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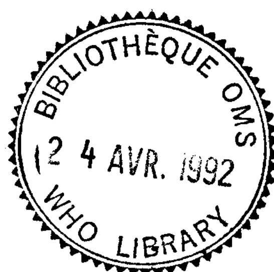
A New Look at Development Cooperation for Health

A Study of Official Donor Policies, Programmes, and Perspectives in Support of Health for All by the Year 2000

LEE HOWARD



WORLD HEALTH ORGANIZATION
GENEVA
1981

A NEW LOOK AT DEVELOPMENT COOPERATION FOR HEALTH

A Study of Donor Policies, Programmes, and Perspectives in Support of Health for All by the Year 2000

by

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WORLD HEALTH ORGANIZATION

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ABBREVIATIONS

ACP	African, Caribbean, and Pacific States eligible for EEC assistance through the Lomé Convention
ADAB	Australian Development Assistance Bureau
ADB	Asian Development Bank
ADB-TASF	ADB Technical Assistance Special Fund
Af. D. Fund	African Development Fund
AFRO	African Regional office of WHO, Brazzaville
AGCD	Administration Generale de la Cooperation au Developpement: official Belgian aid organization
Alma-Ata	Site of the UN Conference on Primary Health Care, 1978
AMRO	American Regional Office of WHO
Arab Fund	Arab Fund for Economic and Social Development
ASEAN	Association of South-East Asian Nations
As. D. B.	Asian Development Bank
Assembly	World Health Assembly
BMZ	Bundesministerium fur Wirtschaftliche Zusammenarbeit: official aid organization (Ministry) for the Federal Republic of Germany
billion	US one thousand million
CDB	Caribbean Development Bank
CDC	1) Carl Duisberg Gesellschaft, Federal Republic of Germany 2) Commonwealth Development Corporation, United Kingdom
CEC	Commission of European Communities
CHP	Country Health Programming, a WHO-sponsored approach to national health planning
CICR	International Committee of the Red Cross
CILSS	Interstate Committee for Drought Control in the Sahel
CMC	Christian Medical Commission, Oecumenical Centre, Geneva
CMEA	Council of Mutual Economic Aid
COR	Division of Coordination, WHO, Geneva
CPD	Office of Cooperative Programmes for Development, WHO, Geneva
DAC	Development Assistance Committee of the Organization for Economic Cooperation and Development, Paris
DANIDA	Danish International Development Agency
DDA	Direction de la Cooperation au Developpement et de l'Aide Humanitaire: official Swiss aid organization
DDG	Deputy Director General, WHO, Geneva
DED	Deutscher Entwicklungsdienst: the German Development Service of the Federal Republic of Germany
DEG	Deutsche Gesellschaftfur wirtschaftliche Zussamenarbeit: the German Agency for Economic Cooperation in the Federal Republic of Germany
DG	Director-General of WHO
DGIC	Director-General for International Cooperation, Ministry of Foreign Affairs, Netherlands
DIE	Deutsche Institute fur Entwicklungspolitik: the German Institute for Development Policy in the Federal Republic of Germany
DMC	Developing Member Country of the Asian Development Bank
DOM-TOM	French Secretariat of State for Overseas Departments (DOM) and Territories (TOM)
EAC	East African Community
EAD	New Zealand Ministry of Foreign Affairs External Affairs Department

ECOSOC	United Nations Economic and Social Council
EDF	European Development Fund of EEC
EEC	European Economic Community
EIB	European Investment Bank
EMRO	Eastern Mediterranean Office of WHO, Alexandria
EPI	WHO Expanded Programme of Immunization
ESCAP	Economic and Social Commission for Asia and the Pacific
ECSC	European Coal and Steel Community
EURO	European Regional Office of WHO, Copenhagen
EUA	European Units of Accounts used in EEC budget calculation
EURATOM	European Atomic Energy Community
FAO	United Nations Food and Agriculture Organization
FP	Family Planning
FRG	Federal Republic of Germany
GNP	Gross National Product
GTZ	Deutsche Gesellschaft fur Technische Zusammenarbeit: the German Agency for Technical Cooperation which serves as the technical implementing agency for aid from the Federal Republic of Germany
HFA	Health for All by the Year 2000
HFA/2000	Health for All by the Year 2000
HRG	Health Resources Group, a multidonor and recipient country committee convened by WHO/Geneva to plan for improved health resource mobilization on a global scale
HRP	WHO Special Programme on Human Reproduction
IADB	Inter-American Development Bank (also referred to as IDB and BID)
IAEA	International Atomic Energy Association
IARC	International Agency for Research on Cancer
IBRD	International Bank for Reconstruction and Development (The World Bank)
ICDDR,B	International Centre for Diarrheal Diseases Research, Bangladesh
ICG	Proposed International Consultative Group on Health Resource Mobilization
IDA	International Development Association
IFAD	International Fund for Agricultural Development
IFC	International Finance Corporation
IGCC	South-East Asia Inter-Governmental Coordinating Committee on Family and Population Planning
IMF	International Monetary Fund
ILO	International Labor Organization
IO	Liaison Office for International Organizations, Division of Division of Coordination, WHO, Geneva
IOTA	Institute of Opthalmology for Tropical Africa, Bamako, Mali
IPPF	International Planned Parenthood Federation
IUSSP	International Union for the Scientific Study of Population
ITC	International Trade Centre
JICA	Japanese International Cooperation Agency
KfW	Kreditanstalt fur Wiederaufbau: Reconstruction Loan Corporation of the Federal Republic of Germany
LOME I and II	The first and second agreements by which EEC extends development support primarily to African, Caribbean, and Pacific States
LDC	Generic term for low income and other developing countries

