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INTERNATIONAL SOURCES OF FINANCIAL COOPERATION FOR HEALTH IN DEVELOPING COUNTRIES[1,2]

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A study of selected organizations has been conducted to assess the current status of international financial support for health activities. This investigation was directed at seeing how effectively international financial cooperation could be expected to support the "health for all" effort and how the pace of such cooperation could be increased. The summary report of that study, presented here, indicates that such support can make a major and perhaps sufficient contribution, but that major changes in the procedures for providing health-related assistance will be needed.

Introduction

In May 1979 the World Health Assembly declared an "overriding priority" to 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." 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 financial resources was essential, that a global information exchange directed toward attaining the objective should be established, and that WHO should play a major role in enlisting the cooperation of those charged with managing the world's resource potential *(1,2)*.

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

Within the specified time-frame of 20 years, the initiative is relatively young. But the total time-frame is short; and the anticipation of varying country interpretations of the undertaking makes it reasonable to ask some questions. For instance, 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? And, in view of global economic stress, What is the realistic outlook for obtaining those resources over the next two decades?

A considerable international flow of health resources is already in progress. It is estimated that over 50 official donor[4] agencies, plus as many as 1,500 nongovernmental organizations, are transferring approximately US$3 billion annually to recipient[4] countries. At the same time, the world's 68 poorest countries are spending an estimated US$14 billion of their own resources on the health sector *(3)*.

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[1]Also appearing in Spanish in the *Boletín de la Oficina Sanitaria Panamericana.*

[2]A summary of a published 649-page report to the World Health Organization by the author entitled *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,* Geneva, 1981 *(4)*.

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[4]The terms "donor" and "recipient" are used in this study only to denote sources and recipients of concessional financial assistance, both grants and low-interest loans. It is assumed that international financial cooperation is inherently interdependent.

Study Methods and Data Sources

Achieving a comprehensive understanding of current international cooperation in health would require a review of donor as well as recipient policies, processes, and programs. Such a study would preferably cover all potential donors, as well as the health sector and health-related development sectors such as agriculture and education.

In view of the Assembly's specific appeal to international funding agencies, the author, in cooperation with the Division of Coordination, WHO/Geneva, undertook a study involving informal consultations with selected external donor agencies in order to understand their views on supporting health initiatives, in particular the campaign for universal health. The intent was to characterize and illustrate the problem rather than to provide an exhaustive review of all potential public and private resources.

This study was conducted over a twelve-month period (August 1979 to August 1980). An initial review of multidonor and multisectoral literature on health was carried out at the Institute of Development, University of Sussex, England. In a second phase, as a consultant to WHO, the author held direct and informal consultations with over 20 donor agencies and organizations and with 200 individuals in Europe, Southeast Asia, and the Western Pacific. Separate profiles were prepared on 16 official external cooperation sources: the Asian Development Bank, the European Economic Community, the OPEC Fund, and the governments of Australia, Austria, Belgium, Denmark, the Federal Republic of Germany, France, Japan, the Netherlands, New Zealand, Norway, Sweden, Switzerland, and the United Kingdom.[5] A detailed report of this study's findings and recommendations has previously been published by WHO *(4)*.

Within the brief period available for each donor consultation, it was not feasible to obtain a comprehensive and authoritative view. Collectively, the consultations illustrated some of the principal features and trends of donor policies and practices. They also demonstrated the difficulty of isolating health-specific data from the records of development agencies and banks that customarily pursue multisectoral activities. Nevertheless, the picture of donor agency trends and problems that emerged has helped to clarify what steps may be necessary should the World Health Organization or any alternative agency seek actively to promote the mobilization of financial resources supporting the goal of "health for all by the year 2000."

A Cross-Sectional Analysis of Illustrative Donor Profiles

Assistance Policies

To understand the health perspectives and practices of a given donor, the donor's general development policy must first be understood. Initially it should be noted that, in response to the multisectoral characteristics and requirements of national governments, most official donor agencies and organizations which support health have an essentially multisectoral organization. However, all the donors interviewed subscribed to the policy that no sector, including the health sector, should be excluded *a priori* as a target for appropriately designed development cooperation *(5)*. Eligibility for health assistance, as for other kinds of assistance, is dependent largely upon whether the recipient country makes a fundable request that has the approval of the recipient's national planning authority. Most donors accept the idea that health is an inherent part of general development. However, preference is given to recipient requests that permit concurrent development in more than one sector.

[5]Subsequently, additional profiles were prepared on the Inter-American Development Bank, UNICEF, the World Bank, and the governments of Canada and the United States.

All the interviewed donors directly or indirectly supported international health programs. And, while few of their parliamentary authorities or governing boards had specifically singled out health as a formal area for support, eight of the 16 donor organizations had issued formal statements or guidelines in support of the health sector.

Distribution of Bilateral Assistance

With few exceptions, all the interviewed official government donors were found to engage in general development assistance within all WHO geographic regions but not in all countries of each region.[6] The Asian Development Bank and African Development Bank work within three WHO regions (Figure 1).

Table 1. The numbers of countries provided with development assistance and health assistance by 17 donor governments and international organizations in 1976-1980. The data shown do not include assistance provided through international organizations, aside from the European Economic Community and OPEC Fund.

