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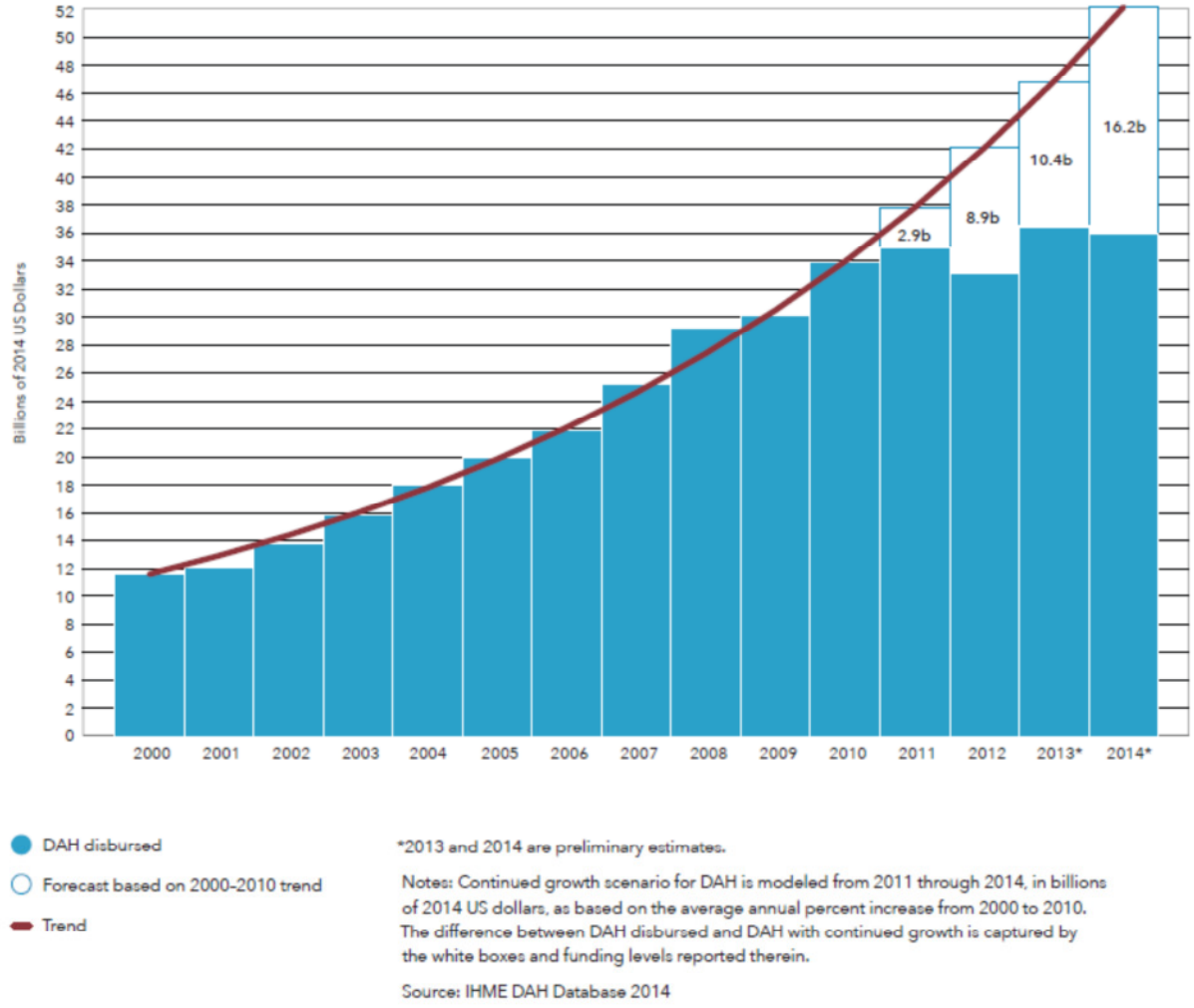
Introduction

Over the last 25 years development assistance for health (DAH)[i] has increased substantially and the global health landscape has evolved into a complex system of players (1;2). DAH grew annually at 5.4% from 1990 to 2000, but the introduction of the Millennium Development Goals (MDGs) sparked rapid growth (11.3% annually from 2000 to 2010). DAH has since plateaued; it has remained steady at approximately $35 billion for four consecutive years. Notably, DAH experienced its first decrease from 2013 to 2014 (-1.6%). If the 2000 to 2010 growth rate had continued into 2014, $38.4 billion more in DAH would have been available for global health. Total DAH in 2014 alone would have been 45.3%, or $16.2 billion, higher (See Figure 1) (3). Sub-Saharan Africa received the largest share of DAH in the MDG era. From 2000 to 2012, on average, it received more than 24.5% of total international expenditure on health. In 2012, $11.8 billion was provided for health in the region, 35.7% of all DAH.

Figure 1. Total DAH, 2000-2014, observed versus potential



In 2012, 73.2% of development assistance for health was funded by the governments of high-income countries (3), but an increasing portion of DAH is provided by private sources (4). Since 1990, private philanthropic donors and private foundations including the Bill and

[i] DAH is generally defined as resources, financial or in-kind, that are channeled into a country from external sources to support health-related activities. DAH includes funding for health sector activities, as well as population programmes, but does not include activities outside the health sector that may impact health (e.g. water and sanitation programmes).

Melinda Gates Foundation were the second largest source of DAH, responsible for providing $69.9 billion between 1990 and 2014, including $6.2 billion in 2014 alone (4). These numbers illustrate the emergence of private foundations as major contributors to global health, but also as powerful and influential actors that are shaping the global health agenda. Despite increased data on *giving*, it remains a challenge to track private donors' contributions at the recipient-level; the vast majority of these funds are channelled through NGO (3).

Another set of development actors of increasing relevance are the emerging economies, most notably the so-called "BRICS countries". The BRICS include Brazil, Russia, India, China and South Africa. They have traditionally received aid, but rapid economic growth over the last decade is converting them into new donors. "For the first time in 150 years, the combined output of the developing world's three leading economies – Brazil, China and India – is about to equal to the combined gross domestic product (GDP) of the G7." (5) According to the report launched by the Global Health Strategies initiatives (GHSi) in 2012, China and Brazil increased aid spending by more than 20 percent from 2005 to 2010, while India, Russia and South Africa's aid budget increased by 11%, 36% and 8%, respectively, over the same period (6).

Several researchers have examined the BRICS' engagement in global health (2;7-10). Despite the evidence of the growth of BRICS' financial contribution to DAH, many authors claim that there are still important barriers in tracking their impact. Flows to development projects coming from emerging economies are often not described or reported as development assistance. Instead, the term South-South cooperation is generally used under the same umbrella to describe complex interventions encompassing/embracing financial aid, technical assistance and trade (5). Attempts to quantify financial flows coming from the BRICS have tended to be complicated; none of the BRICS countries regularly provides data on its foreign aid and it includes sharing and exchange of resources, technology, and knowledge (11).

Our research consortium has analyzed the nature and influence of emerging donors for health- private sources through philanthropy and corporate social responsibility, as well as the BRICS. We investigated their engagement on the global-level through their influence on four international health organisations based in Geneva: the World Health Organisation (WHO), the Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund), the Medicines for Malaria Venture (MMV), and GAVI, the Vaccine Alliance (GAVI). Our research team conducted face-to-face in-depth interviews with Board Members and Senior Management of each organisation. This was coupled with an exploration of Chad, Ghana, Mozambique, and Tanzania's experience as recipients of emerging donors' assistance. Interviewees included representatives from the respective Ministries of Health and Finance, conventional development partners, consultants, and research institutions.