LLDC	Least-developed countries, generally a country with annual per capita income below $400
Mahgreb	Common term for three North African countries (Algeria, Tunisia, Morocco)
MFA	Ministry of Foreign Affairs
MIC	Middle Income Country
MSA	Most-seriously-affected countries, a term essentially synonymous with LLDC in annual per capital income level
MSAC	Most severely affected country
NGO	Nongovernmental organization, a term which includes private and voluntary organizations
NORAD	Norwegian Agency for International Development
OCEAC	Organization for Epidemic Control for Central Africa
OCP	Onchocerciasis Control Programme
ODA	1) Official Development Assistance (concessional aid) 2) United Kingdom Overseas Development Administration: official U.K. aid agency
OECD	Organization for Economic Cooperation and Development
OECF	Overseas Economic Cooperation Fund, Japan
OOF	Other Official Flows
OPEC	Organization of Petroleum Exporting Countries
ORANA	Office of Applied Research on African Nutrition, Dakar
ORSTOM	Office of Scientific and Technical Research Overseas, French Ministry of Cooperation
OSF	OPEC Special Fund
PAHO	Pan American Health Organization, Washington, D.C.
PHC	Primary Health Care
PQLI	Physical Quality of Life Index
RR	Resident Representative, designation for UNDP Country Staff
SAREC	The official Swedish agency for development research
SEARO	South-East Asia Regional Office of WHO, Delhi
SIDA	Swedish International Development Authority
TDR	WHO Expanded Programme of Tropical Disease Research and Training
UN	United Nations
UNCDF	United Nations Capital Development Fund
UNCTAD	United Nations Conference on Trade and Development
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific, and Cultural Organization
UNFPA	United Nations Fund for Population Activities
UNGA	United Nations General Assembly
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children's Fund
UNRWA	United Nations Relief and Works Agency
USAID	United States Agency for International Development
WPRO	Western Pacific Regional Office of WHO, Manila
WHO	World Health Organization
WHO/HQ	World Health Organization/Headquarters, Geneva
WFP	World Food Programme
WPC	WHO Country Representative. The equivalent abbreviation for the PAHO region is CR (country representative)

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FOREWORD

In 1977 an historic moment in health development was reached when the Thirtieth World Health Assembly decided in Resolution WHA30.43 that the main social target of governments and the World Health Organization in the coming decades should be ... "The attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life." The declaration of Alma-Ata adopted on 12 September 1978 singled out primary health care as the key to attaining this health target. Subsequent sessions of the World Health Assembly and the Executive Board have discussed and refined the strategies to be applied and in so doing have made clear that--while Health for All is to be attained within countries--international collaboration and support will be vital.

As the coordinating authority for health development, it devolved upon WHO to study the existing North/South transfers for health as a first step toward ensuring that such transfers are used to best advantage. In order to solicit the views of external sources of funding, WHO invited the author to meet informally with a selected number of development agencies and financial institutions. This monograph presents the author's findings and observations and is a pioneering effort in a complex field which will help WHO and its member states to gain a better understanding of the problems and functional requirements of resource transfers. From this first effort and from discussions with WHO member states, official development agencies, and nongovernmental groups participating in the Health Resources Group for Primary Health Care, it is hoped that a mutually acceptable system to accelerate the magnitude and improve the application of resources can be defined. Without such a system, the achievement of Health for All by the Year 2000 may prove more difficult.

Division of Coordination
World Health Organization
Geneva

PREFACE

In 1979 the goal of Health for All by the Year 2000 was approved by member countries of the World Health Organization and the United Nations. Such a challenge calls for an unprecedented effort to mobilize financial and technical resources. Although the primary commitment to both goals and resources is the ultimate responsibility of each participating nation, the appeal for external public and private resources had been made explicitly clear.

In view of an uncertain world economic outlook for the coming decade, a healthy skepticism is often expressed in unofficial discussions regarding the prospect of achievement of such a goal in so short a time. Although there is emerging consensus on technical objectives and strategies to meet the challenge of HFA, there is less agreement on its economic feasibility within the next two decades. What then can realistically be done to mobilize resources both within and external to countries-in-need to achieve minimum access to health services and outcomes for the world's majority? How is the bill to be paid? Who will pay?

There are economic predictions which describe the general development outlook by the end of the century. On the other hand, there is no established information system of world-wide scope on which to base an economic assessment for health purposes. To ascertain the economic feasibility of HFA/2000, great importance should be attached to direct examination of general development policies and programmes of external financial assistance organizations with particular attention to health or health-related components. Two reasons for this importance are: 1) multisectoral development resources of official multilateral and bilateral development organizations constitute the major external sources for international health efforts, and 2) the health component within development funding may be most critical for the success of HFA within the relatively short time remaining between now and the end of the century.

The complexity and total scope of resource identification, which would include some 50 official sources and as many as 1000 nongovernment organizations, is the task for an international resource mobilization system, a system yet to be established. A comprehensive assessment of economic feasibility would require not only parallel study of the potential domestic resources available within countries-in-need, but also a determination of each country's practical economic commitment to the health needs of its own people.

The Study herein described confines itself to one dimension of a complex, ongoing developmental transition: the policies, programmes, and perspectives of official development organizations in relation to health. It is an early effort to illustrate the magnitude of the problem of external resource generation, to understand the practical requirements for providing support on such a major scale, and to suggest some of the practical alternatives by which it can be accomplished.

Economic and social interdependence between developed and developing countries is an accepted fact. The required partnership and cooperation between countries is more appropriately expressed as "development cooperation." To simplify the description of resource transfers without perjorative connotation and to avoid artifical or extended semantics to connote external sources for financial concessionary assistance, the terms "donor" (in the sense of "source") and "recipient" are used throughout the Study.

The Study makes no value judgements on external assistance nor does it attempt to review the already extensive literature on the pros and cons of development cooperation in its more general multisectoral aspects. In view of the resolutions of the World Health Assembly and the UN General Assembly, it is assumed that a global consensus on the need for resource mobilization has already been formally approved by all participating nations, irrespective of geographic or political orientation.

