3). Its five largest shareholders are the US, the UK, France, Germany, and Japan, who appoint an executive director, with 19 executive directors representing the other member states.

Ismi points to four factors that the structural adjustment programs have contributed to or, in some instances, have caused inequalities and absolute poverty: the IMF and World Bank's financial sector reforms that have imperiled and caused decline in national manufacture, leading to massive layoffs; reforms in agriculture, trade and mining through privatization, wiping out small farmers and poverty-stricken rural communities; lower wages, more layoffs, fewer benefits, low job security and "erosion of workers' rights and bargaining power from "flexibilization measures and privatization"; and reduction of spending in health and education through user fees and higher utilities costs due to privatization, leading to people's inability to afford health and other services. Numerous studies have confirmed these conclusions, which the very IMF and the World Bank have

had to accept as accurate. The *New York Times* has called the two institutions “the overlords of Africa.”

The situation in three African countries, in particular, has clearly demonstrated the harmful effect of the structural adjustment programs (SAPs). By 1980, 36 of the 44 countries receiving the loans with SAPs are said to have experienced the following outcomes: the fall of the African per capita GDP by 15% between 1980 and 2000; the rise of the number of poor people to 350 million or half of Sub-Saharan Africa, which at the time, lived under the poverty line, representing a 75% increase over the 200 million people for 1994; a debt servicing increase of 500% to \$333 billion since 1980, forcing Africans to repay some \$15 billion every day to remain within the terms of the agreements made with the two financial corporations; reducing spending on health by 50% in 42 of the poorest African countries; and the closing forever of hundreds of health facilities such as hospitals and clinics. In countries, such as Ghana, many people were unable to afford clean water due to forced and hurried privatization (Ismi 2004: 12–13).

Despite its \$484 million loan, Zimbabwe’s economy virtually collapsed, and health and other social indicators declined rapidly. For example, with a 4% annual GDP growth during the 1980s, prior to the IMF loan, infant mortality had fallen from 100 per 1000 live births to 50 per 1000 during the period 1980–1988; life expectancy at birth had also risen from 56 to 64 years, and primary school numbers had doubled. However, after acceptance of the loan, which was designed to “jump-start the economy,” recession ensued, and the GDP fell by almost 8% in 1992, while the workforce layoffs reached 25%, unemployment hovering between 35% and 50% in 1997. By 1998, 68% of the population lived under \$2.00 a day, while manufacture had declined by more than 20% in the period 1991–2000, mainly due to increased interest rates and the forced devaluation of the national currency. Health care expenditure fell to 4.3% in 1990, from the previous 6.4%. The same reductions happened to education (Ismi 2004).

Similar economic deterioration occurred in Ghana after implementing the SAPs in 1983, which had forced the country to privatize more than 130 state economic initiatives, including the mining industry. Unfortunately, the latter was Ghana’s major source of revenue, followed by reductions in health and education spending; exports and imports rates were reduced, ballooning the 1980 \$1.4 billion external debt to \$7.0 billion in 1999. With the relaxation of environmental concerns at the hand of private Western companies, air and water pollution

increased, malaria spread, along with other diseases such as TB and silicosis, and stories of corruption due to water privatization appeared in the papers. Ismi dramatizes the situation by noting that: “The World Bank’s structural adjustment of Ghana is a textbook example of how to ruin a country. The ruthless denial of mineral wealth, food, medical care, education, and even water, has made the population destitute spectators of the plunder of Ghana by foreigners” (Ismi 2004). Cote d’Ivoire is another classic example of failure under the SAPs that serious studies have singled out. Its external debt rose by \$3.7 billion in 1989–1991, increasing from 132% to 210.8% of GDP. Under the IMF and World Bank terms in 1989, Cote d’Ivoire had to cut government spending by 30%, capital costs by 15%, increase taxes, privatize state enterprises, and, like in Ghana, “deregulate the labor market, reduce the civil service, eliminate price controls, devalue the currency, and enact trade and financial reforms” (Naiman and Watkins, 1999: 12–13). The consequences were devastating: poverty doubled between 1988 and 1995, from 17.8% to 36.8%; public health and education allocations were slashed by more than 35% for both by 1995; children’s stunted growth went from 20% in 1988 to 35% in 1995, much of it due to the introduction of user fees, according to some sources.

Critics of the IMF, such as Brook Baker, write that this institution,

...is deeply implicated in the history of AIDS pandemic, in the weakness of health systems, and in the ideology of restrained resources that underlies most of the current attacks on AIDS funding. The IMF imposed *structural violence* on developing countries in the 1980s and 1990s through neoliberal and macroeconomic reforms that intensified individual and communal vulnerability to infection and dismantled already weak health systems. Those same policies, now repackaged but fundamentally the same, continue to prioritize low inflation, constricted government spending, robust currency reserves, and prompt repayment of debt at the expense of needed investment in health and more expansionary, pro-growth and job-creation economic policies. (Baker 2010: 348)

A study done by the IMF’s Independent Evaluation Office in 29 Sub-Saharan African countries for the period 1999–2005 reported that “37% of all annual aid increases was diverted to building currency reserves and that 37% was devoted to domestic debt repayment,” leaving only 27% of the annual assistance to health education, infrastructure, and other needs, such as poverty alleviation (Baker 2010: 351). Repaying the chronic debt, dependence on Western consultants and project directors embedded in

bilateral or multilateral agreements that do not focus on technological and knowledge transfer, importation of luxury goods and cheapest goods from abroad, such as soap, cooking oil, coffee, clothes, harmful cigarettes, and health drugs, when they can be produced locally, constitute anomalies that have retarded Africa. In most cases, assistance and loans have gone to corrupt and undemocratic regimes that do nothing but impoverish their people.

As the Global Aids Alliance has put it succinctly, the structural adjustment programs have had two phases: the first aimed at stabilizing macroeconomics by currency control deregulation and devaluation; rebuilding foreign currency reserves to enable countries to repay the debt and pay for imports; reduction of inflation by 5% to stabilize prices, introduction of higher interest rates, while reducing as well real wages and consumption; compulsory budgetary reductions, normally up to 3%, on deficit spending, wage reductions, budget ceilings, and wage caps, what has been called fiscal austerity (Naiman and Watkins 1999). The second phase of IFM reform package involved policies on liberalization of imports and exports, domestic tax reforms under the gun of the institution, to favor corporations, steady privatization and the abandonment of parastatals, weakening labor laws, reducing social spending, implementing user fees, and charging for condoms, all in the name of “cost-recovery,” which favored the rich and contributed to further impoverishment of the poor (see Rowden 2004).

What might be the answers and suggestions for the World Bank and the IMF on how to revamp its approach to eradicate poverty and contain disease in Africa? As consistently noted in this volume, the issue of Africa’s leadership is crucial. As long as we have presidents and ministers of the various departments who seem to show little commitment to the plight of their citizens, and are unable to stand up when needed against the imposition of terms of development by the big financial corporations, pharmaceuticals, and expatriates who think they know better what Africa needs than the Africans themselves, nothing will change. The priorities in Africa are clear: ensuring that people have adequate and quality nutrition; provision of education for all citizens; making health accessible to all, as agreed at Alma-Ata in 1978; building and rebuilding the infrastructure; revolutionizing agriculture; and strengthening the industrial effort. Ismi, of the Canadian Centre for Policy Alternatives, echoes these ideas when he suggests six strategies for the future of Africa: participation of the poor, the vulnerable, farmers, rural populations, workers, women, and the underserved, and not just the elite, in critical decisions and policies

adopted; some “redistribution” of wealth (a concept and word rejected by the neo-liberals and those who believe only in market forces and trickle down theories); promotion of agriculture to increase production and feed and protect farmers from cheap imports and provide credit and subsidies to poor farmers who are unable to compete with the major corporations resulting from privatization policies; concerted work towards a strong industrial base, diversified manufacturing to generate more jobs for Africans; regional integration to accelerate reliance on local and regional products that will benefit directly or indirectly international and domestic output in industry and agriculture; and “South-South” cooperation rather than the current domination of the West and its multinational corporations over the continent of Africa.

Interesting are the conclusions of a seven-nation study (SAPRI) that came out in April 2002 regarding the impact of the structural adjustment programs imposed by the IMF and the World Bank. The study was jointly conducted by the Bank and an international group of non-governmental organizations called the Structural Adjustment Participatory Review Initiative Network. In it, the joint opinion of the participating institutions and organizations conclude that: “poverty has been further deepened by the inability of the poor to access essential services at affordable rates, which was disputed by the two international financial organizations” (Third World Network 2002). The study also noted that the 42 poorest countries in Africa had lost 50% spending on health care during the 1990s, and that they were spending more on repaying the debt than on health or education. It is apparent as well that privatization of health care has moved health from the public to the private sphere through user fees, private insurance schemes, and privatization of medical consultations and treatment. Phillip Michael has argued that, though the IMF emphasis on “earn more” and “spend less” might make it seem that it helps repaying the loans, and through the dependency that sets in, structural adjustment affects health care negatively through the closing of health facilities and preventing the hiring of more staff, or staffing them with “inexperienced health providers” (Michael 2004; Peet 2003).