Interviewees in Geneva, Accra, Dar es Salaam, Maputo, and N'Djamena illuminated perceived benefits and potential obstacles, at the country- and organizational-level, of working with emerging economies as well as their experiences with philanthropic donors and corporate social responsibility programmes. Further discussions highlighted effects of inadequate managerial capacity, changes in multilateralism, and lessons that can be exchanged amongst donors, new and old. The following sections will provide more detailed analyses of these themes.

Rhetoric versus reality of BRICS engagement at country-level

Rhetoric

BRICS countries have individually provided foreign assistance since the 1950s (12). Their contributions have increased rapidly in recent years- approximately 10 times faster than

conventional donors- though the overall contributions are still relatively small in comparison to OECD countries (13;14). Scholars have identified a number of trends in BRICS' development efforts such as applying principles of South-South Cooperation (15) focusing on partnership; avoiding policy conditionality in governance, economic policy, or institutional reform; structuring assistance to complement foreign direct investment; emphasizing individual project feasibility rather than long-term debt sustainability; and applying domestic development lessons (12;16). The intention to develop their own agenda for development assistance is particularly interesting in light of the fact that their domestic health sector resource allocation appears to be still highly influenced by current multilateral donors such as the World Bank and the Global Fund to Fight AIDS, Tuberculosis and Malaria (17).

While the BRICS have declared that health collaboration is a priority, they haven't yet begun working collectively to enhance the impact of their assistance programmes. Of the bloc, China has contributed the largest sum of foreign assistance to low-income countries approximating $3.9 billion USD, as of 2010. Overall, health has been a main focus of Brazil and Russia's foreign assistance agendas, while it has been less emphasized in the agendas of China, India, and South Africa (14).

Brazil defines their foreign assistance as "international cooperation" and emphasizes partnership rather than donorship as a part of its commitment to social equity. A defining feature of their approach is the focus on technical cooperation rather than grants or concessional loans (18). Their model of technical cooperation relies on in-kind technical assistance and technological transfer using civil servants and professionals from Brazil-based institutions (19); this model could ultimately enable recipients to avoid the macroeconomic repercussions associated with (non-)absorption of traditional aid (20). Though it currently lacks a centralized institution responsible for foreign assistance, it is working towards greater inter-agency coordination (18;19). Russia's engagement with the other BRICS nations reflects its general foreign policy which stems from its desire to be a non-Western world power (21;22). Interestingly, unlike other BRICS, Russia has aligned itself with the aid agendas of the OECD-DAC countries (22;23) and favors a vertical approach to foreign assistance (22). It currently lacks as central aid agency, and its plans to launch RUSAID for bilateral assistance have been stalled (14). Russia focuses on global poverty reduction and prioritizes education and infectious disease control (24). One quarter of Russia's foreign assistance is dedicated to health and is channelled through multilateral institutions such as the Eurasian Economic Community, the World Bank, the United Nations (23), the Global Fund, and GAVI. India uses foreign assistance for diplomatic purposes and emphasizes cooperation, South-South partnership, addressing recipient demand, technical capacity building, and sustainability (25). The majority of India's foreign assistance is dedicated to sectors other than health, though there is a predicted increase over the coming years. Domestic obstacles limit foreign health assistance to strengthening of secondary and tertiary care, maternal and child health care, and non-communicable disease prevention and management (14). India favors projects for infrastructure, information technology, and training; the majority of foreign assistance is technical aid (25).

Though China has played a significant part in regional discussions on public health preparedness and disease surveillance, health plays a minor role in their foreign assistance programmes overall. Their primary foci are on health infrastructure, human resources capacity building, provision of international medical teams, reproductive health and family planning, and malaria control (14). Health assistance is used as a diplomatic tool to bolster their image abroad as well as secure access to natural resources (26;27).

Bilateral channels are the primary means of Chinese foreign health assistance with Africa as the principle target. The Forum on China-Africa Cooperation (FOCAC) serves to strengthen trade and development ties (28), and the framework includes malaria treatment and control programmes (27). Their projects are not currently integrated with other global malaria

programme; the Forum issues grants for antimalarials and support to malaria treatment facilities (14). China has been sending medical teams abroad since the 1960s; these teams provide free medical care and train local medical staff in areas lacking access to health services (27;29). In addition to the on-site training programmes, China offers scholarships to health care personnel from low-income countries to receive training in China. China is well-known for its role in infrastructure development, and this extends to the health sector. They have funded the construction of hospitals, clinics, and pharmaceutical manufacturing facilities, primarily in Africa (30). They also provide funds for health commodities and medical equipment.

Due to the high burden of HIV/AIDS and tuberculosis and the resultant strain on the domestic health system, South Africa must focus primarily on domestic priorities. Its primary role in development assistance is arguably as a model for other countries in terms of clinical research, advocacy, policy. Though South Africa receives more funds than it donates, it does contribute to foreign assistance for health through multilateral agencies, bilateral partnerships, and South-South cooperation. Its assistance is delivered primarily in the form of grants and technical support to other African countries. South Africa hosts a number of important research institutes and is a regional centre for research and development of medicines and vaccines for various infectious diseases. Generic drugs, including first-line ARVs, are produced domestically (14).

Reality

Of the 86 interviewees who participated in in-depth interviews, many had not heard of BRICS engagement in the respective health sector or could not comment on the nature of their engagement. They were careful to distinguish between BRICS investment in the economy and their support of health specific activities. One interviewee with a donor organisation summarized his lack of knowledge in a way that reflected the general tone in the interviews, "It is difficult to say if they aren't present, or their contributions are small enough to go unnoticed, or whether they are providing resources off-radar and therefore difficult to track." Overall, all knowledgeable respondents agree that BRICS countries do not yet contribute significantly to the health sector in any of the four recipient countries.

The respondents who were familiar with BRICS engagement in the health sector were able to provide insight into strengths and weaknesses of partnering with emerging economies, and in some cases, unconventional partners of any type. Table 1 provides a comprehensive list of pros and cons as explicitly stated by respondents.