Donor	No. of countries provided with: Development assistance	Health assistance
Australia	52	16
Austria	80	–
Belgium	30	30
Canada	60	21
Denmark	16	4
EEC	126	48
Federal Republic of Germany	110	25
France	49	27
Japan	70	23
Netherlands	90	42
New Zealand	34	15
Norway	39	8
OPEC Fund	66	6
Sweden	21	13
Switzerland	21	16
United Kingdom	132	36
United States of America	88	60

In a review of 17 multisectoral and bilateral donors, only five specifically reported including health assistance in over half of their national development assistance agreements (Table 1). Since assistance to the health sector is generally considered an acceptable proposition, the potential for increasing health assistance is substantial. This observation suggests that recipient countries may not be giving sufficient priority to health in making their official requests for external assistance.

Between 1976 and 1978, the 16 countries of the world most frequently receiving official bilateral health assistance (which received between seven and 12 assistance grants apiece) were also found to be the recipients of the greatest general development assistance within their respective geographic regions. This indicates that a vigorous national program for overall development may offer the most receptive framework for accelerating international cooperation for health.

Distribution of Multilateral Assistance

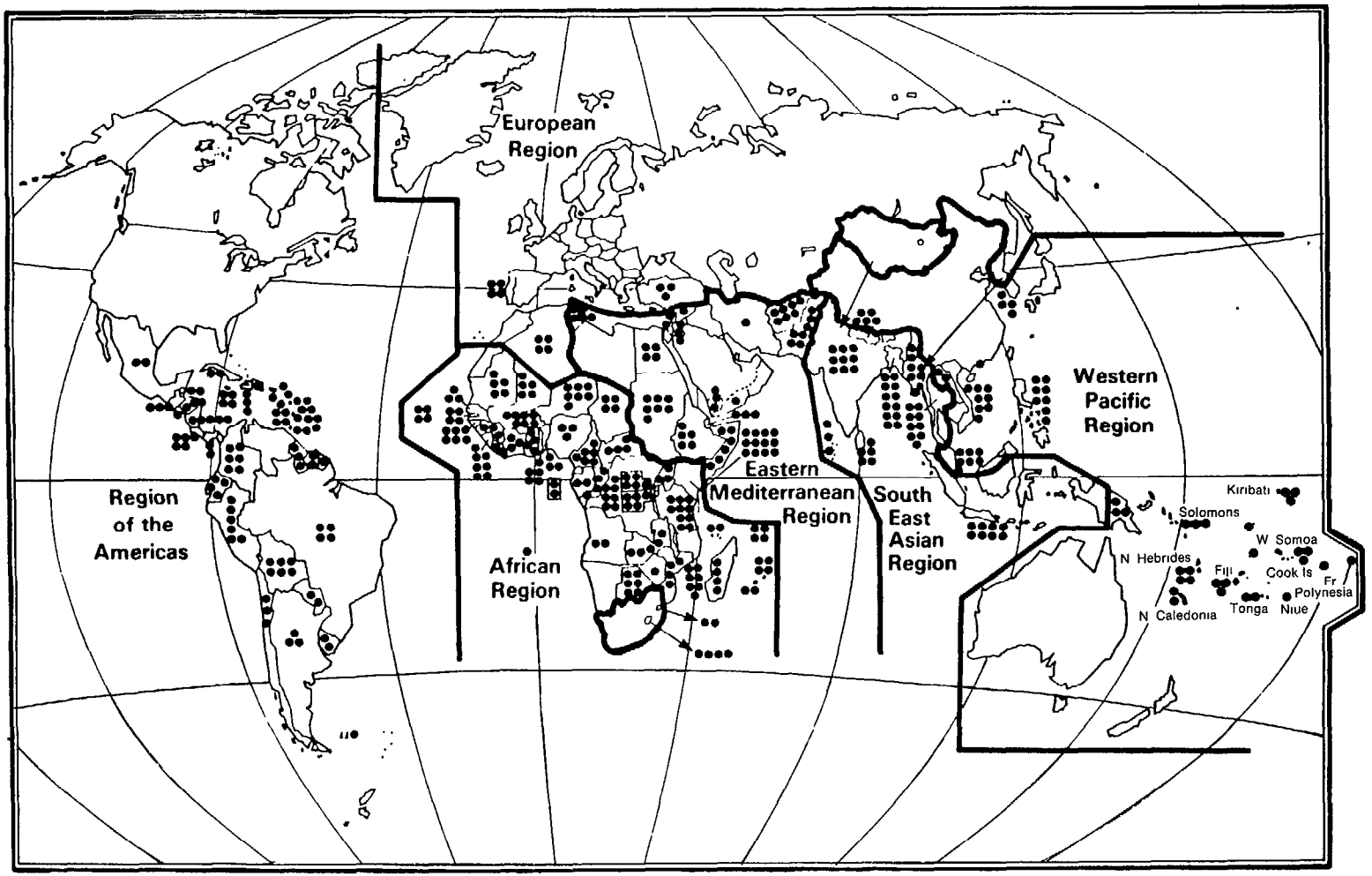
The work reported here did not review the geographic distribution of assistance provided by most multilateral organizations, since the principal multilateral institutions that support health—such as WHO, UNICEF, the United Nations Development Program, and the World Bank—are global in character. Collectively, bilateral donors from industrialized nations provided about one-third of their development assistance (US$6.7 billion) to multilateral organizations *(6)*. For UN agencies, these contributions amounted to US$1.6 billion in 1978, of which US$32 million went to WHO[7] and US$126 million went to UNICEF.