Another recent study of the impact of the SAPs on maternal mortality conducted by Pandolfelli et al. (2014), after examining several independent variables—IMF structural adjustment lending, multilateral debt service ratio, multinational corporate investment, official development assistance, GDP, domestic investment, secondary school enrollment, democracy, public health expenditures, HIV prevalence, and caloric intake

and access to improved water source—against maternal mortality ratio per 100,000, the dependent variable, concluded that, even though they did not find that public health expenditures are related to maternal mortality in the region, they wrote:

We find support for the dependency theory hypothesis concerning the harmful effect of IMF structural adjustment on maternal mortality among Sub-Saharan Africa nations. The coefficients for this variable are positive and statistically significant. We argue that this may be the case because the IMF requires Sub-Saharan African nations to cut spending on health services. (Pandolfelli et al. 2014: 135)

The 1995–2005 study included 36 countries in Sub-Saharan Africa, namely: Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cote d’Ivoire, Central African Republic, Chad, Comoros, Congo, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, South Africa, Sudan, Swaziland, Tanzania, Togo, Uganda, Zambia, and Zimbabwe. Pandolfelli and his colleagues (2014: 137) estimated that the difference between not being under the IMF SAP and being subjected to it would result in much higher maternal death rates per 100,000 live births and many more infant deaths per 100,000. In other words, some 360 maternal deaths per 100,000 live births had occurred under the SAPs over the same period and that, therefore, evidence supported the claim that, in Sub-Saharan Africa, maternal mortality rates are higher among the countries that accepted the World Bank (and the IMF) conditions for a loan (*Encyclopedia of Nations* 1971).

In some countries, as was the case in Algeria, Benin, Niger, Nigeria, Sudan, Uganda, Zaire, and Zambia, and other developing countries outside of Africa, the SAPs resulted in violent demonstrations that, at times, caused several fatalities. As John Rawls theorized many years ago (1971), as long as there is no equal opportunity to resources and social positions and the freedom to use them to one’s advantage, as long as Africa understands that good systems and not persons, leaders, managers, and politicians are the most important prerequisites for good health on the continent, and that the fight against disease should not be focused only on decreasing mortality to increase longevity, progress in people’s health will be minimal. In fact, a health system without gross inequalities in access to resources must guarantee that the most disadvantaged are the most advantaged when resources are available.

Senegal had dedicated a 9% of the national budget for health in 1970–1972; subsequently, it went down to 4.16% in 1990, and then climbed to 7% at the end of the 1990s. Meanwhile, funds allocated to the army remained high, as was the case in peaceful Guinea, where it was 29% of the national budget between 1980 and 1990, contrasted to 3% for health, demonstrating the skewed policy of the leaders (Niang 2008: 37). Linked to the inequities exacerbated by the SAPs in Africa, the World Bank estimated in 1993 that 20% of the poorest in Africa received 10% of the public subsidies in health, while 20% of the wealthiest received 25% of subsidies—women, the majority of the poor, benefitting the least in the distribution of health resources. Women and children were the hardest hit by the required IMF structural adjustments. In his study on the SAPs in Kenya, Damaris Parsitau found a “direct link” between the adjustments and the deteriorating health of women in Kenya, mainly as a result of the imposed reduction in the health budget.

MEDECINS SANS FRONTIERES (MSF) OR DOCTORS WITHOUT BORDERS

Medecins Sans Frontieres (MSF) or Doctors Without Borders is an independent and voluntary humanitarian organization founded by 13 young physicians and journalists (Dr. Jacques Beres, Philippe Bernier, Raymond Borel, Dr. Jean Cabrol, Dr. Marcel Delcourt, Dr. Xavier Emmanuelli, Dr. Pascal Greletty-Bosviel, Gerard Illiouz, Dr. Bernard Kouchner, Dr. Bernard Pigeon, Vladan Radoman, Dr. Max Recamier, and Dr. Jean-Michel Wild) in Paris on December 22, 1971, in the aftermath of the Nigerian-Biafran civil war (1967–1970) in which many Ibo died as a result of the federal government’s use of starvation as a weapon to force surrender. The MSF Secretariat-General is headquartered in Geneva, Switzerland. The top officers consist of the International President, the Secretary-General, the International Medical Secretary, the Executive Coordinator (not Director), and the Executive Assistant. Its charter defines the organization as “an international, independent, medical humanitarian organization that delivers emergency aid to people affected by armed conflict, epidemics and natural disasters,” regardless of race, religion, gender or political affiliation. Indeed, MSF focuses its efforts on alleviating suffering caused by war or any other type of violent conflict and natural calamities, such as earthquakes, hurricanes, tornadoes, flooding, rape and torture, abuse, neglect, poverty, and lack of respect for human and citizen’s rights on the domestic, international, and global arena. Currently, MSF is organized

into 19 sections, 24 associations, and other offices, which are spread over some 70 countries, most of which in the developing world, including Africa. Worldwide, it boasts some 35,000 volunteers, physicians, nurses, journalists, logisticians, lab technicians, scientists, administrators, epidemiologists, mental health experts, and water and sanitation professionals, a far cry from its beginning in 1971 when it had only 300 volunteers.

MSF relies mostly on its own human resources, made up of doctors, nurses, auxiliaries, and local people, who may be hired with pay, and works in partnership with governments only when necessary while making its own independent assessment of a given health situation. The finances of MSF have apparently been quite open to researchers, and the allocation of resources is a transparent process. The organization gets 89% of its budget from some five million private donors, 9% from public institutions, such as the European Community and members, and 2% from other sources. Records also show that MSF spends very little on administration, management, and general activities, which take only about 6–7% of the total budget expenditures. Only 2% of the proceedings are dedicated to fundraising. Over the decades, MSF has spent more funds in Africa than in any other continent, over 60% of its budget. In 2014, the amount spent in Africa rose to 65% or 46 million Euros out of its 1.28 billion Euro budget, an increase of 272 million Euros over 2013 (*Medecins Sans Frontieres Financial Report 2014*), when the overall budget was 1.2 billion Euros.

In its work and distribution of assistance to populations in need, the MSF reached 100 million patients in 2015 alone, with 8.5 million being out-patient consultations in 2014. In its operations, the MSF adheres strictly to medical ethics, tries to preserve its independence, and carefully evaluates the various health needs without regard to the type of government experiencing conflict and violence. Its principles, as stipulated in the charter, are impartiality, neutrality, accountability, and bearing witness by speaking against extreme abuse “when access to lifesaving medical care is hindered, come under threat,” as happened in Kunduz hospital in northern Afghanistan when US airstrikes destroyed the intensive care unit and killed 35 MSF staffers and patients on October 3, 2015, as well as “when crises are neglected by the world community, or when the provision of aid is inadequate or abused...” (*Medecins Sans Frontieres*, Charter 2015: 2).

It appears that, unlike many other international organizations, MSF has received only guarded criticism of its operation. In this sense, MSF, a decentralized organization, wishes to be seen as operating “in the front lines,” but, more importantly, as an organization that is careful about

risking the lives of its volunteering staff. It is frugal and is loosely led by an Executive Coordinator who barely makes \$143,000 a year, contrasted, for example, to the CEO of the American Red Cross who makes \$500,000 a year for leading the organization. On the international scene, it is relevant to note that the MSF enjoys a “consultative status” with the UN Economic and Social Council, helping to provide vaccines and nutrition to children, improving water and sanitation, and fighting, as is the case in Africa, against such diseases as cholera, malaria, yellow fever, polio (now almost eradicated from the globe), measles, pertussis, tetanus, diphtheria, whooping cough, HIV/AIDS, tuberculosis and, most recently, the Ebola virus in Liberia, Guinea, and Sierra Leone in particular, where it lost 13 of its doctors to the highly infectious disease.