Table 1. Strengths and weaknesses of engagement with emerging economies

Strengths	Weaknesses
• Direct interaction with Ministry of Health	• Distance is an obstacle
• Efficient	• High transaction costs
• Filling gaps left by conventional donors	• Lack of accountability
• Identification with the donor eases cooperation	• Lack of data
• More communication at higher levels	• Lack of transparency
• More flexible at higher levels	• Language / communication issues
• Quick response to requests and faster processing	• No 'institutional memory'
• Request and proposals less cumbersome	• No systemic approach
	• Not concerned with overall development

- Not coordinating through the established partner structures
- Not harmonised
- Potentially low quality investment
- Side-step international business standards
- Supply-side- and politically-driven
- Tied to commercial interests
- Time needed for contract negotiations
- Unstructured policies and focus areas

In all four recipient countries – Chad, Ghana, Mozambique, and Tanzania – unconventional partners, including emerging economies when present, are interacting directly, and exclusively, with the Ministry of Health. This is particularly unique in Chad where traditional donors operate more as a network and interact with the government as a unit, oftentimes through the WHO. Direct, exclusive interaction with the Ministry of Health has downstream effects on donor coordination within the recipient countries and will be discussed more in the country-specific sections of the paper. In Mozambique, the direct interaction means that the Ministry of Health finds cooperation with the BRICS much easier; they are more flexible and the process is expedited. For example, with China, it is very easy to submit requests and proposals, and the Ministry gets quick responses. With Brazil, there is more communication at higher levels and procedural flexibility. An explanation was that the common Lusophone identity facilitates cooperation - the Ministry of Foreign Affairs has excellent relations with its counterpart. Tanzania is currently working with selected emerging economies on a public-private partnership project proposal for health infrastructure and medical equipment. Most current donors have restriction in these areas, and Tanzanian officials recognise that medical supplies without proper diagnostics impair mortality rate reduction. Therefore the BRICS are perceived as important for filling gaps left by conventional partners. Many voiced that one issue with BRICS cooperation will be efficiency versus sustainability. Perhaps China can construct a hospital with greater speed, but it is yet unknown how long will it remain in good working condition.

Though there are no insurmountable obstacles to South-South Cooperation there is no "*institutional memory*" like there is with long-standing partners. There will be different challenges in the relationships when compared to conventional donors; there are no systems in place, nor is there available data on working relationship, so there will perhaps be a lag in achieving results.

Many of the downsides outlined by interviewees relate to the nature of BRICS engagement. Their vast resources are needed for quick investment, but time will tell the quality of the product. Many respondents in all four recipient countries acknowledged these relationships are investment-focused and BRICS partners are perceived as working towards economic cooperation, following their own commercial interests, rather than development. Aid tied to commercial interests, and driving social questions, is not a sustainable approach for the future. BRICS involvement will reflect political culture. If there isn't a national drive for social responsibility in their own countries, they won't do it abroad either. One interviewee in Ghana went so far as to say, "*BRICS pose the biggest threat because of their poor business practices*"; there seems to be an almost organisational culture of side-stepping international standards. His examples touched on the theme of accountability, and he repeated "*there is no way of tracing*" to prevent fraud. Even after listing the downsides, he believes that in five to ten years, the "*BRICS countries will be Ghana's largest partners in industry*".

So far, structured policies and focus areas, including development effectiveness, are lacking for unconventional donors. This highlights the importance of addressing partnership concerns upfront.

Many health development actors are not enthusiastic about this type of aid because it short-circuits traditional channels. New partners are not coordinating through partner structures; they are working in parallel without necessarily knowing what is happening in the health sector. Coupled with the lack of coordination is a dearth of information; to-date South-South cooperation is not captured by national aid databases. Country-specific issues surrounding donor coordination will be discussed in the following sections.

Conclusions

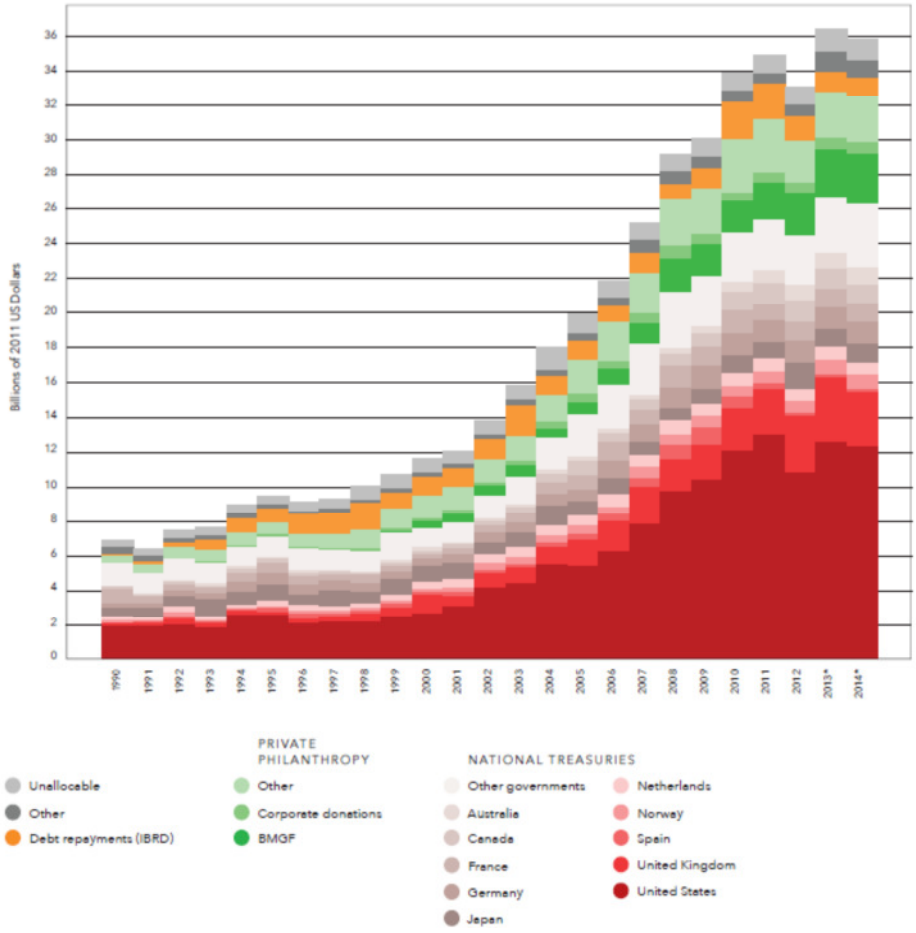
Overall, based on all of the interviews, BRICS do not contribute significantly to the public health sector. Interviewees see space for them in the landscape but acknowledge that myriad obstacles exist. They are not seen as a replacement, but rather as a supplement, for conventional aid. They are not foreseen to provide assistance that resembles conventional aid; they are primarily focused on investment opportunities. Though they reportedly interact directly with the government, they are not participating in donor coordination bodies (though the reasons vary by country).

Perceptions of private assistance for health at the country-level

In 2014, corporate donations made up $662 million or 1.9% of DAH. Other private sources amounted to $2.7 billion or 7.4% of DAH. Of the resources from other private philanthropy (excluding BMGF), 74.8% was provided to NGOs in 2014 ($2.5 billion), while a more minor share went to UN agencies and the Global Fund. The Bill and Melinda Gates Foundation (BMGF) is the largest single source of private financing for global health. In 2014 alone, the BMGF accounted for 8.1% of total DAH and 46.6% of private funding flows for global health ($2.9 billion USD) (3).

Overall, private philanthropy has grown more substantially than corporate donations over the last decade (see Figure 2).

Figure 2. DAH by source of funding, 1990-2014



From 2003 on, sub-Saharan Africa has consistently received the largest share of DAH. It accounts for more than 24.5% of total international expenditure on health, on average, from 2000 to 2012. The vast majority of its support comes from bilateral, multilateral, and partnerships such as the Global Fund and the GAVI. It is difficult tease out how much finance comes from private sources as they enter the recipient countries through other channels, ex. NGOs. The majority of money coming from private foundations and corporations is labelled unallocable. The only private foundation that was tracked from source to recipient was the BMGF which allocated 25.3% of its funds to sub-Saharan Africa in 2012 (3).