The Study is presented in four parts. PART ONE serves as an introduction. Major issues in resource mobilization are discussed, recent trends in resource mobilization within WHO are reviewed, and the Study background, process, and data sources are described. PART TWO

presents a cross-sectional analysis of individual profiles of sixteen interviewed donor agencies and institutions. Each sectional analysis (I through XII) is documented with excerpts from corresponding sections in individual donor profiles. PART THREE contains the Study recommendations. Individuals profiles of the sixteen donor agencies and organizations are arranged alphabetically in PART FOUR.

The Study can only be a preliminary exploration of external resource potential. In the absence of an organized system to provide continuous study and updating in a rapidly changing development environment, it would not be expected that the outcomes of this Study could provide more than a conceptual framework for future activity. The reader will note, for example, that many officials named in the profiles have already transferred to other assignments. However, the continuously changing picture of development cooperation is, in itself, an important fact. Maintaining reasonable currency and understanding in the face of rapid change precludes the possibility that this is a task for any one individual. Recognizing that the subject merits far greater attention and the inclusion of a larger and more representative sample of potential donor countries, it is only fair to acknowledge that the interpretations of discussions with donors and viewpoints expressed are those of the author and do not necessarily reflect those of the World Health Organization, the US Agency for International Development or those of governments and organizations which so kindly cooperated in this effort.

ACKNOWLEDGEMENTS

The author is indebted to many sources for generous support, cooperation, and advice: to the World Health Organization and the Director-General, Dr Halfden Mahler; to the staff of WHO Division of Coordination in Geneva and in particular to its Director, Dr John L. Kilgour, who arranged for the author's consultant travel to donor organization headquarters; to Mr Paul Lawton, Miss M. O'Doherty, and other Division staff who provided warm support for a cold midwinter journey to ten European cities (and five warmer Asian and Pacific climates); to WHO Regional Offices in Copenhagen, Delhi, and Manila who welcomed inquiries and paved the way for visits to donors; to busy officers in many donor organizations and health ministries who graciouly shared their time and informal viewpoints; to the members of the WHO Health Resources Group who reviewed the findings of the Study; to the Institute for Development Studies, University of Sussex, which welcomed access to library facilities and faculty discussions; to the US Mission to the Organization for Economic Cooperation and Development and to the Secretariat of the Development Assistance Committee of the OECD in Paris for logistic and statistical support during the preparation of the first draft report; to Mr Dan Shea and Ms Madelina Hayes of the AID Audio-Visual Arts Division who arranged for many graphs, tables, and other art work; and to Ms Gwen Tjossem who patiently served as the critical point for communication throughout the twelve-month absence from Washington.

Arrangements for final editing, typing, and word processing for a camera-ready copy were made possible by the Pan American Health Organization through the kindness of Dr Hector Acuña, Director, Dr S. Paul Ehrlich, Deputy Director, and Dr J.M. Salazar, Chief of the Liaison Office. Illustrations in camera-ready form were prepared by Mr Vincent P. Lockett of the graphic arts section of the Organization of American States. Ms Karin Skeldon undertook the difficult task of retyping revised portions of the manuscript.

Given the new and exploratory scope of the Study, the number and geographical dispersion of donor consultations, and the time constraints, the preparation of a detailed report and analysis proved to be a challenge. The author is particularly grateful to Ms Maxwell C. Howard for professional assistance throughout the Study in rewriting, editing, and organizing the draft report and for the time-consuming technical task of preparing the final manuscript for publication.

The Study was made possible by the US Agency for International Development through an overseas Development Fellowship Award which authorized twelve months of professional leave and the necessary financial support to cope (almost) with European inflation. The author acknowledges with thanks the support of Mr Daniel F. Creedon and his staff in the AID Training and Development Division which sponsored the Fellowship program.

The period of study coincided with parallel efforts by the World Health Organization's Health Resources Group during calendar year 1980 to assess alternative mechnisms for external resources mobilization. In a joint effort to obtain the views of selected donor organizations, the Director-General of WHO retained the author as a consultant for approximately three months and financed the necessary travel to hold informal consultations and the production of this document.

EXECUTIVE SUMMARY

EXECUTIVE SUMMARY

PART ONE: INTRODUCTION

I. MAJOR ISSUES AFFECTING RESOURCE MOBILIZATION for Health for All by the Year 2000

In May 1979, the World Health Assembly declared "overriding priority" for "the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life" (HFA/2000*). In defining the terms of this unprecedented challenge, the Assembly agreed that the objective could not be attained by the health sector alone, that a global mechanism for attracting bilateral and multilateral resources was essential, that global information exchange on HFA/2000 should be established, and that WHO should play a major role in catalyzing the cooperation of the world's resource potential.

Are the risks and the costs of this challenge fully appreciated? Success will depend on technical objectives and strategies not yet fully determined, on the mobilization of financial and professional resources not yet committed and on mutually-agreed-upon systems for multilateral and bilateral coordination which have not yet been established.

Within the time frame of twenty years, the initiative is relatively young. The total time frame is short. In anticipation of variance in country interpretation of HFA/2000, are the official objectives sufficiently clear? Are the multiple developmental factors influencing national health understood? Have global resources been identified? In view of expected country variations in goal definition, what are the resource requirements? In view of global economic stress, what is the realistic outlook for resources over the next two decades?

II. TRENDS IN RESOURCE MOBILIZATION for World Health Assembly Priorities

Historically, under the terms of its constitutional authority, WHO has provided greater attention to technical coordination than to global resource mobilization. Current WHO budgets represent approximately 10% of total estimated global external resource flows for the traditional health sector. In view of the limited outlook for significant expansion of this proportion of international flows through the Organization, an active role in the promotion of global resources for HFA/2000 suggests the need for new functions and structures to understand and cooperate with international resources which are not currently under the direct jurisdiction of the Organization. To examine the issue of increasing external resource flows, the Organization launched a health resources mobilization group (HRG) in late 1979.