Without the presence of this humanitarian organization, the Ebola crisis might still be present in Sierra Leone today. MSF defied all odds at succumbing to the disease, as it had reached a stage where it could hardly do its work effectively: It was almost completely overwhelmed by the outbreak. Notably, however, by October 30, 2014, some 3,300 MSF staff volunteers had been posted to West Africa as a result of Ebola, and 23 of them contracted the disease, 20 of whom were nationals. By the end of 2014, MSF had treated some 5000 patients, with 3211 confirmed cases. By July 15, 2015, at the height of the Ebola crisis, MSF and its partners were caring for the health of 27,642 Africans from Sierra Leone, Liberia, and Guinea, of whom 11,261 eventually died. It functioned with a staff of approximately 40 international and 1,100 national employees in Guinea, 23 international and 260 nationals in Liberia, 29 international and 400 nationals in Sierra Leone—a total of 92 international and 1760 national employees and volunteers (Snowden 2015). In contrast to most NGOs, therefore, wherever and whenever MSF has opened a health center, most of the workers it employs have been local or national citizens.

The reader may remember that MSF was also present in Sierra Leone during the brutal civil war the country experienced during the 1990s. The fortunate countries in Africa where MSF did its critical work in 2014–2015 on behalf of the sick, the poor, the refugees, and children in time of strife included Burkina Faso, Cameroon, Central African Republic, Chad, Congo-Brazzaville, Congo-DRC (since 1985), Egypt, Ethiopia (during the 1984–1985 famine, which led to its expulsion from the country for speaking out against the government), Guinea, Guinea-Bissau, Cote d’Ivoire (since 1990), Kenya, Lesotho, Liberia, Libya (since 2011), Madagascar, Malawi, Mali, Mauritania, Mozambique, Niger,

Nigeria, Rwanda (in 1994), Sierra Leone, Somalia, South Africa, South Sudan (especially during the outbreak of the kala azar or visceral leishmaniasis in 2010), Sudan, Swaziland, Uganda (since 1980), and Zimbabwe. The war in Liberia, for example, which started in 1989 until 1996 to resume again in 1999 until 2003, appears to have affected some 49% of the women by 1998, who were subjected to at least one act of physical or sexual violence by soldiers or combatants. A study of Rwandan women showed that, for many, rape became their first sexual act, and 95% of these violated women contracted HIV/AIDS, which multiplied the rate of the epidemic in the country; this, of course, occurs on top of robbery, torture of women and children, domestic physical and psychological violence, street incidents, and armed conflict, which often resulted in deaths and injury, poor nutrition, and exposure to infections and deadly diseases, and less access to health care and disease prevention and treatment (see Niang 2008: 11, 35). It is amidst these inhuman occurrences that the MSF gets involved to save the innocent victims that have nowhere else to go to seek assistance, including medical treatment. Finally, it might be important to note that, even though MSF's work has continued to be vital and effective in the world, especially in Africa, the organization reluctantly accepted the Nobel Peace Prize in 1999, three years after it had been a recipient of the Seoul Peace Prize. A major factor that has contributed to MSF's success wherever it has worked has been its emphasis on gathering accurate and vital statistics, which have made it one of the most statistically grounded organizations in the world.

DEPARTMENT FOR INTERNATIONAL DEVELOPMENT
(DFID), UNITED KINGDOM

The British Department for International Development, an offshoot of the Ministry of Overseas Development, was created in 1997 by the Labor government. It is comparable to the US Agency for International Development, whose overall goal is to promote "sustainable development and eliminate poverty," and is led by a Secretary of State for International Development and Minister of State, a Board of Directors, with several Directors-General appointed to perform various tasks (finances, corporate performance, policy) and several Deputy Directors. Headquartered in London, its areas of focus in the developing world are education and health, social services, water and sanitation, government and civil society, the economy, the environment, research, and humanitarian assistance.

DFID's annual budget has been in the billions of British pounds, oscillating between 1 billion and 6.7 billion pounds over the most recent years, but, for the period 2015–2030, it was expected to reach 10 billion pounds. Funds are allocated three ways: through multilateral organizations, including the European Community, the UN, and the World Bank; bilateral agreements with countries around the globe called Country Assistance Plans, and non-governmental organizations or the NGOs. For our current topic, only the focus on health in Africa is discussed, as, at times, it has been difficult to separate the organization's health work in Africa from its other foci related to governance. More recently, DFID decided to help African governments and others experiencing similar problems around the globe meet the MDGs. These include, among others: Cutting by half the rate of poverty and hunger; reducing child mortality and improving mothers' health; and fighting other common diseases such as HIV/AIDS, malaria, and tuberculosis. The more specific goals of DFID in Africa are to:

1. Support almost 3 million people throughout the year to ensure they have enough to eat
2. Help 4 million of the world's poorest from extreme poverty
3. Assist 5 million children to attend school
4. Provide 14 million people access to drinking water
5. Protect 30 million people afflicted with malaria.

There is no doubt that the DFID has done wonders in health for Africans on vaccinations, malaria, HIV/AIDS, and water and sanitation, and has led a robust effort against the Ebola virus crisis in West Africa, especially in Sierra Leone, during the most recent outbreaks. Unfortunately, it is almost impossible to document the health outcomes for each country in which the agency has been active, as the funds are allocated to NGOs and governments. However, DFID provides to researchers and interested others an idea of the allocations or projected allocations to Africa over the years: 26 million British pounds for the period 2001–2030, which targets 22 African countries, including Kenya, Tanzania, and Nigeria in the form of bed nets to fight malaria.

Despite the successes in the region, however, DFID's 2015 report notes that in the health sector "progress is uneven and fragile." For the Africa Regional Malaria Program, Kenya, Tanzania, Somalia, Sudan, South Sudan, Rwanda, Ethiopia, Uganda, Swaziland, Zimbabwe, Malawi, The

Gambia, Burundi, and Niger, have been the major beneficiaries (UKAID 2015: 1–58). From 2010 to 2014, Sudan, for example, received between 30 million and 54 million British pounds annually designed to bolster the domestic budget estimated at only 140 million British pounds a year, some of it going to health. One impressive focus of DFID has been in-depth research, which most African countries simply tend to ignore or to which they pay only lip service. During the most recent Ebola crisis (2014–2015), the Department appropriated some 427 million British pounds to Sierra Leone alone. This was a huge commitment compared to the allocations to the two other countries suffering from the epidemic, Liberia and Guinea.

To strengthen this effort, Great Britain also sent some 1500 British personnel to oversee the treatment centers and trained 4000 Sierra Leonean and international health care workers, apart from the volunteers, to work “on the frontline to support over 1500 treatment and isolation beds—more than half the beds available for Ebola patients in the country.” The UK also set up a 36 bed mobile field hospital, which could be dispatched anywhere in the country within 96 hours and treat Ebola patients and people affected by various other infectious diseases in the country (Gov. UK 2015: 1). The strong UK commitment to Sierra Leone is demonstrated by its effort to provide it with as much structure and capabilities as possible so that it would be ready to withstand the eventuality that the Ebola epidemic might return to the region. Finally, regarding the MDGs, which DFID pledged to help Africa achieve by 2015, the results are not reassuring, as most African countries did not reach any of their goals.

THE TONY BLAIR AFRICA GOVERNANCE INITIATIVE (AGI)

Born in Edinburgh, Scotland, on May 6, 1953, Anthony Charles Lynton Blair became leader of the British Labor Party and England’s Prime Minister twice between 1997 and 2007 after his party won a landslide victory over the Conservative Party. In 2008, Blair founded the Tony Blair Faith Foundation, whose aim was to foster interfaith understanding among the major religions, followed, in 2009, by the establishment of the Tony Blair Africa Governance initiative (AGI), headquartered in London, which is the subject of the next brief discussion. The top organizational structure consists of the Patron (Tony Blair), a Secretary, and a Chief Executive, who works closely with the Trustees. Evgeny Lebedev, a Blair trusted staff member who worked in West Africa—Guinea, Liberia

and Sierra Leone, where the Prime Minister had sent a British intervention force during the Sierra Leone's civil war in 2000—was appointed to ensure the smooth and effective functioning of AGI in the Ebola-afflicted region in early- and mid-2014. Lebedev characterized the purpose of AGI as one not intent on providing doctors or nurses but one that would focus “on something often dismissed or not even considered in modern schools of crisis management: the daily task of governance.”