It is increasingly important that private actors are included in high-level discussions given the complementary role they have assumed in international development. These actors were largely absent in discussions on aid effectiveness until the 2014 Global Partnership on Effective Development Cooperation High-Level meeting in Mexico (31). Only one foundation currently adheres to the principles outlined by the Busan Partnership for Effective Development Cooperation- the BMGF (32). Few philanthropic actors appear to be aware of the aid effectiveness principles first outlined in 2005: ownership of development policies and strategies, alignment of aid with country priorities and systems, harmonisation of donor practices, aid predictability and transparency, and results and mutual accountability (33).

Overview in case-study countries

Despite the marked changes in global trends of private finance for health, discussions with health ministry officials and development partners at the country-level painted a much different picture of the private finance for health landscape. Many interviewees concluded that although private actors are working in these countries (see Tables 2 and 3) as of yet these

contributions are nominal in size and not yet influential in the health sector. For example, interviewees had heard of private financiers acting in Chad but had "*seen no evidence*" of their activities. Respondents in all four countries perceive foundations and corporate social responsibility (CSR) programmes to have a more narrow scope and provide one-off project assistance. In Chad as in Ghana, interviewees also noted that support from private actors has been increasing and this trend will likely continue. One interviewee from Chad drew from his experience in other contexts and said, "*as countries transition economically, the easier it is for them to get unconventional finance*". This could also apply to Mozambique where large-scale changes are having the greatest impact on their role as a recipient; ex. foreign direct investment, government revenue, and lending, have all increased which changes the balance and influence of traditional donors. In Tanzania, private financiers are seen to be complementary sources of finance in terms of approach. These contributions are welcome due to the financial crisis, but they contribute to fragmentation. Additionally, they do not feed their experience back into their aid approaches; there is no local base to systematically filter lessons back to headquarters.

Alignment

Alignment, as one of the Paris Declaration's pillars, refers to alignment with partner countries' development strategies and policies and strengthening country systems (33). In terms of strategy, bilateral and multilateral donors develop official development assistance strategies based on the Millennium Development goals, poverty levels, geopolitics, and national interests. Philanthropic foundations' priorities and strategies differ from bilateral donors because they are determined more by *internal* factors than *external* factors. The interests of the founders, donors, or Board members dictate the priorities and therefore the themes of funding (32). Respondents largely agreed that private sources of assistance are not adhering to the principles of alignment in their respective countries. "*Like the larger funds, these sources tend to want to impose their own agendas.*"

Overall, interviewees agreed that resources coming from philanthropic sources are complementary to conventional development assistance, but replacement isn't feasible due to the narrowly-projectised approach. Respondents in Tanzania highlighted the pros and cons on foundations' lack of alignment with national strategies. Another interviewee implied that foundations' agendas are ideological rather than needs-based, ex. Kaiser Foundation (USA), "*…because of the sensitivity of donors, private sources are reluctant to channel funds to the critical HIV-infected groups.*" On the other hand, when the donor is more liberal than the government and doesn't need to worry about political diplomacy, it can fill gaps. "*The Diana Foundation (UK-based) provides funding for HIV/AIDS to fill gaps left by government due to systemic stigma (ex. criminalisation of certain behaviors that result in increased risk for AIDS – sex workers, men-who-have-sex-with-men).*"

In Chad, Mozambique, and Tanzania CSR contributions are small-scale projects with limited reach. Interviewees identified the extractive industries, namely oil and gas, as the most visible contributors through corporate social responsibility programmes. The locations targeted in these programmes are not necessarily needs-based but rather based on the location of the industry and personal interests (for example, to provide treatment for personnel). In general, these programmes are not focused on the long-term, they are localised, and due to lack of evaluation, it is difficult to gauge how much they actually provide in the short-term. As one respondent said, "*The private sector is better suited for one-off commitments rather than sustained contributions."*

Ghana has a unique example of a CSR programme that has been incorporated into a national strategy. Presently, AngloGold Ashanti is a Principle Recipient of the Global Fund in conducting a malaria control programme in 40 districts. It was replicated on Anglo's

exemplary effectiveness in implementing an integrated malaria programme in Obuasi town and villages of the Obuasi Municipal district. Their project started small to protect employees from contracting malaria. Ghana Health Service approached leaders in the project with the idea to roll-out indoor residual spraying to more districts. The project leaders were reluctant about the level of financial involvement required, and were later reluctant to be a Principle Recipient of a Global Fund grant, but ultimately formed Malaria Control Ltd. Some respondents were not particularly supportive of the programme. Their concern was that though they might have experience and success in a small locality, they do not necessarily have the technical capacity to scale-up to the national level. Overall, CSR programmes have contributed minimally. "*AngloGold Ashanti Malaria Control Ltd is an exceptional case, and its formation and level of involvement is due to Global Fund support*."

Harmonisation

In 2014, the OECD Global Network of Foundations Working for Development (netFWD) developed the "Guidelines for Effective Philanthropic Engagement". The three pillars- dialogue, data / knowledge sharing, and partnering- aim to foster "mutual recognition between philanthropic actors, governments and development agencies on the basis of their respective comparative advantages" (34). Before this the only foundation adhering to the 2011 Busan Partnership for Effective Development Cooperation principles was the Gates' Foundation (32). Interviews highlighted a distinct absence of private actors in established country-level coordinating mechanisms.

In Chad, new partners are expected to enter Chad in the same framework for partnership, but so far they had only participated in dialog with the government and lack structured policies and focus areas. They have not been included in coordination bodies led by conventional development partners, but "*it is unclear whether this is due to exclusivity of development partners or a lack of information or interest of incoming private actors*." In terms of CSR specifically, one respondent reported, "*the results of their efforts are unclear, there are no observers, and there is no cooperation*".

Most respondents had not heard of many philanthropic actors in the health sector. They were more likely to mention channels for private contributions such as the Global Fund or the One Million Community Health Workers Initiative[ii]. Such partnerships can obfuscate the contributions of different actors from the recipient's perspective. There was a significant increase in resources coming from CSR programmes in 2012, but perhaps it's because the data is being captured more effectively rather than an actual increase. Respondents provided a more diverse group of corporate actors than philanthropic in Ghana- banks, the Cocoa Board, mining companies, oil and gas companies, and telecommunications providers. But, as of yet, Ghana lacks a policy for integrating CSR funds. This has resulted in uncoordinated activities and, ultimately, waste. For example, there are some CSR drug-donation programmes that do not necessarily consider context or need, and Central Medical Stores is currently filled with medicines that will not be distributed and must be disposed of. The Ministry of Health and development partners are trying to develop policy for including the private sector.

Respondents in Tanzania felt an overall sense of uncertainty about the activities of different sources outside of the Development Partners Group for health. One development partner argued that although they participate in some coordination activities through the Development Partners Group, they only do so to "*push their own agenda rather than move forward together as a group*". With regards to harmonisation of actual funds, private actors do not provide finance to the basket due to the lack of visibility and lack of "branding".

[ii] http://1millionhealthworkers.org/ "The 1mCHW Campaign, which has a partnership base of over 150 organisations from United Nations agencies, civil society, the private sector, and academia, was launched in January 2013 at the World Economic Forum in Davos. Since its launch, the Campaign has been actively supporting African governments and partners who are dedicated to increasing the number and quality of lay health workers in the region."