III. A STUDY OF DONOR POLICIES, PROGRAMMES, AND PERSPECTIVES: Background, Process, and Data Sources

A considerable international health resource flow is already in progress. It is estimated that over fifty official donor agencies plus a very large number of nongovernmental organizations are transferring an estimated $3 billion annually to recipient countries. Recipients themselves are sending an estimated $14 billion of their own resources in the health sector.

A comprehensive understanding of the current international cooperation in health would require a review of donor as well as recipient policies, processes, and programmes. Such a review would preferably include all potential donors. Health and health-related development sectors such as agriculture and education should also be examined.

* Health for All by the Year 2000

In view of the Assembly's specific appeal to international funding agencies, it was agreed jointly by the author and the Division of Coordination, WHO/Geneva, to begin by seeking the cooperation of selected external donor agencies in order to understand, through informal consultations, their views on support of health initiatives and, in particular, HFA/2000. The intent was to characterize and illustrate the problem rather than to provide an exhaustive review of all potential public and private resources, a future task for a continuing and established resource mobilization group.

The Study was conducted over a period of twelve months (August 1979 to August 1980). An initial review of multidonor and multisectoral literature on health was carried out at the Institute of Development Studies, University of Sussex, where the author served as a Visiting Fellow. In the second phase, as a consultant to WHO, the author held direct and informal consultations with over twenty-one donor agencies and organizations and two hundred individuals in Europe, South-East Asia and in the Western Pacific. For the final report, sixteen separate country profiles* and a cross-sectoral analysis of findings were prepared.

Within the brief period available for each donor consultation, it was not feasible to obtain a comprehensive and authoritative view. Collectively, however, the consultations illustrate some of the principal features and trends of donor policy and practice. In spite of excellent cooperation from donors, health policies and programmes are often organized within geographic area administrative structures. Development agencies and banks are not health agencies per se. There were, therefore, difficulties in accurately identifying official compilations of health-specific data. An appreciation of trends and problems, nevertheless, serves to clarify those steps which may be necessary should the World Health Organization or any alternative agency seek actively to promote the mobilization of resources for HFA/2000.

PART TWO: A CROSS-SECTIONAL ANALYSIS OF ILLUSTRATIVE DONOR PROFILES

I. ASSISTANCE POLICY

In response to the multisectoral characteristics and requirements of national governments, most donor agencies and organizations which support health are essentially multisectoral in organization. To understand the health perspectives and practices of a given donor, general development policy must be understood first.

Development Policy

All interviewed donors subscribe to the policy that no sector, including health should be excluded a priori as a target for appropriately designed assistance.

Eligibility for health assistance, as for other sectors, is dependent largely on whether the recipient country makes a fundable request which has the approval of the recipient's national planning authority.

Most donors accept that health is an inherent part of general development. Preference is placed on recipient requests which permit concurrent development in more than one sector.

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* Profiles were prepared on official donor agencies representing the Asian Development Bank, Australia, Austria, Belgium, Denmark, European Economic Community, Federal Republic of Germany, France, Japan, Netherlands, New Zealand, Norway, OPEC Special Fund, Sweden, Switzerland, United Kingdom.

Health Policy

All donors directly or indirectly now support international health programmes. Few parliamentary authorities or governing boards have specifically singled out health as a formal area for support. However, eight of sixteen donor organizations have formal statements or guidelines in support of the health sector.

II. DISTRIBUTION OF BILATERAL ASSISTANCE

With few exceptions all interviewed official government donors now engage in general development assistance within all WHO geographic regions but not in all countries of each region. The Asian Development Bank and African Development Bank work in three WHO regions. The Inter-American Development Bank is limited to the Western Hemisphere.

The Study illustrates with maps the geographic distribution of donor assistance.

Among thirty multilateral and bilateral donors, only five report health assistance in more than half of their national assistance agreements. In view of the policy acceptability of health, the potential for increasing health assistance is substantial. This observation suggests that recipient countries may not provide health sufficient priority in their official requests for external assistance.

The sixteen recipients of health assistance from the largest number of official donors (seven to twelve per country) are those who are the largest recipients of general development assistance. A vigorous national programme for overall development may offer the most receptive framework for accelerating international cooperation for health.

III. DISTRIBUTION OF MULTILATERAL ASSISTANCE

The Study does not assess geographic distribution of multilateral organizations (with some exceptions) since the health-related institutions are global in character (WHO, UNICEF, UNDP, IBRD, and the Regional Banks as a group). The aspect examined is the degree to which bilateral donors support the work of multilateral organizations.

Collectively, bilateral donors from industrialized nations provide about one-third of their development as assistance to multilateral organizations. In absolute terms, the contributions now stand at $1.6 billion of which US$32 million went to WHO(1979)* and $126 million to UNICEF.

While the trend among official donors is to support and increase contributions to UN organizations, there is no evident trend to suggest that collective contributions will increase significantly beyond an average one-third of all contributions. Bilateral donors will continue to allocate a major share of assistance directly to recipient countries.

IV. ASSISTANCE TO NONGOVERNMENT ORGANIZATIONS

An estimated 3000 NGOs mobilize on the order of $1.5 billion of their own resources for international assistance in general. Allocation of their resource for health purposes is not known with accuracy due to limited documentation of NGO programmes in a global sense. It is estimated that as much as one-third of total flows are in health-related fields, possibly $500 million. To this total, official donor agencies collectively provide an estimated $200 million through grants and co-financing arrangements.