If the figures can be believed, AGI had an income of \$3.16 million pounds in 2012, said to be slightly down from the previous year which has been estimated at \$3.2 million pounds (about \$4,814,720), employing some 32 staff, whose average salary was \$56,000 pounds, a big bonanza in such developing countries as Sierra Leone and Liberia. Drugs and medical staff were no use for AGI if they could not get where they were needed. What was required, said Lebedev, was “command and control.” Lebedev further wrote that AGI was

...specifically designed to help those governments build the capacity to deliver. That is what we did with Ebola. The situation was spiraling out of control and the governments were struggling. Then you had a vast influx of international help. But it needed to be channeled. That was the key, and out people played an absolutely crucial part in putting that together. (Lebedev 2014: 6)

Thus, the most important mission of AGI was ensuring that data on the origins of the disease were collected and activities prioritized and properly planned, all of which would lead to effective delivery of whatever was required of the effort to eradicate Ebola. Proper handling and advising on logistics became the espoused philosophy that would result in efficiency and fair distribution of resources, such as the building and location of headquarters and centers to facilitate the reception of patients and dispensation of medications, drugs, and critical treatment to the affected West Africans, especially in Sierra Leone. Here, some 45 million British pounds were spent on health-related projects and 18 million British pounds on governance. It must be said that, no matter what its final verdict will be, AGI is thought to have contributed positively to the more effective running of the Ebola logistics operations, as happened at Freetown's Connaught Hospital. One other strong element of AGI was that the civil staff was drawn from the civil service and the city, and from what is called “management consultancy.” As a result, Tony Blair became a major humanitarian celebrity among most West Africans.

In summary, AGI helped governments and international NGOs to “build a system and analyze information and build decision-making and operational structures to respond to the information.” Since its existence, AGI has contributed to the training of 198 Ebola operators at the 117 hotline call center in Sierra Leone. It has prepared 190 briefings on the crisis and on the methods to provide more efficient assistance to the victims, helping Sierra Leonean and British army personnel to establish the first Ebola National Situation Room in the country, transporting the sick from one region of the country to another to optimize the resources and distribution centers—as was the case with the transfer of beds from areas that might have had too many to those where there were too few. Unfortunately, the alleged waste of resources and political influence were said to interfere with the ethical goals of AGI. Blair was accused of wasting many thousands of British pounds in such countries as Malawi and of supposedly exerting undue pressure on big donors who worked for the government to contribute to AGI. On the waste of resources, indeed some programs had to be cancelled in Malawi, the former British protectorate, at a cost of some 300,000 British pounds, following six months of planning and the critical work already done (See BBC News [2005](#)).

THE CLINTON FOUNDATION: CLINTON HEALTH ACCESS INITIATIVE (CHAI)

The Clinton Foundation, which has an annual budget of \$2.0 billion (2014 figure), of which about 89% is said to go to charity, was established in 2002, and it is described in its charter as a private organization that focuses on “strengthening health systems and expanding access to life saving treatments; providing farmers with tools they need to increase their incomes and strengthen their communities; and addressing climate change by making forests and cities more sustainable.” The Clinton Health Access Initiative (CHAI), which is a component of the several other organizations that emanated from the Foundation in 2010, deals specifically with Africa’s health needs, particularly mother-to-child HIV transmission prevention, access to antiretroviral treatment against HIV/AIDS, availability of vaccines, and the reduction of all drug and medication prices to make them affordable to the poor and to those who, because of ill health, are unable to pay the bill. The organizational structure is simple, and is headed by a President (Bill Clinton) and a Board of Directors under a Chair and a Vice-Chair (Chelsea Clinton).

In this context, CHAI has had an impact on the fight against diseases on the African continent. At its founding, in low- and middle-income countries, only 200,000 people were being treated for malaria, tuberculosis, and HIV/AIDS, and were paying as much as \$10,000 per person per year for treatment. The number of people has, however, reached over 9.9 million worldwide now. CHAI seems to have tripled the number of patients being treated and has negotiated prices that convinced pharmaceuticals of the need to reduce them sometimes by as much as 80 to 90%. The Foundation has been operating in 38 partner countries, and 70 others have benefited from the negotiated price reductions on medical devices, diagnostics, and vaccines (The Clinton Health Access Initiative 2015). In Tanzania, where the first pilot project was introduced, CHAI, for example, has been able to reduce the price of artemisinin-based combination therapies against malaria, thus enabling the number of patients buying the therapies in private drug stores to increase from 1% to 44%, as is the case in Swaziland. In fact, as a result, Swaziland is the first country in Sub-Saharan Africa that might be “on the verge of achieving” the goal of eradicating malaria. We end our discussion by noting that the Clinton Foundation has been a target of considerable negative publicity leveled by journalists, politicians, and some philanthropic organizations for allegedly not being transparent or forthcoming with its budget, and the fact that it seems to be receiving donations from several questionable foreign sources due to suspected inappropriate influence exerted by Hillary Clinton while secretary of state in the 2009–2013 period and as a candidate for the presidency in 2008 and 2016. In the 2016 presidential campaign, the Foundation came under heavy scrutiny and criticism, which may have contributed to Hillary’s stunning defeat by Donald Trump. Apparently, Chelsea Clinton, daughter of the Clintons, has brought some transparency to the charitable contributions, one of the reasons why the Foundation is now called the Bill, Hillary & Chelsea Clinton Foundation, even though many still call it the Clinton Foundation. Unfortunately, it is difficult to ascertain precisely how much the Foundation has spent on and in Africa, though the 2013 report gives a figure of \$52,058,000, which is a significant contribution to the health needs of the continent (The Clinton Foundation 2013).

FOOD AND AGRICULTURE ORGANIZATION OF THE UNITED NATIONS (FAO)

The Food and Agriculture Organization (FAO) is an agency of the UN whose purpose is to assist governments to develop agriculture, forestry, fisheries, and land and water resources to end hunger in the world, eliminating

inequalities, many of which are gender-based, and increasing agricultural output to provide nutritious food to people suffering from hunger, famine, and natural disasters. The human conditions just mentioned are applicable to most of the countries of the Sahel, whose cyclical famines kill thousands of children and poor people when they strike, and in Sub-Saharan Africa, and have a direct impact on people's health. FAO was founded in October 1945 in Quebec City, Canada, and is headquartered in Rome, Italy, after it was moved from Washington, D.C., but has offices around the globe. Its decisions are made by the biennial FAO Conference, which has representatives from each member nation and the European Union. The Conference elects a 49-member Council, which acts as its executive body. Members serve for three years on a rotating basis. FAO is headed by a Director-General who presides over a Board of Directors consisting of 12 members.

As known, Africa is never properly prepared for natural disasters, even when scientific mapping and forecasts are announced, or when we know that they tend to occur every few years. Unfortunately, the media responds slowly and the international community, even though fast to assist, tends not to figure into the equation the health needs of the affected population and does not look for and treat the structural causes. If there is attention given to recurring phenomena, it is usually short-lived. It is important, therefore, that we comment briefly on the issue of famine as it relates to disease. As a result of the food shortages in Sub-Saharan Africa, particularly in the Sahel, during the 1970s, FAO took on the role of contributing to world food security and helping small farmers to grow better crops in 1974 at the World Food Conference. This phase was followed by a focus also on sustainable agriculture in rural areas and technologically meeting the level of technological advance of the host country during the 1980s and 1990s (Mingst, *Encyclopedia Britannica* 2014).

Several reasons seem to contribute to the series of famines that occurred and continue to occur in several parts of Africa, which include: Africans being suddenly forced to grow cash crops to pay taxes and satisfy Europeans' search for raw materials to feed their home industrial projects; forced reliance on cereal, which is easier to grow for survival but is not as nutritious; the new need to buy Western type of colonial clothing and utensils to conform to European styles; imposition on storing grain surplus for the colonial administrators, which forced the Africans to buy it back at inflated prices in times of famine; the impact of the Great Wars' effort; increased price of even wild meat from restricted hunting for Africans, while Europeans continued to shoot animals at leisure; and European troops going on a rampage on African farms, as the German East African soldiers would do during war times.

NOVO NORDISK WORLD DIABETES FOUNDATION (WDF)

The Novo Nordisk Foundation was created in 1923 by the Nobel Prize winner August Krogh, Professor at the University of Copenhagen, Denmark, who decided to start an international organization that would specialize in the production of insulin and other products to fight diabetes. Novo Nordisk Foundation maintains its headquarters in Denmark, employs a staff of some 40,700 people in 75 countries, and has been able to market its products in 180 countries. In 2002, Novo Nordisk created the World Diabetes Foundation (WDF) in an attempt to make insulin more affordable to the least developed countries. It enlisted the assistance from pharmaceuticals that promised not to charge more than 20% of the patients it treats in the developed world. In Africa, the following countries have benefited from this organization's effort: Mauritania, Senegal, Gambia, Cape Verde, Guinea-Bissau, Guinea, Sierra Leone, Liberia, Burkina Faso, Togo, Benin, Sao Tome e Principe, Equatorial Guinea, Central African Republic, Angola, Democratic Republic of Congo, Mali, Niger, Chad, Sudan, Eritrea, Djibouti, Ethiopia, Somalia, Uganda, Rwanda, Burundi, Mozambique, Malawi, Lesotho, Zambia, Comoros, Madagascar, and Tanzania.