Although official donors have increased support for United Nations organizations during the past decade (1968-1978), there is no

[6]Reference *4* provides maps showing the distribution of each donor's assistance.

[7]These data exclude the official assessed contributions of Member Countries to WHO.

Figure 1. Countries where externally funded health programs were underway in 1976-1980, by WHO region. The dots indicate the number of bilateral donors providing financial resources to each country.



evident current trend suggesting that future contributions to such organizations will increase significantly beyond the present average of one-third of all official development assistance (grants and concessional loans). That is, bilateral donors can be expected to continue allocating the major share of their financial assistance directly to recipient countries.

Assistance by Nongovernmental Organizations

An estimated 3,000 nongovernmental organizations annually mobilize on the order of US$1.5 billion of their own resources for international assistance in all sectors *(6)*. The allocation made for health purposes is not known with accuracy due to the limited availability of worldwide data on this subject. Highly tentative estimates suggest as much as one-third of the total flow (i.e., US$500 million) could be going to health-related fields. In addition, official donor agencies collectively contribute some US$200 million more through grants and cofinancing arrangements. Within both donor and recipient nations, greater efforts are needed to document the current and potential resource flows to the health field from the private sector.

The Scope of Development Assistance Activities

All of the interviewed donors were found to provide assistance in the areas of health, agriculture, banking, construction, education, industrial activities, mining, public administration planning, public utilities, social infrastructure improvement, and trade. The precise configuration of the assistance in each case depended upon the nature of the recipient's requests and the donor's program policies. The general nature of the assistance also varied, consisting in different instances of debt relief; provision of commodities; budget support; and technical advisory services (technical cooperation) for planning, training, and managerial assistance.

Consistent with the strategy of "health for all by the year 2000," besides providing assistance to the health sector, the sources of international assistance provide parallel support to critical sectors that encourages productive employment, food production, education, and general development planning. This broad development approach fosters the preconditions required for improvement of national health levels.

Within the traditional health sector, the qualitative range of assistance provided is quite wide. Of course, donor preferences are influenced significantly by officially-approved recipient preferences; and despite their support in principle for primary health care, most recipient governments have not yet formally restructured their national plans along the lines called for by the "health for all" strategy. Thus traditional requests, biased toward institutional medicine and infrastructure development, predominate.

Considering all potential assistance-related activities, the single most obvious need is for increased emphasis on strengthening development-related national health planning. At present, the lack of experienced institutions and trained planners is seriously limiting recipients' ability to identify, plan, and justify requirements of the "health for all" effort. Yet among all categories of joint cooperation, health planning is one of those least requested by recipients and least supported by donors.

Development Funding

Total "concessional" and "nonconcessional" assistance-related resource flows in 1979 totaled US$81.9 billion. So-called "official development assistance" (grants and concessional loans) accounted for about one-third of this amount (US$29.9 billion), the remainder being made up of nonconcessional assistance.

Concessional aid is the primary source of international financial cooperation in the health sector. In 1979, US$24.2 billion of the total US$29.9 billion in concessional aid was

obtained from the "DAC" countries (17 industrialized countries belonging to the Development Assistance Committee of the Organization for Economic Cooperation and Development). Another US$4.7 billion was contributed by OPEC countries. The countries of Eastern Europe contributed less than US$1 billion *(7)*.

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

The traditional health sector receives on the order of 8-10 per cent of all concessional aid. It is also true, however, that major concessional aid allocations to agriculture, education, food aid, and general development contribute directly to national health improvement goals.

Sectoral allocations for health or other sectors do not commonly represent predetermined donor preferences; rather, they typically result from donor-recipient negotiations based on recipient proposals. Consequently, priorities set for the use of donor funds are subject to considerable flexibility.

Collectively, donors continue to argue for increasing the total flow of concessional aid. Therefore, the prospect for increased development funding over the next two decades would appear to depend upon donor perceptions of the balance between the need for international economic interdependence and the realities of domestic inflation, energy shortages, employment policies, and levels of external debt.

Health Funding

Variations in donor reporting patterns and sector definitions preclude precise estimation of the total flow of assistance to the health sector. However, estimates based on the available data suggest the total flow in 1978 came to approximately US$3 billion (Figure 2).

As of that time, no individual bilateral or multilateral donor was contributing more than 14 per cent of the total health assistance *(4)*. Although very large World Bank investments in water supply (if they are categorized as health assistance) would make the Bank the largest single donor, it would appear more accurate to conclude that there are no over-

Table 2. Net disbursements in 1978 and 1979 by member countries of the Development Assistance Committee of the Organization for Economic Cooperation and Development (DAC), the Organization of Petroleum Exporting Countries (OPEC), and the Council for Mutual Economic Assistance (CMEA).