The long experience and credibility of many voluntary agencies in the health field warrants greatly expanded efforts to assure their participation in the HFA/2000 objective. A greater effort should be made to ascertain and document current and potential resource flows for health from the private sector within both donor and recipient nations.

* Data excludes official assessed contributions of member countries to WHO.

V. TYPE OF DEVELOPMENT ASSISTANCE

All interviewed donors provide assistance in health, education, social infrastructure, trade, banking, construction, agriculture, public utilities, plannning public administration, industry, and mining. The precise configuration of assistance depends on the nature of the recipient request.

Specific content varies from debt relief, to provision of commodities, budget support and technical advisory services (technical cooperation) for planning, training, and managerial assistance.

It is relevant to the HFA/2000 purpose that international sources provide, in addition to health support, parallel support to critical sectors which offer productive employment: food production, education, and general development planning. This broad development approach permits the precondition for improvement in the health of a nation.

Characterization of development is not novel. Of greater importance is the operational acceptance by national and international health authorities that the achievement of HFA/2000 cannot be accelerated without greater specific attention to concurrent acceleration in the critical nonhealth sectors which support the achievement of health results.

Within the traditional health sector, the qualitative range of assistance is wide. Donor preferences are influenced significantly by recipient preferences. In spite of continued progress in support of primary health care, most recipient governments have not as yet formally restructured their national plans along lines of HFA/2000. Traditional requests, with bias towards institutional medicine and infrastructure development, predominate.

In the gamut of potential cooperation between donors and recipients, the single most obvious need is for increased emphasis on national health planning. For lack of planning facilities, methodology, and trained personnel, the fundamental ability to identify and plan for HFA/2000 requirements is seriously diminished.

VI. DEVELOPMENT FUNDING

The two predominant sources of external funds for health are the multilateral and bilateral development agencies and organizations. The potential for accelerating and increasing resources for health requires an understanding of trends in development funding.

Table VI-7 (page 182) summarizes contributions from various sources. Among the essential points, resource flows in 1979 totalled $81.9 billion. One-third of this amount ($29.9 billion) is derived from official development assistance (ODA) which represents funding by grants or concessional loans. Two-thirds of the total is derived from nonconcessional sources.

Concessional aid (ODA) is the primary source for assistance in the health sector. In 1979, $24.2 billion of $29.9 billion derived from the DAC countries (17 industrialized countries of the Development Assistance Committee (DAC) of the Organization for Economic Development and Cooperation). Another $4.7 billion was contributed by OPEC countries. The countries of Eastern Europe (CMEA) contributed less than $1 billion.

Concessional aid (ODA) from DAC countries is predominantly and increasingly provided in the form of grants and technical cooperation (technical advisory services). Two-thirds of such assistance is concentrated in low-income countries.

The traditional health sector receives on the order of 8-10% of total ODA flows; however, larger allocations to agriculture, education, food aid, and general development support are directly contributory to national health improvement.

Sectoral allocations for health or other sectors infrequently represent predetermined donor preferences but rather the consequence of donor-recipient negotiations based on recipient proposals. Consequently, priorities for the use of donor funds are subject to considerable flexibility.

Collectively, donors continue to argue for increasing the total flow of ODA. The prospect for increased development funding over the next two decades will depend on donor perceptions of the balance between the need for international economic interdependence and the realities of domestic inflation, energy shortages, and employment policies.

VII. HEALTH FUNDING

Variations in donor reporting patterns and sector definitions preclude precise estimated of total health flow. On the basis of available data, the estimates for total flow in 1978 was approximately $3 billion as shown in Fig. VII-1, page 214.

No individual bilateral or multilateral donor contributes more than 14% to total health assistance. Although very large World Bank investment in water supply, if defined as health, would make the Bank the largest single donor, the more accurate perspective is that there are no overwhelmingly predominant donors for health. The fact that the health sector as a whole is the fourth largest sector of investment is an indication of recipient national priority.

The contribution of the World Health Organization (10%) to the total health flow is relatively modest. The way in which the Organization uses its limited resources to promote the more efficient use of the larger non-WHO flow may be more significant in the long term than promotion of directly sponsored and managed intramural WHO programmes.

The outlook for increasing the total flow of health resources is related intimately with the outlook for increase in all development resources. It is evident, however, that there is substantial room for increasing health flows within the currently available $30 billion ODA each year for all development purposes (Fig. VII-2, page 215). A major factor for increasing health flows is the success with which recipients are able to define their own needs, formulate proposals and obtain the approval of national planning commissions (or equivalent authorities) for submission of such proposals to donors.

Donors favor the development of a more active and catalytic role by WHO, including PAHO, to assist countries to develop their own capability to identify, formulate, justify, and present national health requirements through the approved national development process. The WHO system offers available on-site professional manpower not available to the same extent by development assistance agencies.

On the basis of estimated requirements for external assistance to achieve primary health care objectives, the Study concludes that the outlook for resources is adequate subject only to the effective management of external need definition by recipient countries and the equally effective utilization of available national and external resources. The absence of cost estimates for PHC or HFA/2000 for most recipient countries precludes either precision or prediction beyond noting the favorable potential.

VIII. PROGRAMMING PROCESS

The programming cycle is highly specific to each donor and recipient. Familiarity with detail is important for the objective of resource acceleration. See Fig. VIII, page 235.

As a basic pattern, health requests are normally included as an inherent part of national development requests. The normal channel for the recipient is to forward proposals through its national planning commission or equivalent authority. Normally, donors respond only to national requests which are officially endorsed; consequently, great emphasis is placed on the recipient government's internal process for justifying health proposals in competition with other development priorities.

Exceptions include recipient country requests made directly by the ministry of health through its WHO or other UN representative to the intended UN agency. The route, while valuable, permits access to no more than 10% of the potential donor resources since 90% of external resources are administered by the bilateral agencies and the large multisectoral banks. A second important exception is the direct request from the national private sector to NGO external sources.