An interviewee in Mozambique best summarised the sentiments of many others in response to questions about coordination with corporations in the health sector. "*So far this type of support is uncoordinated, and there is no real model. It is actually Corporate Social (Ir)responsibility.*"

Mutual accountability

Models of 'mutual accountability' between donors and recipients inherently vary between countries as the mechanisms of aid delivery are fundamentally different amongst recipients. For example, in Chad no donor funds go through the government; all funds go through United Nations bodies. In Tanzania all external finance goes to the Ministry of Finance which allocates funds among the sectors. Ghana and Mozambique both have more mixed models; their governments do receive funds from donors, but these funds can enter at any level (central, regional/provincial, or district), and many actors act outside of government channels altogether. Therefore, although the underlying principles of mutual accountability should remain consistent across the countries, the means for achieving this goal will naturally vary.

In Chad, the largest philanthropic donor is the Gates Foundation which, like many donors, channels resources through the WHO and UNICEF. Communication between BMGF and the Ministry of Health is through either UNICEF, WHO, or the Chadian Comité de Coordination Inter-agences. Despite all of the potential channels of communication, the Ministry of Health is uninformed of BMGF activities in Chad, "*unless Bill Gates is in the country for a meeting*". Overall, there was disagreement between the Ministry of Health and development partners about who private actors were coordinating with. The ministry said that they had little to no contact with foundations and corporations. Interviewees from development agencies reported that, so far, these newer actors only coordinated with the ministry.

In Tanzania development partners seem much more aware of private actors and partnershipping. Lack of awareness of the development partners must stem from insufficient communication from the government. Due to Tanzania's strongly centralised system, all actors must act under the auspices of the Ministry of Health. Tanzania's new health financing strategy includes, for the first time, the government's expectations to involve the private sector in health financing through their corporate social responsibility programmes. The Ministry of Health did report that they open lines of communication with companies in the extractive industries, but their money goes directly to health facilities and hospitals. This indicates a different standard to which industry is held to. All conventional development assistance for health is required to be channelled through the Ministry of Finance. Another inconsistency is that while submitting reports to the Ministry of Finance is mandatory for conventional donors, it is voluntary for unconventional sources.

In Mozambique, there is no reported coordination between corporations and the Ministry of Health, and they actually contribute to brain drain as they hire people from the ministry. "*It is the role/onus of the government to regulate the extractive industry.*" The government has proposed innovative health financing strategy for 2019, but there is a gap in rhetoric versus reality for integrating private resources and a persistent lack of coordination with private actors. Multiple interviewees converged on the idea that the best thing that the private sector could do, including the extractive industry, is pay taxes. The revenue generated through fair taxing would far outweigh any contribution they would make through a corporate social responsibility programme.

Conclusions

A few interviewees in Mozambique were keen to discuss prospective roles for private partners. As many of the partnerships with recipient countries are currently undefined, they could experiment with alternative approaches to assistance. For example, Development

Impact Bonds would result in a longer-term commitment, guaranteed results, and risk-sharing. There is a need for the collaboration with, and inclusion of, the full range of stakeholders. The government would be involved in developing the terms of reference and governance of the bond, NGOs would be needed for implementation, and the private sector would provide capital. Private foundations have the flexibility to innovate and take higher risks. They could partner with conventional donors who might mitigate initial risk. A challenge would be in bond price estimation. These more complex approaches would be more appropriate for addressing the complexity of the social determinants of health, for example.

Additionally, interviewees suggested that best thing that the private sector could do, including the extractive industry, is pay taxes. The revenue generated through fair taxing would far outweigh any contribution they would make through a corporate social responsibility programme. They concluded that corporate social responsibility is insubstantial and, as of yet, there has been a failure to harness public-private partnership.

Currently, in the four case-study countries, there are no policies, there is little information available, and, therefore, there is no means for accountability. This type of assistance is complementary to conventional bi- and multi-lateral assistance, but in order to prevent further fragmentation, they should be informed of, and included in, development partner group discussion.

Table 2. Philanthropic Foundations engaged in the health sector as reported by respondents

		Health-specific focus-areas (interviews)			
		Chad	**Ghana**	**Mozambique**	**Tanzania**
Philanthropic Foundations	Abott Fund				refurbished regional and district-level laboratories (built labs in 23 regional hospitals)
	Aga Khan Foundation			direct implementation and community development	training through district public health facilities
	Bloomberg Philanthropies				availability of vaccines and medicines; research
	Carre Foundation	●			
	Carter Center	guinea worm eradication			
	Clinton Foundation			matching partners with those who need assistance; finding better prices of pharmaceuticals; support for laboratories; child health	HIV/AIDS; improving quality of services; availability of vaccines and medicines; innovative financing mechanisms; systems strengthening; rural deployment of staff; fellowships for medical personnel; family planning
	Comic Relief				●
	Doris Duke Charitable Foundation				●
	East Meets West	●			
	Elizabeth Glaser Pediatric AIDS Foundation				●
	Foundation for Community Development (FDC)			●	
	Oswaldo Cruz Foundation (Fiocruz)			●	
	Gates Foundation	polio outbreak response and immunization (incl routine);	malaria control	malaria control	research and innovation; malaria control projects; family planning
	Kaiser Family Foundation				grant assistance for HIV/AIDS
	Lions Club	●			
	Manhiça Foundation			●	
	Mozal			●	
	Novartis Foundation				access to malaria medication
	The Diana, Princess of Whales Memorial Fund				HIV/AIDS for stigmatized high-risk groups (sex-workers, MSM)
	Rotary Club	polio vaccination			subsidies for tertiary care referrals to India
	Touch Foundation				●
	World Vision	●			

Table 3. Corporations engaged in the health sector through CSR programmes as reported by respondents

		Health-specific focus-areas (interviews)			
		Chad	**Ghana**	**Mozambique**	**Tanzania**
Corporations	Airtel		contributed 500 mobile phones to MoH for the midwife program		
	Anadarko			social investment programs; health centers; malaria; implementing local and regional strategies with MoH	
	AngloGold Ashanti		integrated malaria programme		
	Bank of Ghana		has its own hospital		
	Barrick Gold				construction of health facilities
	Coca-Cola Foundation				malaria control projects; supply chain management
	Ghana Cocoa Board		•		
	EcoBank		cash and in-kind support (training for Global Fund and fundraising support, supply, and service provision)		
	ENI			money to build a small clinic	
	Exxon-Esso	integrated with some healthcare schemes; capacity development; training; Malaria No More initiative			
	Mcel			mobile phones for mHealth interventions (maybe airtime as well)	
	MTN		adopting health clinics and hospital wards; infrastructure and equipment for community health centers		
	Petrobras Malaysia	•			
	Total France	•			
	Tullow Oil		building health centers		
	United Hydrocarbon International Corp.	•			
	Vale do Rio Doce			built night-clinic for sex workers; has HIV/AIDS mobile clinics; supported a local clinic but it primarily refers to the private sector	
	Vodacom				•
	Vodafone			mobile phones for mHealth interventions (maybe airtime as well)	mobile clinics

Managerial gaps and financing decisions in Mozambique

Low absorption capacity has been blamed for the failure of many development assistance projects in African countries. Donor agencies complain that insufficient physical infrastructure and technical expertise at the local level generate high transaction costs and, thus, inefficiency in project implementation. Although many projects now include training modules to train technical experts and some funds for infrastructure needs, the managerial needs of aid administration and implementation are often overlooked. This leads, among others, to slow delivery of assistance and reporting problems.