Type of contribution and source	Amount of contributions, in US$ billions		% of all contributions		
	1978	1979	1970	1978	1979
Concessional assistance:	*26.4*	*29.6*	*47*	*33*	*36*
DAC[a]	21.5	24.2	40	27	30
OPEC	4.3	4.7	2	5	6
CMEA countries	0.6	0.7[d]	5	1	1
Nonconcessional assistance:	*54.5*	*52.3*	*53*	*67*	*64*
DAC[b]	53.0	50.9	51	66	62
OPEC[c]	1.4	1.3	2	2	2
CMEA countries	0.1	0.1	–	–	–
Total assistance:	*80.9*	*81.9*	*100*	*100*	*100*

Source: Organization for Economic Cooperation and Development, Press Release A/A(80), 19 June 1980.

[a]Including grants by private voluntary agencies.

[b]Including international lending by private banks.

[c]Official sector only.

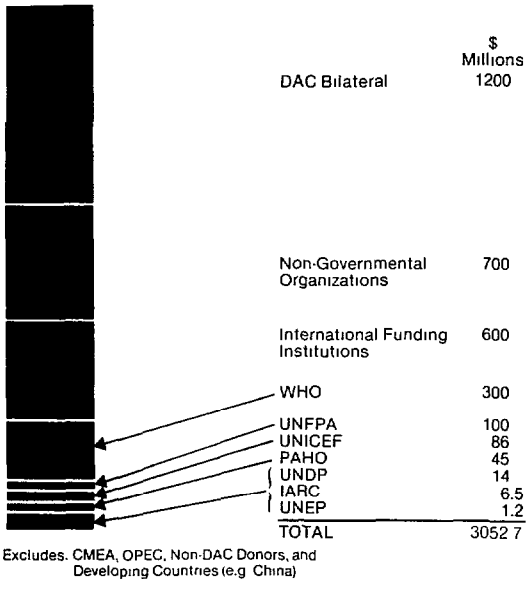
[d]Estimated.

Table 3. Total bilateral contributions and health sector contributions of countries belonging to "DAC," the Development Assistance Committee of the Organization for Economic Cooperation and Development, in 1977-1978.

Country	Year	Bilateral official development assistance allocable by sector (in millions of US$)		Official development assistance allocated to the health sector (in millions of US$)		% of each donor's total (column 3) devoted to official bilateral health total (column 6)
		Total	Project aid	Estimated total bilateral/multilateral health contributions, 1978	Official bilateral totals reported to OECD for 1978 based on direct donor consultations	
Australia	1977	184.1	138.8		1.5	
	1978	138.5	96.0	31	4.8	3.5
Austria	1977	86.6	59.4		x	
	1978	114.3	79.6		0.1	0.8
Belgium	1977	191.6	40.1		6.4	
	1978	248.8	58.7	60	10.0	4.0
Canada	1977	558.8	480.4		11.2	
	1978	668.8	570.1		17.1	2.5
Denmark	1977	100.4	67.8		17.1	
	1978	159.9	108.8		4.2	2.6
Finland	1977	13.9	–		0.2	
	1978	31.5	–		0.4	1.2
France	1977	2,264.8	714.2		266.3	
	1978	2,867.4	796.9		409.2	14.2
Federal Republic of Germany	1977	1,509.6	912.4		27.7	
	1978	1,893.8	1,029.8	51	32.8	1.7
Italy	1977	38.1	–		3.7	
	1978	40.9	–		4.5	11.0
Japan	1977	1,565.9	1,397.3		22.4	
	1978	1,784.2	1,530.6	87	75.4	4.2
Netherlands	1977	770.6	558.8		57.9	
	1978	937.9	643.4		72.9	
New Zealand	1977	26.7	17.4		2.6	
	1978	38.5	23.8	5.0	2.9	7.5
Norway	1977	150.3	52.8		3.1	
	1978	209.6	87.4	51.5	43.5	20.7
Sweden	1977	485.1	177.3		47.2	
	1978	136.0	56.4	65.6	16.6	12.2
Switzerland	1977	56.2	51.3		2.1	
	1978	92.2	89.9		2.2	2.3
United Kingdom	1977	468.0	247.0		19.1	
	1978	1,031.7	733.0	24	17.8	1.7
United States	1977	1,099.4	1,099.4		198.4	
	1978	2,269.4	–		294.0	12.9
Total DAC	1977	9,570.1	6,014.4		686.9	
	1978	12,663.4	–		1,008.4	

Source: Organization for Economic Cooperation and Development, *Development Cooperation, 1979 Review (6).*

Figure 2. Estimated health assistance provided by external donors in 1978. (DAC = 17 industrial countries belonging to the Development Assistance Committee of the Organization for Economic Development and Cooperation; UNFPA = United Nations Fund for Population Activities; UNICEF = United Nations Children's Fund; UNDP = United Nations Development Program; IARC = International Agency for Research on Cancer; UNEP = United Nations Environmental Program; CMEA = Council for Mutual Economic Assistance; and OPEC = Organization of Petroleum Exporting Countries.



whelmingly predominant donors to the health sector. At the same time, the health sector as a whole receives the fourth-largest amount of concessional funding cooperation provided for any sector—a fact giving an indication of recipient national priorities (Table 3).

The WHO budget's contribution to the total flow of health assistance funds is relatively modest (10 per cent). Therefore, the way in which WHO uses its limited resources to promote more efficient use of the larger non-WHO flow may be more significant in the long term than its promotion of directly sponsored and managed intramural WHO programs.