On the donor side of the cycle, the total number of officials with specific health responsibility are few when compared to the professional staff of UN agencies, the WHO in particular. Among eighteen major bilateral donors, twelve have no field health representative and nine have no health professional staff at headquarters.

Allowing for many exceptions in actual practice, the key constraints to accelerating the flow of resources may be characterized as follows:

1. Most ministries of health lack the professional capability for needs identification, determination of internal versus external requirements, the design of proposals for external funding and the defense of such proposals before the national planning commissions in competition with other sectoral needs.

2. External representatives, multilateral and bilateral, are seldom oriented towards helping governments to expedite national health requests in contrast to development of donor-specific projects.

3. WHO representatives, in particular, are engaged more actively in helping governments formulate WHO-specific projects than in aiding governments to mobilize external resources regardless of source.

4. Recipient governments continue to have significant managerial difficulties in disbursing and utilizing external resources effectively.

5. Most recipient governments and their current resident advisors are unaware of the number of potential external sources.

6. Most donors do not receive timely information on recipient health requirements.

IX. ORGANIZATIONAL STRUCTURE

Within donor countries or organizations, where is official responsibility for health cooperation located?

The Study presents tabular data to indicate the responsible authority which, with few exceptions, is the ministry of foreign affairs. In the case of Banks, Funds or UN organizations, authority lies with a constituent assembly and is represented by a board.

Administration of external assistance is largely in the hands of semi-independent development cooperation authorities which are responsible to their foreign ministries or their equivalent for policy and budget review.

In cooperating countries, resident donor missions may number from eight to twelve, supplemented by embassy services.

Health professional staff at donor agency headquarters is limited. Staff in cooperating countries is even more limited. For a few donor countries, however, technical advisory personnel working directly on projects are substantial in number.

Only two donors rely regularly on the services of the ministry of health in the donor country. This organizational distinction between donor-country ministry functions may explain why the message and debate of the World Health Assembly and its committees, being represented by ministers of health, may be inadequately communicated to donor agencies in ministries of foreign affairs which have the authority and responsibility for administration. As evidence, half of the sixteen donors visited in the Study were only marginally familiar with the rationale or urgency of the HFA/2000 initiative.

The Study suggests that each donor-country ministry of health (or equivalent) should assume a more active advocacy role for HFA/2000 in relation to development authorities in their respective countries.

X. DONOR PERSPECTIVES ON HEALTH FOR ALL BY THE YEAR 2000

There is policy consensus among interviewed donors on the eligibility and desirability of support for improving national health conditions in developing countries. For many donors, policy and programme support for a basic human needs approach preceeded the 1978 Alma-Ata conference by many years.

Organized and separately identifiable programming in specific support for "Health for All" (HFA) is not as yet a characteristic of most donor activities, frequently because components of HFA already exist under other health categories. While there are no constraints in principle against a more identifiable HFA content, it would appear that official donor organizations are not always as fully informed on HFA content as their health ministry counterparts in the same country. In order to plan effectively for greater technical and financial support for HFA, donors would welcome closer collaboration with their health ministry counterparts in the work of the WHO and its Assembly. In this respect, health ministries may wish to exert a more active promotional role to strengthen donor country commitment through joint interministerial cooperation and planning.

An increasing number of donors indicate preparedness to provide additional support subject to formal requests by countries-in-need. Donor agencies, which have the official authorization and financial responsibility for administering health cooperation activities with developing countries, continue to ask practical and necessary questions on implementation.

- Are the goals of Health for All adequately defined?
- Are the definitions, as presented by the Assembly, subject to misinterpretation in the form of expectations?
- Is health improvement likely to occur without concurrent investment in general development?
- Does WHO have documented and evaluated experience upon which to base its expectations by the Year 2000?

XI. VIEWS ON ACCELERATION AND COLLABORATION

Over the past decade, external financial organizations have collaborated in joint efforts to expedite the process and rate of disbursement for general development purposes, including health. Systematic and specific donor efforts to accelerate health programming, as distinguished from general development, have not received special global attention. In view of the officially-accepted interdependence between health and general economic development, there is a recognized need for accelerating all basic human needs components. Can a strategy for Health for All be accomplished in the absence of a concurrent strategy for expediting general development?

As to the Health for All objective per se, there is a policy consensus on the need for acceleration although there are differences of opinion of the rate at which such a goal is likely to be achieved. There is also consensus that combined donor/recipient country resources are adequate to meet the minimal requirements for primary health care providing that acceptable mechanisms for resource mobilization can be established.

Major constraints in rates of disbursement and utilization at the recipient country level include the following:

1. Poor project identification and preparation
2. Poor defense of health projects vis-a-vis other sectoral demands
3. Inadequate effort to obtain national planning commission approval
4. Limited continuity in self-reliant health sector planning

Important constraints to acceleration at the donor organization level include the following:

1. Multiplicity of approval procedures
2. Limited numbers of multisectorally-trained health personnel
3. Limited systematic cooperation between donors for common health objectives

Donors acknowledge that joint donor/recipient cooperation is essential for improved aid implementation. Accountability for health sector acceleration lies with the recipient countries which, in the last analysis, have the responsibility for determining their own health affairs.

The largest proportion of currently available global financial resources for Health for All are those which are available within recipient countries themselves. The effectiveness and quality of external aid depends, therefore, upon the quality of recipient country planning and commitment.

For high-volume acceleration of external assistance, health requirements should be planned as an inherent part of general development requirements. Effective donor response requires that proposals be submitted by recipient country development planning authorities (or equivalent).

In the absence of a current international system for health resource mobilization, new forms of donor/recipient collaboration should be fully explored.