During the field visit to Mozambique for this SNIS-sponsored project many of the experts interviewed, both local and expatriate, from government, donor agencies, and intergovernmental organizations (IGOs), commented on the need to strengthen managerial and administrative systems at the government level. This confirms observations in the academic literature, for example in (35;36). It also addresses a key issue in the business literature on the critical role played by managers in fostering organisational efficiency and success, such as Coase (1937) (37;38).

Origins of the problem

The number of university-trained experts in Mozambique is low, although it has been increasing in recent years. As one of the interviewees commented, "*when I graduated from medical school, there were only ten other graduates; now there are 40-60 graduates per year*". Many university graduates choose to work for higher salaries in the private sector. Even in the case of graduates who choose to work in the non-profit sector, they often begin their career in government, but are later "poached" by NGOs or other aid agencies. In the latter case, some individuals commented that the move is due not only higher salaries, but also because of higher prestige associated to working for a foreign donor and the sense that their efforts will have higher impact.

Although Mozambique has been relatively stable since the end of the civil war and there has largely been political continuity at government level, state institutions have not developed strong managerial systems or procedural routines that are embedded institutionally, as opposed to embodied by individuals. This is due to high rotation at middle management levels, that prevent the long term informal relationships that are "indispensable to and consequential for the formal system of delegation and control itself" (39).

Systems strengthening in the health sector

Government officials complain of the complicated procedures to obtain and then administer funding from donors. The reporting systems may be reasonable from a donor's home country perspective, but are impractical or too complex for the Mozambican reality. As one interviewee put it, "*you are asking for oranges, but we only have bananas.*"

Recognising this, some donors have begun to address funds directly address the issue. The Global Fund and GAVI have targeted funding for health systems strengthening to build capacity among ministry officials for strategic planning and reporting tasks. Yet, other donors have chosen to send instead expatriates to perform monitoring and evaluation tasks, hopefully training local experts in the process. Whether either of these efforts will succeed in creating the necessary institutional capacity to administer large-scale projects, remains an open question. An IGO official, with experience in other parts of the world, commented that this problem may be overcome in the capital, Maputo, as it has been in other parts of the world, but that given Mozambique's size and national reality, the issue needs to be addressed at provincial level.

The issue of health systems strengthening is tied in to the debate on general budget support. The government and some donors/IGOs would like to increase general budget

support in order to strengthen absorption capacity; a group called G19 was created to discuss and coordinate these efforts. Yet, other donors, notably the US government, have preferred to pursue their development efforts on their own projects, prioritising the need to achieve health goals rapidly. As one donor representative put it: *because of the low absorption capacity of the ministry some donors wanted to pool funding for sector-wide approaches; this involves high costs of coordination. Other donors have gone for direct project funding, but this involves high management costs.* (Slightly paraphrased.)

Proliferation of coordinating bodies and transaction costs of coordination

As a result of the challenges of absorption capacity, a large number of coordinating bodies have been created. These include the G19, the Health Partners Group, the National AIDS Council (Conselho Nacional Contra o SIDA), NAIMA+ (NGOs working on HIV), PROSAUDE (Common Fund for Health), and many others. As one donor representative put it, [the coordinating bodies] *"in Mozambique they are a nickel a dozen! This is due to a very weak civil society. If you get an organigram of the Ministry of Health, you will so many directors and sub-directors, but not many technicians."*

This has led to both donors and local officials spending a lot of time on coordination, rather than on implementation issues. Coordination among different "market players" involves notably high transaction costs (37). Yet, integration into a single organisation with unified goals involves either high bureaucracy costs (40) or requires very strong leadership (39).

Conclusions

In Mozambique (and many other countries) donors will need to pay closer attention to building managerial capacity that will not only strengthen recipient local institutions – government or NGO, but will also improve operational efficiency of development projects. This will hopefully also translate into long term administrative continuity and leadership at government institutions.

The role of private donors in four global health organisations

The influence of private donors on the global health landscape can be seen through the experiences of the WHO, the Global Fund, MMV, and GAVI. Though differing in nature, each of these organisations has integrated private financing in to their operational and governance structures in varying forms. In certain cases, including GAVI, MMV and the Global Fund, this influence has been inherent from the start, whereby private donors were welcomed through overt private-public partnerships and became an integral part of these organisations' governance and operational mechanisms. For others, such as the WHO, the role of private donors is a matter of ongoing discussion, both on the extent to which non-state actors might affect decision-making processes, and the degree to which they contribute financing – and with it – exercise influence.

The perception of influence in WHO

WHO depends primarily on assessed and voluntary contributions of member states and other organisations. Assessed contributions are calculated based on population size and wealth and due from all member states and associated members on 1 January of each year as part of their membership commitment. They are a relatively dependable and sustainable source of funding for the Organisation that can be used flexibly across the Programme budget. In 2015, assessed contributions accounted for 23.36% of the approved 2014-15 approved programme budget. The remainder of the funds stem from voluntary contributions of which core voluntary

contributions can be used flexibly at the programmatic level or are earmarked according to specific programmes, diseases, or priorities for the organisation and specified voluntary contributions, which are earmarked for particular activities or budget lines.[i] As shown above, these specified voluntary contributions accounted for nearly 73% of the 2014-15 programme budget (31).

This funding structure has major implications for the functioning of the organisation and led to the currently ongoing WHO Reform. While the question of donor influence on governance and decision-making at WHO is not new (32;33), a new generation of non-state private donors has emerged with considerable financial resources, and consequentially, a certain amount of influence on how funds are to be used within the WHO operational structure. Contributions by the private sector have risen substantially in recent years, mainly pushed by the contributions of foundations rather than private companies. In 2012-13, the Bill & Melinda Gates Foundation was the largest voluntary contributor to the WHO, ahead of members states including the United States and the United Kingdom. [iii] This trend continued in the 2014-2015 budget.

Regarding private donors' contributions, the major concern for WHO is to avoid conflicts of interests, which is also reflected in the negotiations on the '*Framework for Engagement with Non-State Actors*': Despite many formal and informal consultations, this new framework addressing the categories of actors and their role within the organisation has not been approved by Member States. The point of dissent concerns mainly the involvement of the private sector, independent of its legal identity. The WHO respondents interviewed expressed concern around the influence and thus power the donors might exercise on the decision-making processes within the organisation. One interviewee also added the need for more transparency and the need for donors to "*make the donations more in line with the core interests of the organisation instead of their own interests*".

The allocation of funding to particular earmarked programmes of course appears not only at the level of private sector funding, but also applies more generally to all funding contributions WHO receives. Member States themselves exercise a similar level of influence through their earmarked contributions and are just as much interest-oriented. Nevertheless, the big difference remains that the influence at the programmatic – i.e. operational – level differs from the influence at the political – i.e. policy - level. Member States, with or without large financial contribution, can exercise this second level influence due to their membership in the organisation, whereasprivate companies (or privately funded foundations) have much more limited channels of influence. They "*cannot participate in the entire decision-making process*" as one of the interviewees mentioned and thus, do need to operate differently.