It should be remembered that the prospects for increasing the total flow of health assistance is related to the potential for increasing all development assistance. Nevertheless, there is also substantial room for increasing the proportion of health funding within the currently available US$30 billion in concessional aid committed each year for general development purposes. In this regard, a crucial factor in increasing health funds is the success with which recipients are able to define their own needs, formulate proposals, and get national planning commissions (or equivalent authorities) to approve the submission of such proposals to appropriate sources of cooperation.

Within this context, it is noteworthy that donors favor the development of a more active catalytic role by WHO and its regional offices in assisting member countries to develop their own abilities to identify, formulate, justify, and present national health requirements through the approved national development process. In 1979, the WHO personnel structure included approximately 2,500 professional staff members, a far greater number than that which is provided for health by development assistance agencies.

In terms of the estimated external cooperation required to achieve primary health care objectives, it appears that the outlook for financial assistance is adequate—assuming that needs for external assistance are effectively defined by recipient countries and that equally effective management of available national and external resources is provided. However, in the absence of national cost estimates for either the primary health care or "health for all" objectives on the part of most recipient countries, precise and rational forecasting is not possible.

The Programming Process

The programming cycle is highly specific for each donor and recipient *(4,8)*. However, it is important to be familiar with the general nature of the cycle and its limitations, espe-

cially in view of the accelerated resource transfer requirements of the "health for all" effort.

In general, health requests are normally included as a part of national development requests. Usually, such requests are forwarded by the recipient through its own national planning commission or equivalent authority. By their own regulations, donors generally cannot respond to national requests without such official in-country approval of those requests. Consequently, the recipient government's internal process for justifying health proposals in competition with other development priorities becomes a central factor in the ability of ministries of health to mobilize international resources.

Exceptions to this general rule may include recipient country requests made directly by a ministry of health to WHO through its resident WHO representative. But that route, while technically valuable, permits access to no more than 10 per cent of the potential external financial resources, because approximately 90 per cent of the external funding for health is provided by official bilateral agencies, multilateral banks, and nongovernmental organizations.

On the donor side of the cycle, the total number of professional health officials with specific responsibility for negotiating health projects is small (approximately 200) when compared to the number of professional staff members employed by UN agencies, WHO alone having approximately 2,500. Of the 18 major bilateral donors, 12 have no field health representatives and nine have no professional health personnel at their headquarters.

Partly because of these circumstances, if one allows for the many exceptions that occur in actual practice, it appears that the key procedural constraints on accelerating the flow of international financial assistance are as follows:

- Ministries of health often lack the professional capability to identify needs, determine internal versus external requirements, design external funding proposals, and defend such proposals before the national planning commission or other authority in competition with other sectors.
- Representatives of external multilateral and bilateral organizations customarily emphasize specific projects rather than helping governments expedite national health sector objectives as a whole.
- WHO representatives, despite their constitutional responsibility for cooperating with their respective ministries of health, are often heavily engaged in implementing specific ongoing WHO projects, and so their ability to assist new activities and to mobilize external resources is restricted.
- Recipient governments, depending on their countries' levels of development, often experience significant difficulty in trying to effectively manage the disbursement and utilization of external resources.
- Recipient governments and their resident international advisers are often not fully aware of the range of potential sources of external financial assistance.
- Donors are often unaware of the health program and financing requirements of a recipient country's overall health sector.

The Organizational Structure

Within donor countries or organizations, where is official responsibility for health cooperation located? With few exceptions, it appears that individual government agencies' responsible authorities are located in the ministry of foreign affairs, while the multilateral banks, funds, and UN organizations assign this responsibility to a constituent assembly or board.

Administration of official bilateral financing and programming is normally the responsibility of a semi-independent development cooperation authority, for example the Swedish International Development Authority (SIDA), which is responsible to its foreign ministry (or equivalent) for policy and budget review.

As already noted, the number of professional health personnel at donor agency headquarters is limited, and the number of their resident health representatives in cooperating countries is even more limited. Certain countries, however, provide a substantial number of technical advisory personnel for specific project assistance.

Since most donor agencies are accountable to the ministry of foreign affairs, only two of the donors surveyed were found to rely regularly on the services of their national ministries of health. This organizational distinction between foreign ministry and health ministry functions may explain why the messages and debates of the World Health Assembly and its regional committees—represented as they are by the ministers of health—may not be adequately communicated to authorities in the donor countries' ministries of foreign affairs that have responsibility for administration of development assistance. This view is supported by the observation that half of the 16 donors visited were only marginally familiar with the urgency of the "health for all" initiative or the rationale behind it. This finding suggests that each donor-country ministry of health (or its equivalent) should serve as a more active advocate of the "health for all" effort before the country's international development authorities.

Donor Perspectives on "Health for All by the Year 2000"

All the interviewed donors agreed that measures for improving national health conditions in developing countries were eligible for support and that such support was desirable. Indeed, many donors had been providing policy and program support for a basic human needs approach to health years before the Alma-Ata conference on primary health care in 1978.