For resource acceleration, the suggested functional requirements for recipient countries include the following:

1. Improve the quality of health sector planning through training, experience, and information exchange between countries and international organizations

2. Define more explicitly national commitment towards Health for All

3. Keep currently informed on potential global sources of external financial and technical cooperation

4. Identify specific projects consistent with national development planning

5. Improve the quality of project preparation, including project justification in relation to other national sectors

6. Process proposals through the national development authority as the primary channel for major external resource increases

7. Participate with external financial organizations in rationalizing allocation of resources for Health for All objectives

8. Make the fullest use of WHO, UNICEF, and UNDP assistance in programme design, project identification, preparation, and justification

9. Participate in the development and use of a new international system to match needs more rationally with potential resources

10. Take greater advantage of project preparatory funds which are readily available from numerous external donor sources

For resource acceleration, the suggested functional requirements for <u>external financial and technical cooperation organizations</u>, (multilateral and bilateral) include at least 6 points:

1. Engage in major retraining of expatriate personnel and advisors for orientation towards

   a) The health/development relationship

   b) Programme preparation and justification

   c) Donor programme procedures

   d) Potential donor and recipient country resources

   e) Information exchange procedures

2. Encourage and support a new and more assertive role by UN agencies (WHO, UNICEF, UNDP) at the country level for the purpose of assisting governments with programme planning, identication, justification, and presentation

3. Assess and apply the comparative advantages of the UN versus non-UN organizational potential. Given the large volume of external assistance required, donors perceive that the comparative strength of WHO is to assist requesting countries in needs assessment, project preparation, and project approval at the national level. The comparative advantage of the donor is bilateral negotiation and implementation of well-prepared projects with continued cooperation of WHO at the project level

4. Develop a mutually acceptable system for regular exchange of programme and financial information on needs and resources

5. Analyze, jointly with recipients, alternatives for increased efficiency of resource utilization

6. Develop, jointly with recipients, a new and systematic global mechanism for matching needs with resources

XII. VIEWS ON THE ROLE OF WHO

The World Health Organization continues to be highly regarded for its technical prestige, political neutrality, and programme initiatives in support of global health priorities. Donor representatives welcome a WHO role which, with the agreement of governments, provides major guidance to governments in health sector planning, needs identification, project preparation, presentation, and definition of external financial requirements. On the other hand, donors which have major programming and implementation responsibilities for the use of development funds, as authorized by respective parliaments, legislatures, and governing boards, ask if WHO would seriously consider serving beyond its traditional technical advisory functions in order to catalyze and accelerate development funding for health objectives.

On the potential, new catalytic resource mobilization role, donors pose largely unanswered questions.

- Is WHO able to distribute evaluated experience on 'what works' in Primary Health Care?
- Could WHO provide the required health/development training to reorient national and expatriate personnel working towards HFA?
- Is WHO prepared to revise its own organizational structure to provide time, attention, and essential staffing for financial mobilization?
- Is WHO prepared to serve as the global focus for gathering, analysis, and dissemination of donor and recipient programme and financial data?
- Would WHO be prepared to respond to government requests with sufficient rapidity to meet the needs for project preparation prior to the annual lapse of donor funds?

Such questions, asked in good faith, do not affect the underlying willingness of donors to accept WHO as the appropriate coordinating focus for HFA resource mobilization. Donors recognize their own limitations in expediting health planning at the country level. The questioning and reserve of donors reflects their own legal accountability for programming commitments of development funds and their uncertainty that WHO, which does not have constitutional responsibility for development coordination, would be prepared to make an organizational commitment for necessary staffing and functional changes to influence significantly the global flow of development resources for HFA goals.

PART THREE: RECOMMENDATIONS FOR A GLOBAL RESOURCE MOBILIZATION SYSTEM

The central recommendation of this study is that significant acceleration of international health improvement during the next twenty years will require a more formal and systematic resource mobilization system than presently exists.

I. BASIC ASSUMPTIONS

Member states of the World Health Assembly already agree on the following points:

1. Health for All by the Year 2000 is an overriding priority
2. Resource acceleration is required if HFA is to succeed
3. Health is an inherent component of development programming
4. Regional and global information exchange on needs and resources is essential for HFA planning
5. A global mechanism for resource mobilization is essential
6. WHO has a constitutional responsibility to bring into being the necessary cooperative mechanisms to support Assembly objectives

II. IMPORTANT CONSIDERATIONS

Approximately 90% of estimated global external resources for health are derived from sources other than WHO.

The preponderant source of external funds for health is multisectoral and developmental in purpose. A new cooperative framework must take into consideration that no single source or international institution holds constitutional authority over the spectrum of available development funds.

Although international consensus confirms that WHO should play the leading catalytic role in health resource mobilization, success of a global programme will require the fullest cooperation from development-oriented multilateral, bilateral, NGO (private and voluntary), and other government institutions which must necessarily remain accountable to their own legal and constitutional authorities and to their cooperating partner countries.

As of early 1981, the WHO, including its regional offices, had not yet established a structure or function with the capability of mobilizing resources on a global scale for Health for All.

A key advantage of WHO, in comparison with other international multilateral and bilateral institutions, is its universal distribution and large number of professional staff (approximately 2500 worldwide).

III. FUNCTIONAL REQUIREMENTS

To accelerate the rate of resource mobilization for HFA/2000, the following functional requirements are proposed:

1. Establishment of a data management system to identify donor health resources
2. Establishment of a data management system to identify recipient country needs and resources
3. Analysis and rationalization of resource flows
4. Mobilization of resources through matching of needs with potential resources
5. Training for resource mobilization

Essential associate requirements are: 1) monitoring and evaluation of progress in the acceleration of resources, 2) administering the PHC Initiative Fund for seed and catalytic actions, and 3) the active promotion of resource mobilization based on the foregoing functions.