The lack of funding for particular programmes within WHO resulted in the increased need for WHO team leaders and staff to fundraise for their own programmatic activities; a phenomenon which can be observed both at headquarters and country level. Therefore, the dependency on the private sector increases in proportion to their contributions and yet these contributions are quite transparently reported, given that they serve a very specific programme. More subtle, however, is the influence at the policy level as confirmed by one respondent, who said "*private foundations do have the power, but I cannot directly feel it* […]"(RGOV1) and that the influence of private foundations is exerted more on "*the level of the Secretariat, the enforcement of the motion, but not the decision-making*".

The research findings re-confirmed concerns withregard to the possible negative impact of private finances on the decision-making and governance of WHO; it also explored the positive impact the increased relationship with private sector or private-sector foundations may have. In a nutshell, one interviewee summarised this value-added as follows: *"[…] collaboration with these private foundations […] is giving another dimension to the*

[iii] Note that voluntary contributions by member states are in addition to their assessed contributions to the regular budget.

organisation in providing different insights, different priorities, different ways of thinking. […] The way of doing things is changing and it brings more value to WHO".

The composition of the governance board

Despite the ongoing discussions on the role of non-State actors within WHO, the governance structure of the world's most important health organisation is set-up by Member States. This is in contrast to the governance structure of the Global Fund. The Global Fund is considered a partnership governed by governments, civil society, the private sector, and communities. It represents an innovation in the mechanisms for international health financing. According to the Global Fund's own data, approximately 95% of total funding comes from donor governments and the remaining 5% from the private sector and innovative financing initiatives (34). Similarly to WHO, Bill and Melinda Gates Foundation is the largest private donor, but other private foundations, public corporations, and private companies also contribute to the financial pool.

Private sector funding within the Global Fund is perceived as much less controversial and the research findings appear to confirm that this stems from its hybrid governance structure. Private donors obviously influence the policies and programmes of the Global Fund, but this is rather perceived positively; their expertise in private sector management is as much appreciated as their contribution to the implementation of programmes. Private donors generally "*help us to become more effective and efficient*". Therefore, the role of private donors is quite different within an organisational context where results-oriented programming is highly valued and where many stakeholders, including private donors, characterise the governance structure. Private donors "*affected the very rule of governance*" and the big donations by the private sector "*gave them a lot of leverage*".

The importance of history

Similar to the Global Fund, GAVI is a public-private partnership funded through direct contributions (63%) and innovative financing (37%). 77% of Gavi's funding is from governments, 22% comes from foundations, corporations and organisations and 1% comes from the private sector (35). While private funding accounts for approximately a quarter of GAVI's funding, it is almost entirely dominated by the Gates Foundation (36). Almost all GAVI respondents mentioned the Gates Foundation as the most influential donor, not only because of its financial contributions to the organisation, but especially due to its role in creating GAVI. "*GAVI was basically created by a donation of the Gates Foundation, even if today their share is only 10%. They still have a strong voice*". Indeed, in 1999, the Gates Foundation pledged 750 million USD as seed money over a period of five years to launch GAVI (37).

None of the other organisations have this same striking history. Even though the Global Fund is a similar hybrid organisation, its history differs considerably. It was set-up as a response to the HIV/AIDS crisis at a time when there was much political support at highest levels, including UN Security Council resolution 1308, which was adopted unanimously on 17 July 2000 as the first resolution to address the impact of HIV/AIDS worldwide (38). Only a few days later, on 21 – 23 July 2000, the G8 Heads of States met at the 26th G8 summit in Okinawa, Japan and called for the creation of a Fund for the first time. The African leaders meeting in Abuja voiced support in 2001, as did UN Secretary General Kofi Annan, and consequently, the UN Special Session on AIDS was held in June 2001 calling for the formal creation of the Global Fund.

Each organisation must therefore be considered in its particular political context. GAVI, with its vertical programming focused on increasing immunisation coverage and reducing global disparities in access to vaccines, has been the Gates Foundation's vehicle to promote their interests in this area. This very limited approach of the organisation, however,

was viewed more critically a few years after its creation when discussions occurred within the organisation to expand its services to health systems strengthening (HSS). This brought about fundamental discussions concerning the organisation's orientation which was intimately linked to the priorities of the Gates Foundation at that time. One interviewee described this as follows:

> *"There was actually a bigger schism inside of GAVI in which the Gates Foundation had a very significant position and our CEO had an opposing position. But it was not just those two parties. It was really around to what extent GAVI should be expanding into health systems strengthening. The Gates Foundation was of the opinion that our focus really should be immunisation services and that's it – delivering vaccines. What we were hearing on the other side from many other donors was – and including our CEO – that you can't just continue creating these vertical programs that are not integrated. And so the real argument and battle was in the board, that means in our governance structure, on 'how much should we expand into HSS?"*.

Following those discussions, the GAVI Board took a first decision in 2005 to widen its support to HSS, even though the Board had expressed the need to strike a balance between immunisation, country-driven demand and innovation (39). Despite this decision, the Gates Foundation continued its support to GAVI, but the pledged amount in 2005 was 'only' 75 million USD over a period of 10 years (37). Thus support by the 'founding' donor decreased at this point of time, which may have been linked – at least partly - to the HSS discussions.

However, five years later, the GAVI Board formally recognised HSS as an 'underfunded' programme. In June 2010, the Board decided upon a new resource allocation method and affirmed a range for cash-based programme funding between 15-25%. This was likely a decisive moment for GAVI and brought an end to the 'schism' dating back to 2005; this policy meant that the maximum share for HSS funding would not exceed 25% and at the same time, it may not go lower than 15%. It seemed a good compromise at the time, balancing the different interests (39). Strikingly, just precisely one year after the above decision, in June 2011, the Gates Foundation pledged a further 1 billion USD at GAVI's Pledging Conference.

Organisational interests versus donor interests

Medicines for Malaria Venture (MMV) is a product development public-private partnership and was launched in 1999, with initial seed money from the Government of Switzerland, the UK Department for International Development, the Government of the Netherlands, The World Bank and the Rockefeller Foundation (40). This funding structure changed over time and today, the Gates Foundation accounts for approximately 60% of MMV's total funding alongside other funders, including government agencies, private foundations, international organisations, corporate foundations and private individuals (41). The financial contribution of the Gates Foundation is significant, and therefore, it is particularly interesting to analyse its real and perceived influence.

The Gates Foundation is the only private donor represented in the Board of Directors of MMV, which otherwise includes representation from academia, health organisations and health initiatives, as well as product development companies and organisations. This gives the Gates Foundation a very particular status and influence within MMV. The research tried to explore the nuances of this influence. One interviewee referred to this influence by stating that the Gates Foundation has been "*overall very respectful of the autonomy of MMV and its governance mechanism*". At the same time, the Board of Directors has to obviously balance the interests of the biggest donor – who in recent years seems to express more directly how they want their investments being used – and the interests of the organisation. The interviews

indeed confirmed that the Board wishes to keep its independence but also sees "*what the key funders understand of their vision and making sure that we don't entirely misalign ourselves with [these funders]"* as critical elements for the success of the organisation in the long-term. Ideology meets pragmatism in this approach.