On the other hand, organized and separately identifiable programming specifically supporting the "health for all" objective is not yet a typical feature of many donor activities, partly because various components of the "health for all" effort exist already but are classified under other categories of health assistance. And while there are no constraints in principle against more identifiable "health for all" programming, it would appear that official donor organizations are not always as fully informed about the content of the "health for all" effort as are their health ministry counterparts in the same country. Furthermore, to effectively plan greater technical and financial support for this effort, such donor agencies would welcome closer collaboration from their health ministry courterparts regarding the work of WHO and its Assembly. Therefore, it would appear that donor country health ministries may wish to exert a more active promotional role in order to strengthen their countries' commitments through joint interministerial cooperation and planning.

The responsible donor agencies said they were prepared to provide additional financial support if such support were formally requested by countries in need. However, these agencies, which have the official authorization and financial responsibility for administering health cooperation activities, have also asked a wide range of questions about implementation of the "health for all" endeavor, including the following:

- Are the goals of "health for all" adequately defined?
- Are the definitions of primary health care presented by the World Health Assembly subject to misinterpretation, especially with regard to expected benefits?
- Is the health improvement being sought likely to occur without concurrent investment in general development?
- Is there documented and evaluated experience upon which to base expectations for the year 2000?

Views on Acceleration of Funding and Collaboration

Over the past decade, organizations providing external financial assistance have collaborated in joint efforts to expedite the funding process and rate of disbursement for general development purposes, including health. Nevertheless, systematic and specific donor efforts to accelerate health programming, as distinguished from general development programming, have not generally received special attention. That is largely because officially accepted views on the interdependence between health and general economic development

have led to the need for accelerating assistance to many sectors of development. This, of course, raises the question of whether a strategy of "health for all" can 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 accelerating appropriate assistance, although there are differences of opinion on the rate at which such a goal is likely to be achieved. There is also a consensus that combined donor and recipient country resources are adequate to meet minimal primary health care requirements, provided that acceptable mechanisms for mobilizing the necessary resources can be established.

At present, major constraints on rates of fund disbursement and utilization of assistance in recipient countries are perceived to include the following:

- poor project identification and preparation;
- poor defense of health projects vis-á-vis the demands of other sectors;
- inadequate effort to obtain national planning commission approval; and
- limited continuity in self-reliant health sector planning.

Important constraints upon acceleration of financing inside donor organizations include the following:

- existence of a multiplicity of approval procedures;
- availability of only limited numbers of multisectorally trained health personnel;
- limited systematic cooperation between different donors for common health objectives.

Donors acknowledge that joint donor/recipient cooperation is essential for improved aid implementation. However, accountability for accelerated health sector development obviously lies with the recipient countries, which have the responsibility for determining their own health matters. Overall, the largest proportion of financial resources currently available to support the "health for all" effort are those available within the recipient countries themselves. This means the effectiveness and quality of external aid will depend upon the quality of recipient country planning and commitment.

Other important points to recognize are that if there is to be high-volume acceleration of external assistance, health requirements should be planned as an inherent part of general development requirements; and in order for donor responses to be effective, proposals must be submitted by the recipient country's development planning authorities or their equivalents. It would also appear that, in the absence of a current international system for health resource mobilization, new forms of donor-recipient collaboration should be fully explored.

In this same vein, acceleration of external assistance would appear to place certain requirements on recipients and donors alike. In the case of recipient countries, the actions required include the following:

- Improve the quality of health sector planning through training, experience, and information exchanges between countries and international organizations.
- Define the national commitment to "health for all" more explicitly.
- Keep currently informed on potential sources of external financial and technical cooperation.
- Identify specific projects consistent with national development planning.
- Improve the quality of project preparation, including project justification in relation to projects proposed by other national sectors.
- Process proposals through the national development authority, which is the primary channel for major increases in external assistance.
- Participate with external financial organizations in rationalizing the allocation of resources directed at attaining "health for all" objectives.
- Make the fullest possible use of WHO, UNICEF, and United Nations Development Program assistance in designing programs and identifying, preparing, and justifying projects.
- Participate in the development and use of a new international system designed to match needs more rationally with potential resources.
- Take greater advantage of funds which are readily available from numerous external donor sources for preparing projects.

Similarly, needed actions by donor orga-

nizations for the purpose of accelerating their assistance activities would appear to include the following:

- Engage in major retraining of international personnel and advisers for the purpose of providing orientation regarding (a) the relationship between health and development; (b) program preparation and justification; (c) donor program procedures; (d) potential donor and recipient country resources; and (e) information exchange procedures.
- Encourage a new and more assertive role by UN agencies at the country level for the purpose of assisting governments with identifying, justifying, and presenting health programs.
- Assess the potential comparative advantages of WHO as a channel for project acceleration. Given the large volume of external assistance required, donors perceive that WHO is in a relatively advantageous position to assist requesting countries with needs assessments, preparation of projects, and approval of projects at the national level. Meanwhile, bilateral and other donors are in a relatively advantageous position to conduct project negotiations at the country level and to implement well-prepared projects (with continued WHO cooperation at the project level).
- Develop a mutually acceptable system for exchanging information about needs, resources, programs, and financing.
- Engage in joint analysis with recipients of the alternatives for increasing the efficiency of resource mobilization.
- Undertake joint development with the recipients of a new and systematic global mechanism for matching needs with resources.