Working closely with the World Health Organization (WHO) and the Foundation for Global Development (WDF), the Novo Nordisk Foundation tries to impress governments on the need to adopt the following four goals related to diabetes: (1) formulation of national health strategies; (2) building national health care capacity; (3) promoting the best possible pricing practices; and (4) providing and seeking additional funding, and working through several charity organizations, such as the WDF. Presently, the International Diabetes Federation, African Region, has many members, including more than 37 countries in Sub-Saharan Africa, and the islands of Madagascar and Seychelles (Azevedo and Alla 2008: 101–108). In million DKK, Novo Nordisk Foundation's total budget for 2010 was total budget for 2010 was DKK 13,988, in 2011 it was DDK 16,582, and DKK 22,458 for 2012 and employed about 34,731 people (*Novo Nordisk Annual Report 2012*: 56, 95).

THE PARIS CLUB

The Paris Club, founded on May 16, 1956, as a spin-off of an economic crisis in Argentina and its various creditors, is one of the major unofficial organizations for debt relief schemes that recommends to the IMF and the World Bank millions of dollars' worth of debt relief every year to respond to the repayment problems plaguing numerous developing countries globally. Even though health is not its direct target, it is "the key forum for

the delivery of bilateral debt relief from (mainly OECD) governments.” Development Financial International notes that, “while the Paris Club has provided significant debt relief under the HIPC initiative, non-HIPC low income and middle income countries have also received relief, albeit often on less favorable terms, or debt restructurings to help them deal with balance of payments problems” (Development Finance International 2014). In other words, the Paris Club is an informal corporation that recommends funding to indebted countries unable to fulfill their financial responsibilities in the form of debt relief, debt restructuring, and cancellation, most often on the recommendation of the IMF and World Bank.

However, given its dealings with the World Bank, the IMF, and some 20 global financial giants, and lending institutions that have a direct interest in Africa’s health, the Paris Club merits brief mention in this section. Essentially, the Club, which consists of with 19 member states, is “A group of international creditor nations that meet voluntarily to negotiate debt rescheduling and restructuring for nations that owe them money, which includes the European Union countries, Australia, Japan, Russia, and the United States. It meets 10 to 11 times a year ‘to review issues concerning debtor countries’” (Weiss 2013: 1). Since inception and up to December 11, 2013, the Club has rescheduled or reduced debtor countries loans in the tune of \$573 billion. Since 1983, it has negotiated 429 agreements with 90 debtor countries for the IMF. The US became a member in 1994 through authorization by Congress. In 2008 alone, the Club helped dispense about \$3.12 billion, with \$1.6 billion going to debt cancellation (Club de Paris, *Annual Report 2008*: 2).

In Africa, the Paris Club has dealt with some 34 debtor countries as of the year 2013. As the designation implies, the Club is headquartered in Paris, where it also has its Secretariat, and holds its meetings every six weeks in the French Ministry for the Economy and Finance. It calls itself a “non-institution institution.” In the present context, one can say that it has some connection with the French government but it is not funded or led by France, even though it is chaired by a senior official in the French Treasury. To demonstrate how secret the Club’s decisions are, its by-laws were first publicized only during the 1970s as a part of the dialogue between North and South or the Northern and Southern Hemispheres. At first, the Club dealt only with Latin America, but later Africa was added, the DRC having been the first to sign an agreement with it. The IMF, the World Bank, UNCTAD, and the OECD attend the Club’s meetings as observers only, at least in theory. Talks between credi-

tors and debtor countries take place in Paris and are chaired by France, as noted above, even though another country can perform this task, as Ghana did in London during the debt relief negotiations in the 1970s.

The secret nature of the loan negotiations and the Paris Club's inflexibility in accepting requests for debt relief has been the major source of criticism. Other issues that have received criticism include its secret practices and the absence of transparent guidelines, except to the treasurer, and the fact that its members are not permanent and function only under consensus. Its recommendations are not legally binding but have been always accepted by the parties involved. Participants in the Club include four representatives: Delegates from the debtor country; creditor countries; the IMF, as the advisory board; and international organizations, such as OECD, the World Bank, and regional development banks from Asia, Africa, the Caribbean, the Inter-American Development Banks, and the UNCTAD, participating only as observers. The Club commands billions of dollars for its purposes, the reason why it works so closely with the countries and organizations which, for various reasons, include health and negotiating loans for Africa. How exactly the Club impacts Africa's health can only be inferred, since only the funds that are included in the various debts from the IMF and the World Bank are a part of the operation of the health systems in Africa, especially Sub-Saharan Africa. How does this work? In their authoritative study of the Club in 2001, Juan Carlos and Mathew Martin (2001: 15) note that "Having signed an Agreed Minute [signed agreement] with the Paris Club, the debtor country negotiates bilateral agreements with each Paris Club creditor government (and in some cases with separate agencies within that government)." Though the Club sets deadlines for the conclusion of these agreements, usually around six months after the multilateral meeting, the process can be lengthy, often up to 18 months.

US AGENCY FOR INTERNATIONAL DEVELOPMENT
(USAID), NATIONAL INSTITUTES OF HEALTH (NIH),
AND CENTERS FOR DISEASE CONTROL AND PREVENTION
(CDC)

USAID, the NIH, and the CDC have not received much attention like the other international agencies and organizations in this volume. USAID, established in its present form by President John F. Kennedy in 1961, has

been working in other forms in Africa since the 1950s and, using its multi-focused purpose, it has done important work that has improved the health of the Africans on the continent. This work has ranged from funding studies on infant mortality and maternal health, to health and sanitation programs, malaria eradication campaigns, and HIV/AIDS containment and eradication, and to other social and political issues such as the improvement of women's opportunities for economic self-sufficiency, women's education, democratic governance and participation, and women's reproductive care. Through provision of grants on a competitive basis, the agency has benefited individuals, nations, organizations, and civil society in Africa and in the developing world, and has enabled the implementation of innovative ideas and unique development projects in 42 African countries totaling \$4.5 billion in 2014. Its website lists its focus for Africa as the following: Boosting agricultural productivity through the feed the Future Initiative to fight "chronic hunger and poverty; strengthening health systems through the Global Health Initiative; supporting democracy, human rights, and good governance thus fighting corruption, and expanding civil society, helping citizens choose their leadership; increasing resilience to climate shocks; and leading quick responses to humanitarian crises (US Agency for International Development: Africa 2015).

Even though it has been one of the premier US agencies in Africa, USAID has encountered much criticism most recently. Critics have charged that the agency has attempted to impose US views and values on grant recipients, pointing as an example to the latest aggressive promotion of mass circumcisions in Africa and US involvement in the internal issue of homosexuality in Uganda. Others have impugned the agency for allegedly favoring certain applicants and organizations over their competitors, who receive grant cycle and focus information in advance, thus stifling competition to favor those that may have received several grants in the past, and that the agency does not care much for applications coming from minorities and minority institutions. One of the best outcomes of the agency's effort in Africa has been the periodic reports that it disseminates to interested parties and scholars, which are available free on the Internet.

The NIH and the CDC are primarily designed to serve American citizens' health needs in case disease occurrences elsewhere in the world might affect American domestic national security. For that reason, the two agencies were involved in the failed HIV/AIDS clinical trials in Africa, especially in East and Southern Africa. On this, said Aida Alami in the *New York Times*, February 6, 2015: "Failure of large-scale National Institutes

of Health clinical trial aimed at preventing spread of HIV in Africa has led the scientific community to re-examine how such trials should be conducted in poor countries; results show high percentage of women falsely claiming they took medication; main concerns are whether results are scientifically trustworthy.” In 2013, the NIH awarded \$17 million in grants to “augment genomics research in Africa” (NIH, 1–5: 2013). The two agencies are also seen in Africa as elitist, as they tend to work only with universities and large pharmaceuticals, while they seem to show little knowledge about Africa’s health priority needs, in which they have shown little interest, just as the Ebola virus scare demonstrated. When they have involved themselves in issues of health on the continent, the NIH and the CDC have channeled their meager foreign funding to limited and specific projects. The CDC’s fiasco regarding preparedness to stamp out the spread of the Ebola virus in Africa and the US did not help the image of the agency in Africa and the world. Mishandling of the situation resulted in two deaths in US hospitals in Texas and Nebraska, as well as the infection of several nurses, which served only to discredit the agency and its Director, Thomas Frieden, who many experts and observers thought he should have been immediately fired for incompetence and negligence.