IV. ADMINISTRATIVE ARRANGEMENTS

Context

In view of the varying (and largely development oriented) sources of external funds for health, the nucleus of a new system should be a consultative group of donors, recipients, and international organizations convened by the Director General of the WHO. The title of the group should reflect this context (for example: "Consultative Group on Health Resource Mobilization").

Membership

The Group should include representation from multilateral, bilateral, UN, and NGO potential sources, and from recipient countries by geographic regions.

Structure and Function

While the proposed consultative group would meet once or twice annually, the work of the mobilization system would be the responsibility of a formal structure characterized by a full-time Secretariat at WHO/Geneva, by comparable supporting units in WHO Regional Offices, and by retrained UN and WHO staff at country level.

The Secretariat would be established under the direct authority of the Director General of WHO. To convey the multidonor/multicountry consultative and cooperative role of WHO in promoting the resource mobilization, the Secretariat would be placed in relation to the Director-General in such a way as to avoid perception that international financial cooperation for Health for All is an intramural programme of WHO. Counterpart Secretariats or resource mobilization units would be established in each WHO regional office under the authority of the regional director.

Functions of the WHO/HQ Secretariat would include preparation and updating of guidelines for the following:

1. Donor and recipient information systems
2. Analysis and rationalization of global needs and resources
3. Matching resources to needs
4. Mobilizing resources
5. Training
6. Evaluation

The predominant central operational functions would include systematic collection of donor resource and programme information, the analysis and matching for interregional HFA programmes, global monitoring and evaluation.

WHO regional offices would, of necessity, be the organizational focus for gathering HFA needs requirements from regional member countries, for analysis of regional needs in relation to potential resources, for assistance to member countries for preparation of fundable programmes, for encourging negotiation between countries and external sources, and for training regional and country WHO and non-WHO personnel.

Underlying all administrative arrangements is the original context that the coordinating functions of WHO require that it systematically promote cooperation among representatives of all external sources through consultation at headquarters, regional, and country levels.

The full text contains illustrative details of administrative arrangements at headquarters, regional, and country levels.

Financing Arrangements

Total estimated costs for an operational global system would be of the order of $1.5 million annually. The total cost would be one-third of one percent of the current annual total WHO budget of approximately $400 million. Costs could be reduced through detail of personnel from participating organizations. It is assumed that a staff service, such as the HRG system implies, would rely in a major way upon services provided by other WHO technical divisions and offices at the headquarters, regional, and country levels.

In view of the constitutional role of WHO in promoting coordination and the special requirement of WHO to support Health for All as an "overriding priority", resource mobilization should be considered as a central activity of WHO. Source of funding could, therefore, be a legitimate requirement from the WHO Regular Budget or, alternatively, a specially established Trust Fund to which participating donors and international organizations might contribute.

Accepting that the administration and programming of an estimated $3 billion in development-related funds will remain the primary responsibility of the various sponsoring multilateral, bilateral, NGO, and UN agencies, a new mobilization system coordinated under the auspices of WHO will not be required to manage or administer ongoing or new funds other than a relatively

small administrative fund for staff and catalytic purposes. A new system does not require the provision of technical advisory services as distinguished from building up the reorientation of current national and international personnel to carry out new functions.

The proposed system is primarily a data management and analysis system to identify needs and sources, to catalyze, facilitate, and promote the acceleration of resource flows. Essentially it is a system of strategic planning for financial and administrative support to achieve Health for All.

A new system does not propose duplication or competition with other funds. The measure of progress is the rate and distribution of resource flows for HFA, regardless of source or organizational sponsorship. Evaluation of progress is a joint donor/recipient/international function.

PART FOUR: ILLUSTRATIVE DONOR PROFILES

Sixteen illustrative donor profiles were developed, based upon informal consultations with representatives of donor agencies, ministry of health officials, and a review of available current data.

Within the brief time allotted for individual donor consultations, a full and comprehensive official view of health assistance was not feasible. The resulting profiles are preliminary notations which attempt to identify some of the principle features of donor policy, programme, organizational structure, and process. It would be expected that material gathered from informal consultations and current official literature would become rapidly out-of-date. Policies are subject to modification. Personnel change. The specific detail included in each profile would, therefore, serve as an illustration of the kind of data upon which a practical data-gathering system may depend. With constantly changing data, nothing short of a structured, continuous system of data-gathering can meet the international requirements for rapid recource mobilization.

The sixteen profiles are as follows:

1. Asian Development Bank
2. Australia
3. Austria
4. Belgium
5. Denmark
6. European Economic Community
7. Federal Republic of Germany
8. France
9. Japan
10. Netherlands
11. New Zealand
12. Norway
13. OPEC Special Fund
14. Sweden
15. Switzerland
16. United Kingdom

Each profile was developed along the following outline:

I. ASSISTANCE POLICY

   A. Official Development Policy
   B. Official Health Policy

II. DISTRIBUTION OF BILATERAL ASSISTANCE

   A. Distribution of Bilateral Development Assistance
   B. Distribution of Bilateral Health Assistance

III. DISTRIBUTION OF MULTILATERAL ASSISTANCE

A. Distribution of Multilateral Development Assistance
B. Distribution of Multilateral Health Assistance

IV. ASSISTANCE TO NONGOVERNMENT ORGANIZATIONS

A. Development Assistance to Nongovernment Organizations
B. Health Assistance to Nongovernment Organizations

V. TYPES OF ASSISTANCE

A. Types of Development Assistance
B. Types of Health Assistance

VI. DEVELOPMENT FUNDING

VII. HEALTH FUNDING

VIII. PROGRAMMING PROCESS

IX. ORGANIZATIONAL STRUCTURE

A. Responsible Donor Agency(s)
B. Country Representation
C. National Health Ministry
D. Official Correspondence

X. DONOR PERSPECTIVE ON HFA/2000

XI. VIEWS ON ACCELERATION AND COLLABORATION

XII. VIEWS ON THE ROLE OF WHO