Views on the Role of WHO

The World Health Organization continues to be highly regarded for its technical repute, political neutrality, and program initiatives in support of global health priorities. Donor representatives thus tend to welcome a WHO role which, with the agreement of governments, provides major guidance to those governments in health sector planning, needs identification, project preparation and presentation, and definition of external financial requirements. On the other hand, donors that have major responsibilities for how development funds are used—under terms established by respective parliaments, legislatures, and governing boards—also ask if WHO would be prepared to serve beyond its traditional technical advisory and coordinating role in order to catalyze and accelerate development funding for health objectives. For example, the following queries have been noted:

- Is WHO able to distribute evaluated experience on "what works" in primary health care?
- Could WHO provide the health and development training required to reorient national and international personnel working toward the "health for all" goal?
- Is WHO prepared to revise its own organizational structure so as to devote the time, attention, and essential staffing needed to obtain the desired financial mobilization?
- Is WHO prepared to serve as the global focus for gathering, analyzing, and disseminating donor and recipient program and financial data?
- Would WHO be prepared to respond to government requests with sufficient rapidity to meet the project preparation needs 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 of "health for all" resource mobilization. Donors recognize their own limitations in expediting health planning at the country level, and their questions and reservations reflect their own legal accountability for commitment of development funds. Such questions and reservations also reflect uncertainty about whether WHO, which does not have constitutional responsibility for development coordination, would be prepared to make an organizational commitment to provide the staffing and functional changes needed to significantly influence the global flow of development resources serving "health for all" goals.

Recommendations for a Global Resource Mobilization System

Basic Considerations

The central conclusion of this study is that significant acceleration of international health improvements during the next 20 years will require a more formal and systematic resource

mobilization system than presently exists. This conclusion assumes that the WHO Member States already agree on the following points:

- Health is an inherent component of development programming.
- "Health for all by the year 2000" is an overriding priority.
- Resource acceleration is required if the "health for all" effort is to succeed.
- Regional and global information exchanges on needs and resources are an essential part of "health for all" planning.
- A global mechanism for resource mobilization is essential.
- WHO has a constitutional responsibility to bring into being the cooperative mechanisms needed to support World Health Assembly objectives.

Another basic consideration is that approximately 90 per cent of the external assistance funding available for health purposes is derived from sources other than WHO. More specifically, the main sources of external health funds are donors providing multisectoral funds for development purposes. Furthermore, any new cooperative framework must take account of the fact that no single donor source or international institution holds constitutional authority for the utilization and coordination of worldwide development funds.

An international consensus has affirmed that WHO should play the leading catalytic role in health resource mobilization. However, success of the current global program will require the fullest possible cooperation from all the development-oriented sources of assistance—multilateral institutions, bilateral donors, other government entities, and private and voluntary organizations—all of which must necessarily remain accountable to their own legal and constitutional authorities and to their cooperating partner countries.

A key advantage of WHO, in comparison with other international multilateral and bilateral institutions, is its universal distribution and large number of professional staff members. For the purpose of establishing a global resource mobilization system under WHO sponsorship, the following measures would seen appropriate:

- Establish a data management system to identify donor health resources.
- Establish a data management system to identify recipient country needs and resources.
- Analyze and rationalize resource flows.
- Mobilize resources by matching needs with potential resources.
- Provide training for resource mobilization.

Administrative Agreements

Given the varying (and largely development-oriented) sources of external funds for health, the new system's nucleus should consist of a consultative group of donors, recipients, and international organizations convened by the Director-General of WHO.[8] Specifically, the group should include representatives of potential donors (including multilateral organizations, governmental donors, and nongovernmental organizations) as well as representatives of recipient countries by geographic region.

While this proposed consultative group would meet once or twice annually, the daily work of resource mobilization should be assigned to a formal structure comprised of a full-time Secretariat at WHO Headquarters in Geneva, comparable supporting units at the WHO regional offices, and especially trained UN and WHO staff members at the country level.

The Secretariat should be established under the direct authority of the Director-General of WHO. However, in order to properly express WHO's consultative and cooperative role in promoting resource mobilization with many donors and countries, the Secretariat's relationship to the WHO Director-General should be such as to prevent any perception that international financial cooperation in the "health for all" effort is merely part of an in-

[8]Since 1980 the Director-General of WHO has authorized periodic meetings in Geneva of a Health Resources Group for Primary Health Care.

tramural WHO program. Additional counterpart secretariats or resource mobilization units should be established in each WHO regional office under the authority of the regional director.[9]

Among the functions that the WHO Headquarters Secretariat should perform are preparation and updating of guidelines for the following: donor and recipient information systems; analysis and rationalization of global needs and resources; matching resources to needs; mobilizing resources; training; and evaluation.

Other functions should include systematic collection of donor resource and program information, analysis and matching of interregional "health for all" needs based on member countries' requirements, analysis of regional needs in relation to potential resources, provision of assistance to member countries for preparation of fundable programs, encouragement of negotiations between potential recipient countries and external donor sources, and training of appropriate regional and country WHO and non-WHO personnel.

Underlying all these proposed administrative arrangements is the original intent that WHO should systematically promote cooperation among representatives of all external funding sources through consultation at country, regional, and WHO Headquarters levels. Illustrative examples of these administrative arrangements are contained in the full report of this study *(4)*.