Indeed, the CDC staff’s mishandling of the Ebola infected blood in a CDC laboratory shattered beyond words the reputation of the agency and of its Director. The confusing, unclear, vague, and piecemeal guidelines and protocols promulgated much later to physicians and nurses on the isolation and quarantine of infected individuals and the protection of the health workers created a situation that the governors of New York and New Jersey took matters into their own hands and passed their own quarantine ordinances. These were applied by Governor Chris Christie of New Jersey to a nurse who had just returned from Liberia, only to be rebuffed by a court order. The NIH’s work in Africa is even more obscure, even though the agency has participated in research and in some projects that not many Africans can point to, except perhaps the now failed HIV/AIDS clinical trials in East and Southern Africa as alluded to earlier.

CONCLUSION

No matter how much criticism is leveled against the WHO, its existence, its work toward the elimination of illnesses, especially infectious diseases, and its committed application of the research advances toward the prevention and treatment of diseases are undeniable facts. To briefly point to its

successes since its inception in the 1940s: The WorldPress (2014) notes, for example, that in 1967, some 31 countries in the world had endemic outbreaks of smallpox that affected between 10 million and 15 million people, killing some 2 million, blinding, and disfiguring thousands. As the WHO put together all its resources to eradicate the disease through preventive measures and vaccines, the last successful case recorded occurred 10 years later in Somalia on October 26, 1977. Ironically, “the eradication of smallpox was initially rejected by member states as being too difficult and too complex,” but it proved to be “one of WHO’s greatest achievements” (Clift 2013: 23). The fierce and difficult battle against polio, partly due to cultural misunderstandings, had only a dozen of cases remaining in such countries as Northern Nigeria, India, and Pakistan by the end of 2014.

Yaws, a terrible crippling disease, which affected some 50 million people worldwide, saw a breakthrough through penicillin in 1948, declining to 46 million cases in 1965. Since then, it has virtually disappeared from the globe even among the world’s 49 most affected countries. The WHO and its international partners’ battle, which began in 1974 against the black fly that causes river blindness, was known to affect some 10 million people annually, killing so many of its victims, especially in parts of West and Central Africa, while displacing millions of others, has now been tamed. Consequently, more than 40 million people have been able to return to their original homes in such countries as Burkina Faso, Ghana, and Mali. The same story applies to leprosy, for centuries the most abominable disease in Africa. It has been eradicated in several developing countries, especially in Africa, and fewer than 10 million people in the region see it now as a health threat. Currently, the sting of the six most deadly children’s diseases, diphtheria, pertussis, tetanus, measles, and rotavirus, pneumococcus, and HIB vaccinated diseases—meningitis, sepsis, septic arthritis, periorbital cellulitis—which killed some 540,000 people a year worldwide by 1990, and poliomyelitis, have been reduced through immunizations and preventive educational strategies, hygiene and sanitation. Infant mortality, one of the first targets of the WHO and its affiliate, UNESCO, following the Alma-Ata Conference which declared 2000 to be the year when health care would be accessible to all as a human right, affected eight out of 10 children. It had been reduced from 134 per 1000 in 1970 to 80 per 1000 by 1995. Since then, the rate has declined by 37% and has continued to decline in most parts of the world (WorldPress 2014: 2).

The effort at eradicating cholera began in earnest in April 1991 through the WHO's Global Task Force, and had successfully reduced its prevalence to 293,125 cases by 1998. The MDGs, though they may not be achieved by all by 2015, have energized the world, and provided a clear global pathway to good health during the coming decades, including in the developing world. People are, indeed, excited at the prospect of eliminating various infectious diseases and reducing the impact of their twin sister, poverty. The UN hopes to be able to reduce maternal mortality at birth by half by the year 2020. These were causes of death that became a major target of the work of the WHO. Guinea worm disease and *chagas* are also slowly being eradicated in the developing world, having been eliminated from the most advanced countries decades ago.

For PEPFAR, on balance, the good outweighs any of the shortcomings it might have had during the past decade (2003–2014). The past 10 years have witnessed a proliferation of what are commonly called global health initiatives (GHIs), and PEPFAR is a most important one among them, which has competed effectively with the Bill and Melinda Gates Foundation. These initiatives were implemented as emergency responses for the scale-up of control of the major communicable diseases, especially HIV/AIDS. GHIs are characterized by their ability to mobilize huge levels of financial resources, linking input to performance; and, when possible, by channeling resources directly to civil society and NGOs. Three GHIs—the World Bank's Multi-Country HIV/AIDS Program, GFATM, and PEPFAR—have contributed more than two-thirds of all direct external funding to scaling up HIV/AIDS prevention, treatment, and care in resource-poor countries such as Tanzania (Biesma et al. 2009). Increasing access to health initiatives, doubling the employment of skilled health care providers, educating the community, addressing safety issues, improving water and sanitation, and discussing universal precautions at the workplace for nurses and physicians are ways of increasing involvement and efficacy of the health care system and optimizing public health outcomes. Indeed, HIV/AIDS is a lifelong illness and affects women, men, and children and all nationalities, no matter the socioeconomic status.

Accusations of corruption and fraud in the disbursement of GFATM funds in certain countries have surfaced over the years, an issue that, brought up by journalists, forced the organization to prosecute the clear cases and ask for the return of misappropriated or misspent funds. For example, Zambia, Cameroon, Mali, and Mauritania were accused of defrauding the organization at the tune of \$25 million that simply disappeared and could

not be accounted for, which caused Sweden and Germany to withhold their contributions to GFATM. The other problem has been the justified concern that the US wishes to impose its rule when it caps its contribution to 33% of the total contributions made by the donors. A further issue has been associated with the fact that some countries at times have been unable to disburse the funds as promised and have asked for extensions. These are not allowed any longer, as happened with Kenya and Uganda. In such cases, funds will be reclaimed. It is refreshing to know that, as a result of the unpleasant experiences over the years, GFATM announced its new strategies in November 2011, applicable to the period 2012–2016. The organization announced that:

In a move that aimed to transform the Global Fund from an emergency funder to a sustainable and strategic funder... [and is] based on the strategic objectives the strategy's underlying model is to 'invest for impact' in order to sustain and build upon gains made in previous years, with an overarching target to save 10 million lives by 2016. (The Global Fund 2011)

The Bill and Melinda Gates Foundation has had its detractors, as expected, some complaining of the vertical approach it takes to disease, especially in Africa, neglecting such issues as nutrition and infrastructure (transportation, for instance); the siphoning of technical personnel and higher paid clinicians and specialists who abandon the primary health care responsibilities; and its collaboration with corporations, such as pharmaceuticals, and the IMF. These have been associated with increasing poverty in Africa from jacked up drug prices people cannot afford and the emphasis on co-payments and reduction in free social programs as part of the SAPs discussed here. However, critics need to realize that the Foundation also supports the “development of integrated health solutions for family planning, nutrition, and maternal and child health” (www.gatesfoundation.org). No matter what the criticism might be, without the funds provided by this philanthropic organization, Africans would be in a worse situation regarding the ravages of HIV/AIDS, tuberculosis, and malaria. Incidentally, there is also a Bill Gates Foundation Trust which is not discuss here because it would cause a major confusion in trying to understand how the two work together and complement each other.

UNAIDS, on the other hand, has been a most worthy organization in Africa, as shown in this chapter. Its efforts and victories over the decades are clearly embedded in the firm believe in and defense of social justice

and human rights, echoing the 1978 Alma-Ata Conference, where these tenets were embraced by the international community. UNAIDS does not claim a victory of its own, given its meager annual budget provided by the WHO and philanthropic organizations, but it is entitled to share on the success. It has provided global leadership in the fight against HIV/AIDS, informed and urged member states to apply the best practices in the field of HIV/AIDS advances, has served as the most powerful advocate of those living with HIV/AIDS since 1996, and is the appropriate coordinating body for the eradication of the disease. Africa has been the greatest beneficiary of the creation of UNAIDS, as the figures on people being treated, saved from the disease, and the reduced rate of infections demonstrate. Some things are getting better in Africa in this respect but the battle is far from being won. According to the President of Benin and Chairperson of the African Union, one problem UNAIDS has had is the fact that concerted plans and strategies to eradicate AIDS have fallen short on the continent.

Considering the number of children the organization has saved since 2000, on balance, it is a blessing that the founders of GAVI had their noble vision, which they have pursued vigorously. In other words, it was better to have the organization than not to have it. The fact that it has survived so far and plans to be here for many years to come, GAVI will continue its humanitarian work and learn from any mistakes it has made in the past. To claim that the organization is satisfied only with short-term gains cannot be justified, as the countries' contributions it requests for assistance points to a long-term thinking that will make the programs sustainable, as noted in the organization's own long-term goals. In fact, since 2007, GAVI has used its funds to strengthen local health systems' programs and has "encourage[d] and enable[d] countries to identify infrastructure and resource weaknesses that are barriers to the achievement of immunization and other public health goals...They ensure that trained professionals are given the tools they need to give proper care to those who need it most" (WHO, GAVI Alliance 2014), and complement the health-related strategies contained in the MDGs accepted by the international community.

What about UNESCO? There are calls for UNESCO to change the way it functions and to not ally itself with member states or dictate policies on the ground. However, one should remember that this UN agency describes its functions as that of a laboratory of ideas for member nations; a clearing house for gathering, transferring, dissemination, and sharing information, knowledge, and best practices; a standard-bearer, allowing

the member states to accept common rules to draw up an international instrument; a capacity-builder for member states; and a catalyst for international cooperation (UNESCO 2002–2013). UNESCO would also like to be seen as an intergovernmental and universal global organization; an international intellectual cooperation agency; and the conscience of the UN (Galan-Sarmiento 2000: 1–3). Galan Sarmiento charges, however, that UNESCO was not established to enter into bilateral relations with its members states or to provide funding and technical assistance. Similarly, in its relations with civil society, “UNESCO is not a wet nurse for non-governmental organizations, and its relationship with them should be aimed at strengthening civil society in a context of mutual respect and cooperation” (Galan-Sarmiento 2000: 4). It is hard to prove that UNESCO has not strived to correct any missteps it has had over the decades.

In view of the shortcomings and some of the nefarious impact that the IMF and the World Bank loans have had on Africa, it is high time for Africa to make the wise decisions and take the decisive steps to move its health systems at all cost forward, lest it continues to lag behind other continents (see Yaya et al. 2010: 39–42). As a result of the stinging criticism the two institutions have received from the developing world’s leaders, intellectuals, and health professionals, the IMF has tried to respond by increasing the amount of loans as well as the time they would be available for use. Furthermore, the IMF has temporarily frozen its performance criteria and it monitors the structural conditions through structural benchmarks, while the structural conditions themselves have been reduced from nine to six per grant since the 2000s. In addition, the institution has decreased its “formal ceiling on wage-bills so that the 37% Fund-supported programs in low-income countries contain a wage-bill ceiling as a performance criterion, and only three have indicative, non-binding targets” (see Moghadam et al. 2009).

FAO has also played a significant role in Africa. Beyond helping governments to provide nutritious food to their people, especially children, women, and vulnerable citizens through advice, special projects, and financial assistance, the agency has worked diligently with the relevant ministries of member states to adopt policies that promote good nutritional habits that will necessarily contribute to public health. FAO consists of seven departments that assist Africa: Administration and Finance, Agriculture and Consumer Protection, Economic and Social Development, Fisheries and Aquaculture, Forestry, Natural Resource Management and Environment, and Technical Cooperation. FAO’s budget for the biennial fiscal year (2012–2013) was just over \$1 billion. The funds come

from voluntary contributions by member states and organizations. To the extent that FAO stresses proper nutrition, this UN agency contributes to health and public health in Africa, the reason why it is relevant and crucial. On its part, the Novo Nordisk World Diabetes Foundation, despite its small size in funds and personnel, is a most relevant foundation for Africa, given that diabetes, a chronic disease, is currently affecting millions of Africans. Not only does it contribute to the treatment many Africans would not have but it has raised awareness of the diabetes epidemic on the continent, which no other organization has done so far. In sum, no one in his or her right mind can dismiss the work that the unselfish and impeccably ethical MSF has done in Africa and other parts of the world whenever there has suffering from civil strife and war or natural disaster, such was the case the Ebola crisis in parts of West Africa where the organization deployed a staff of some 2,000 paid and unpaid, national and international volunteers. Virtually in every country that has experienced civil war such as in Angola, Mozambique, Liberia, and Sierra Leone, this humanitarian organization has been present. During the Ebola crisis, MSF lost some of its most dedicated physicians, nurses, and others that were involved in their mission to save lives, while overseeing the affected Africans and treating some 2,760 saving the lives of affected Africans and over half of them.

Since 1977, the UK's Department for International Development has in Africa helped governments to fight malaria, provide vaccines, and improve drinking water and sanitation, with its impact being better gauged in the wake of the effort to stamp out the Ebola virus epidemic in Liberia, Sierra Leone, and Guinea in 2014 and 2015. Here it had its greatest impact through the thousands of effectively distributed hospital and mobile beds it provided and helped to recover, assisting the government, health officials, and health workers relocate and isolate the sick and placing them in safer hospitals and health centers. Beginning in 2009, the Tony Blair Africa Governance Initiative, on its part, has been assisting Africa in training health workers, with some 200 of whom becoming vital in the management of health centers also during the recent Ebola crisis. One of its most significant contributions in this recent crisis has been the collection, analysis, and provision of data, as well as making available critical health information through consistent and substantive briefings. These helped the government authorities and the rescue operators to identify the sources of the disease and the most effective approaches to manage resources and help the sick and those who were still at risk during the

crisis. The AGI helped to highlight the risks of Ebola and find ways to contain its ravages.

Similar remarks can be made about the humanitarian work of the Clinton Foundation's Health Access Initiative which has touched millions of Africans since its establishment in 2002. It has tirelessly contributed to the dispensation of vaccines, while urging and participating in immunization campaigns, especially for children, against TB, malaria, and HIV/AIDS, and providing antiretroviral treatment, while successfully pressuring pharmaceuticals to lower their drug prices on behalf of the poor, the disabled, the sick, and those who cannot afford to purchase life-saving medications. Thus, the international organizations, such as the Clinton Initiative, both individually and collectively have been critical in the struggle to protect the health of the Africans and improve their health systems during the crises as well as under normal conditions. The humanitarian organizations in Africa have so far poured billions of dollars annually, in the hopes of raising simultaneously the consciousness of our, at times, seemingly insensitive, uninterested, incapable, and oblivious leaders in the face of the health catastrophes plaguing their own people, while spending the least of the vast resources in the struggle to stamp out even those epidemics easiest to contain or eradicate, as is the case with several children's diseases including measles and whooping cough.

Where the philanthropic organizations might be faulted perhaps is the lack of more organized and integrated approaches to meet the health needs of the Africans as a unit by agreeing on priorities, on the pragmatic distribution of specific tasks towards for cost-effectiveness and maximum impact, while making an effort to render their mission and work sustainable once funds are withdrawn or become scarce. This may be done mainly through active and focused training of the locals. Above all, however, stands the absolute need for all humanitarian organizations to demand more accountability on the part of the African political leaders and those who manage the health ministries which have often become institutions simply looking for information and dispensing treatment rather than preventing disease. Indeed, they deserve the epitaph of *Ministries of Disease*, as some scholars have suggested. Yet, notwithstanding all their shortcomings, international humanitarian organizations have been and will continue to be vital as long as Africans, for one reason or another, are unable to meet on their own the overwhelming health needs they face daily.

Perhaps some time in the future Africans will finally be able to better manage their resources by rethinking their priorities and, as they say,

“put their money where their mouth is.” Unfortunately, as things stand now in most of the continent, such change will most likely continue to be wishful thinking for the next 50 years. However, this author joins others who agree that the Paris Club has been as disappointing as the IMF and the World Bank with which it works closely. To say the least, it has been a strange and cumbersome organization that has no funds of its own but works in tandem with the two gigantic financial institutions, the debtors, and the creditor countries. Lack of transparency has continued to be a major criticism of this organization. The publication of its by-laws perhaps is the harbinger of better policies to come. Generally, the issue of corruption and international assistance has had many detractors and defenders.

This is the time and place for the author to make a few comments about what is being proposed in the face of the failures that the African continent has experienced since independence. Regarding over-reliance on foreign aid for health and other needs in Africa, some anti-neocolonialists and dependency theorists have suggested that Africa simply stop paying the debt to the institutions they have borrowed the money from and refuse to accept any assistance be it in loans or grants—the reason being that, since Africa started accepting or asking for foreign aid, the level of poverty has continued to rise, economic development has stagnated, and suffering has not abated. Zambian Dambisa Moyo, who once worked for Goldman Sachs and as a consultant for the World Bank, writes in her *Dead Aid: Why Aid is not Working and How There is a Better Way for Africa*, that Africa has been trapped in and has become too dependent on the outside world’s assistance, namely, the Western World, and that things will never improve unless the stream of assistance is stopped. She sarcastically writes: “The four horses of Africa’s apocalypse—corruption, disease, poverty and war—can easily ride across international borders, putting Westerners at just as much risk as Africans. Of course, stolen money sent to European bank accounts can fund terrorist activities; disease, poverty and war induce waves of disfranchisement of refugees and unchecked immigration, which can place inordinate burdens on Western economies” (Moyo 2009: 151).