In view of WHO's constitutional role of promoting coordination and the special requirement that WHO support "health for all" as an "overriding priority," resource mobilization should be considered a central activity of the Organization. Modest funding for Secretariat activities, therefore, could be a legitimate requirement built into the WHO Regular Budget or, alternatively, one fulfilled by a specially established Trust Fund to which participating donors and international organizations might contribute.

If it is accepted that the administration and programming of an estimated US$3 billion in development-related funds will remain the primary responsibility of various sponsoring multilateral, bilateral, nongovernmental, and United Nations agencies, then any new resource mobilization system coordinated under WHO auspices would not be required to manage or administer either ongoing or new funds—aside from a relatively small administrative fund used for Secretariat and "catalytic" purposes. And while a new system of this kind would require the reorientation of personnel (both national and international) to carry out new functions, no significant increase in the number of technical advisory personnel would be required.

As this implies, the proposed system would consist primarily of a data management and analysis system to identify needs and funding sources, and to catalyze, facilitate, and promote the acceleration of resource flows. In essence, it would be a strategic planning system designed to ensure that the "health for all" effort receives the necessary external financial and administrative support. Secretariat activities would not involve duplication of effort or competition with currently funded WHO program categories. The progress achieved would be measured in terms of the rate of flow and the distribution of external resources channeled into the "health for all" effort, irrespective of the sources or organizations that provide them; and the evaluation of that progress would be engaged in jointly by all of the interested donors, recipients, and international organizations involved.

[9]Within the Pan American Health Organization, resource mobilization is an established function of the Office of External Cooperation.

SUMMARY

Is it realistic to expect that sufficient external financial resources can be mobilized to supplement national support for approved WHO objectives by the year 2000? What is the current status of external financial cooperation in the health sector? What could be done to accelerate the rate of external support?

A study of 16 selected official sources of international financial cooperation was carried out in 1979 and 1980. By direct consultation and review of published sources, an effort was made to assess the policies, programs, and prospects for support of established international health goals.

This study demonstrated that approximately 90 per cent of the external health sector funds are provided via development-oriented agencies. The major agencies providing such assistance agree that no sector, including health, should be excluded *a priori,* providing that the requesting country conveys its proposals through the appropriate national development planning authority. Also, the agencies included in the study were found to be supporting health-related programs in all the geographic regions of WHO.

On the other hand, an associated review of 30 external funding agencies showed that only five reported providing health assistance in more than half of the countries where they provided assistance for general development purposes. Interviewed sources ascribe this to the limited manner in which health proposals have been identified, prepared, and forwarded (with national development authority approval) to international agencies.

In 1979, concessional development financing totaled approximately US$29.9 billion, US$24.2 billion being provided by 17 major industrial countries, US$4.7 billion by OPEC countries, and less than US$1 billion by the countries of Eastern Europe. Approximately two-thirds of such concessional financing is administered bilaterally, only one-third passing through multilateral institutions. United Nations agencies receive only 12 per cent of these total concessional development financing resources.

In 1979, concessional funding for health totaled approximately US$3 billion, approximately one-tenth of which was administered by WHO and its regional offices. It is anticipated that future international funding for health in developing countries will continue to come primarily from public and private development institutions directly, rather than being passed through WHO or United Nations channels.

In this regard, it is important to recognize that each donor has a very specific programming cycle, and that donors' organizational structures and professional health staffs vary greatly. It is also important for the ministries of health of recipient countries to become more familiar with the processes of program identification, proposal preparation, and proposal justification within the context of their own national planning commissions' approval procedures.

Another significant point is that agencies providing external assistance perceive the possibility of expediting the funding process by reducing constraints on program processing that exist in the recipient countries, and they feel that reduction of such constraints is needed. Overall, however, it would appear that a more organized system for mobilizing international financial assistance will be needed if appropriately expeditious support for the goal of "health for all by the year 2000" is to be provided. Such a system, described more fully by the complete report of this study *(4),* is discussed briefly in the foregoing presentation.

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SPECTINOMYCIN-RESISTANT, PENICILLINASE-PRODUCING *N. GONORRHOEAE* IN U.S. MILITARY PERSONNEL

Transmission of spectinomycin-resistant penicillinase-producing *Neisseria gonorrhoeae* (PPNG) was recently documented for the first time in U.S. military personnel. Between August 1982 and January 1983, 27 cases of spectinomycin-resistant PPNG infection were reported by U.S. Air Force Facilities in the Pacific. Twenty-five of these cases occurred among U.S. Air Force personnel stationed at Osan or Junsan, Republic of Korea. At least eight spectinomycin-resistant PPNG isolates were identified in pretreatment cultures obtained from individuals with recently acquired gonococcal urethritis.

In 1982, the U.S. Air Force (Pacific) began testing all gonococcal isolates for penicillinase production. All PPNG isolates and all isolates from patients who failed spectinomycin therapy were tested for spectinomycin-resistance. Because of the implementation of this surveillance system, the occurrence and distribution of this outbreak can be readily described.

Strains collected from six of the patients have already been confirmed by the Centers for Disease Control (CDC) as spectinomycin-resistant and penicillinase-producing. Additional analyses show that all these strains contain plasmids of 2.6, 4.4, and 24.5 megadaltons.

Source: World Health Organization, *Weekly Epidemiological Record* 58(18):137, 1983.