Obviously, such a non-tenable position is easier said than applied. First of all, killing the four apocalyptic horses, if possible, might definitely end the misery, but these are iron horses that cannot be easily killed and there is no guarantee that other horses, such as ethnic rivalry, nepotism, non-Western-induced corruption, and infectious and chronic diseases that defy all logic would not emerge. Were Africans to simply refuse all aid, refuse to pay back any portion of the loans and relinquish even grants, the whole

health system would collapse, because the trillions of dollars poured into the continent annually would leave a deep crater with not enough dirt to fill it and restore the landscape. With assistance from abroad, both disease and poverty have, in fact, decreased in some corners of the continent. The problem is that they have not decreased as fast as on other continents. Smallpox, yaws, and polio have been eradicated from the continent. The prevalence of leprosy, river blindness and trypanosomiasis is at the tipping point where there is the probability that we can eradicate them during the next two decades. Maternal and infant mortality rates have relatively gone down. This would not have happened without the assistance received from the developing countries, no matter how one feels about the former colonizers. In fact, many Westerners unconsciously see assistance as veiled reparations for the resources they took from Africa to develop their own economies and reduce their own rate of poverty and disease. Africans do not receive the aid at gun point from the West—they are the ones who ask and even beg for it through negotiations.

The relevant question to be asked in the face of the failures in Africa is this: Why is it that Africa still has so much poverty and disease when other developing continents are doing better? The reasons are many. Africa has the least hospitable climate, the most difficult topography, and the least portion of arable land (6%) of all the major continents of the world. Corruption in Africa does not come just from foreign assistance: It is ingrained in the upbringing of many leaders. Thus, if the aid were to be removed tomorrow, corruption would not end. In addition, technology is still slowly trickling down to Africa. Who is responsible for the situation? Rather than advocating radical, unrealistic solutions, it is best to examine how foreign assistance is dispensed to Africans. First of all, the negotiators of the terms are the same people who siphon the funds for themselves, their families, and their cronies and are directly involved in the evaluation and assessment of the outcomes. Impartial and honest brokers, such as intellectuals and the people for which the assistance is targeted, are never present in the halls of the presidential or ministerial offices. Second, accountability is lax, as the donors do not critically and carefully scrutinize how the funds are spent, who benefits, and whether the outcomes are those intended in the first place.

Wherever feasible, this author thinks, all funds provided should be contingent upon the achievement of the desired timelines and realistic measurable outcomes. It would also make sense if most of the aid went to the neediest countries in the developing world. Any country that moves

up to the rank of a high income developing country ought to be given proportional assistance and thus compel it to live within its means, develop its natural resources, diversify its farming and mineral activities, and invest in the citizens' future, an element of development that receives little attention in Africa from both the leaders and the people who have the means to put aside some of their personal wealth. Consequently, what is needed is transparency at the negotiations and during implementation of any project and assessment of how funds are used; clear targets of the funds appropriated; funneling of most assistance to social programs (education and health) and infrastructure building; developing and transferring technologies, which Africans should insist during negotiations of the projects; provision of funds for projects where the recipients must prove their sustainability; insistence on democratic governance where civil society can actually be a witness to the honest use of funds; and, on the part of the givers, ensuring that Africans are not treated as *ignorami*, who do not know the needs of their continent. Donors are admonished to stop the imposed vertical approach to issues that are vital to Africa's well-being and to their common good based on the principle that, even though appropriate to one part of the world, imposed solutions may not be culturally or environmentally applicable.

Praising China, as many Africans seem to do for what it is doing in Africa, is forgetting that Chinese assistance goes mostly to countries that have vast oil and gas reserves and, like all nations, the Chinese are working only in their own interest and not in those that Africans have at heart. Protecting national security and interest is the principle that all nations follow, and it is regrettable that, quite often, African leaders seem to forget this simply common sense international relations goal. Finally, Epidemiology 101 and Demography 101 warn all nations that, if the population goes unchecked, it will continue to choke any attempts at development, education, and adequate provision of health care. Africa is the only continent that is demographically growing carelessly in a world where resources are finite. Finally, posing the question: "Why Aid is not Working" in Africa is tantamount to a tautology, as one has already conditioned the reader to believe that it is not working. Overall, Africa's aid is not "dead aid": it is working, even though it could work much better if the necessary checks and balances were always present. Two African experts, Yaya & Ilekia-Priouzeau, make the exactly opposite point, namely, that Africa needs international assistance to achieve its health goals and that an apportionment of about 7% of the GDP of the industrialized world would go a long way in helping the developing world achieve the MDGs.

What is needed, the two authors say, are more effective partnerships with the developed world, which would be strengthened if the international community provided assistance to sub-regions and regions rather than to the individual little countries. The donors' present approach brings no permanent progress unless Africans are beneficiaries of assistance that permits them to determine, anticipate, sustain, and overcome the obstacles their own health systems face (Yaya and Ileka-Priouzeau 2010: 88).

We need to remember as well that giving is a human virtue, and that true global citizens choose to help others less fortunate by compelling their governments and representatives to show generosity, never forgetting that, when one part of the world improves, there is a ripple effect on other nations because the consequences of disease and ill health affect us all. Indeed, as the adage goes, we need to think globally and act locally. Thus, regardless of how much this author disagrees with the overall policies of the IMF, he still agrees with the World Bank when it notes on the structural adjustments that:

Successful implementation of these reforms implies a fundamental transformation of the role of the state in the African context of weak intense political opposition. Even if the necessary policy reforms can be carried out, adjustment programs will not solve all of Africa's problems. Adjustment can only create the necessary foundation for the resumption of growth. Reducing poverty and improving standards of living will require continuing investments in human capital and infrastructure and improvement in institutional capacity...*Strong leadership and good governance are needed above all*, perhaps, to ensure that resources are used to achieve development goals. (World Bank 1994: 219)

In conclusion, as the WHO says, among other goals, "There is an urgent need to establish accountable and transparent systems to monitor and evaluate health expenditures as health spending from public and private sources increases. Getting this right is one of Africa's big public health challenges" (*African Region Health Report 2013*: 125). Reliance on private donations, especially if faith-based, may soon disappear, and the fact that these often tend to discriminate against certain segments of the population becomes problematic in the long-run. Mbacke is blunt in his criticism of Africa's leadership when he notes that:

The 21st century began hopefully with growing African leadership in the health policy arena and an unprecedented surge in donor assistance for health. But after one decade it is clear that the current situation is not conducive to

building strong national health research systems in Africa. Consequently, the promise of strengthening the health care systems may remain elusive, despite the positive efforts. African countries are not acting to their declarations, and are renegeing on their commitment to take the lead by increasing their investments in health and research for health. Although international support for health has increased substantially in recent years, there has been a continued focus on disease-specific initiatives. Much donor support funneled through international organizations, and country support continues to flow mainly to non-governmental organizations. The guidance of the Paris Declaration and the Accra Plan of Action are being royally ignored with more than two-thirds of donor assistance for health bypassing government. (Mbacke 2013: S15)

One other important prerequisite in Africa's fight against disease, which has usually been ignored, is "inter-nation's" collaboration, given that the frontiers do not protect anyone from cross-border infectious diseases and epidemics. Disappointingly, as the UN says, each African country has its own approaches to "developing national health policy," and that "only a few [e.g., Burundi, CAR, Mauritania, Gabon, and Tanzania], have recently developed or reviewed these policies with WHO support to make their health-care services stronger, more efficient and more widely available" (*African Region Health Report* 2013: 109). In sum, developing national health policies across regions has yet to be done as a "key step towards taking a sector-wide approach" that will contribute in its own way to the survival of our planet, Africa, and its people.

It must be said loud and clear that Africa should not blame NGO international or bilateral state assistance for the failures and the misery in which many of its people find themselves. Assistance is a beautiful and noble thing! Blame it on the way aid is dispensed by our own leaders. The solution is squarely on the shoulders of the African leaders, who are responsible, as Moyo puts it, for Africa's "four horses of apocalypse" pulling the chariot: "corruption, disease, poverty, and war." Indeed, it would be too simplistic and ludicrous to argue that the Bill and Melinda Gates Foundation, GAVI, PEPFAR, WHO, UNAIDS, UNESCO, the Novo Nordisk Diabetes Foundation, FAO, the Global Fund to Fight AIDS, Tuberculosis, and Malaria, the Clinton Foundation, Doctors Without Borders, and other philanthropic initiatives discussed here have made no difference in Africa in terms of preventing and controlling disease and providing antiretroviral treatment for at least 60% of those who need it, while saving millions of lives, preventing a plethora of deadly infections, and helping create awareness for chronic diseases, the second disease burden on the continent. Indeed, assistance to Africa should be mended or fixed but not ended.

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