Though this may be a realistic and pragmatic approach, MMV nevertheless seems to intend to operatetrue to its own purpose and principles. One other interviewee mentioned: "*Of course donors do influence […] but it is important that the organisation retains the capacity to be able to stand up and say 'no' to a donor if what is being proposed is negative or not desirable*". A clear organisational vision, good donor diversification and above all, a strong board are needed to be able to act in this way.

Conclusions

The following elements influence the role of private donors in the four analysed global health organisations: (a) the historical and political context of its creation, (b) the composition of the governance structure of the organisation, (c) the clarity of the vision of the organisation, and (d) the dependency on the donor to function. Donors are usually not passive actors but want to shape the agenda and exercise power. They either directly or more subtly influence the organisation, both at the operational and policy level. Consequently, organisational interests have to be balanced with the interests of the donors, often requiring negotiated compromises. Depending on the complexity of the organisation, its governance and funding structure, it can be said that individual donors can position themselves within the organisation and influence its operations.

Changing multilateralism – lessons from four African countries

Multilateralism has been defined as "the practice of coordinating national policies" among several states in order to achieve goals of common interest. Historically, multilateral arrangements have been designed to subsume one or more stronger powers in a cooperative relationship in which all member states are given a voice and voting capacity which they would not otherwise have. Analysis of the impact of funding patterns on the operations of the WHO, Global Fund and GAVI – with special reference to four African countries – provides insights on the principles of multilateralism.

Concentration of funding sources

There is a high concentration of funding in both GAVI and Global Fund reflecting the fact that they were largely created at the instigation of the major donors. In GAVI, eight Western governments have provided 70 percent of the funding, with most of the rest coming from BMGF. In the Global Fund, ten governments plus the European Commission have provided 87 percent of the funding. WHO is a much older organisation. At its inception, there would have been a similar domination of the major donors. Over time, its funding has become much more diversified. But, while there are now over 300 contributors to its funding, just three sources now provide one third of its total resources: USA, UK and BMGF.

Non-traditional sources and sustainability

GAVI has the most original funding structure, as well as the most sustainable, thanks to its Advance Market Commitment and International Finance Facility for Immunisation programmes which permit it to plan its funding several years ahead. GAVI also organises pledging conferences every five years and encourages multi-year contributions. The Global Fund also benefits from non-traditional funding sources, and has successfully attracted private sector support. Its replenishment programmes are every three years. WHO has been a pioneer

among UN organisations in successfully attracting support from many foundations, non-governmental and private sector sources, in addition to the contributions from all of its members. WHO has therefore become something of a hybrid organisation: intergovernmental in its governance, but with a growing number of private partners. Its funding basis is more precarious because of pressure from some major donor governments to limit its budget, and because its budgetary cycle is only biennial.

Influence of funders

The major donors to the funds were instrumental in their establishment and have therefore had a large say in determining their governance structures. But their governing boards are mixed, representing a range of different interests, and the continuing influence of individual funders is therefore only moderate. The same is true of WHO where there are large individual donors, but where decisions are subject to approval by the whole intergovernmental membership.

Influence of private sources of funding on the vertical funds

When it comes to organisational management, the influence of individual donors in the two funds is more visible. The three successive CEOs of both GAVI and the Global Fund have come from the largest donor countries. In the case of GAVI, the BMGF was considered to have been instrumental in the choice of the most recent CEO. In WHO, the major funders do not exert the same degree of influence, although they played an important role in urging WHO to undertake its latest major reform programme at the Geneva headquarters. Of the global multilateral organisations, however, WHO has a uniquely strong regional structure. The regional directors are chosen by the respective member states and are relatively autonomous.

We can also observe that the vertical funds have incorporated elements of business-sector management that are not present in the UN agencies or other IGOs. These include notably results-based management and modern marketing or financial mechanisms to raise funds. This would be consistent with theories of organisational evolution.

When it comes to programmes, the major funders exert a moderate influence. The two vertical funds, by their nature, have well-defined programming priorities which are much narrower than the health agenda of WHO. Within these confines, beneficiary countries are invited to define their needs. In WHO, the larger donors can implant their preferences, and their influence has grown with the increase in earmarked funding. However in 2013, as part of its reform process, WHO undertook two “financing dialogues” which have helped to achieve greater alignment between programme priorities and financial support from all sources. From the 2014-15 biennium onwards, programme-budgets reflect this better match between demand and supply.

Transparency

From the outset, the vertical funds – which were essentially the creations of donors – have shown considerable transparency in both processes and results. This degree of transparency has been demanded by donors and is critical for their ability and willingness to channel resources into these funds. WHO is by nature a much more complex, variegated and geographically dispersed organisation, for which an equivalent degree of transparency is more difficult to achieve, especially given the substantial number of programmes and their supporting funders. As discussed above, it is also more difficult for WHO, given the nature of its mandate, to show clearly attributable results in its programmes. One of WHO’s greatest strengths is the quality of health data which it generates and publishes. One of its shortcomings is in the objective evaluation of the performance of its programmes and the performance of beneficiary countries.

Table 4. Multilateral tests: a comparison of the three organisations

Criterion/test	WHO	GAVI	Global Fund
Funding concentration	Medium	High	High
Proportion of non-traditional funding	Medium	High	Medium
Funding sustainability	Low	High	High
Funding influence on governance	Medium	Medium	Medium
Funding influence on management	Medium	High	High
Funding influence on programmes	Medium	Medium	Medium
Influence of beneficiary countries	Medium	Medium	Medium
Transparency & accountability	Medium	High	High

Conclusions
The Global Fund and GAVI have very similar characteristics. Perhaps this is due to the fact that they were both created by donors around the same time, reflecting the then-current ideas on how to compensate for the UN system's failings. At the time of its creation, some features of the WHO more closely resembled the vertical funds. It will be interesting to see if the funds' profiles will converge on one more similar to WHO over time or if they will adapt to evolving principles of aid effectiveness and diverge further (e.g. on influence of beneficiaries).

Vertical funds: what lessons for multilateralism and the UN?

UN development organisations have several functions, including norm-setting, information dissemination, advocacy, humanitarian response and country operations. Their universality is the basis of their legitimacy in all these functions, but in its operational role, the UN's inter-governmental structure has contributed to its bureaucratic and cumbersome performance. UN operations, moreover, are increasingly in competition with other sources and mechanisms of technical assistance, and there is little doubt that the creation of the vertical funds was in part a response to the UN's operational shortcomings. There is a case to be made for the UN to abandon its operational roles entirely. Since this is unlikely to happen, however, it may be instructive to summarise the opportunities for mutual benefit.

Governance
The vertical funds have boards of limited (and rotating) membership, including civil society and private sector representatives. Even while formal approval and oversight of their operations continues to be the responsibility of all member states collectively, UN organisations should consider establishing advisory boards of limited size and mixed state and non-state membership.

Innovative funding sources
UN organisations have been successful in enlarging somewhat the range of funding sources, although the traditional donors remain dominant. They should endeavour to attract more innovative multi-year and multi-donor funding mechanisms like those established by the vertical funds in order to provide more programming continuity and security, while diluting the influence of individual donors on programming patterns.

Programme performance and transparency
While the much narrower operational mandates of the vertical funds are more amenable to establishing clear performance metrics, UN organisations should continue to elaborate criteria for programme success in creating longer-term sustainable capacity in developing countries. These criteria should be drawn up – or at least agreed to – by programme countries themselves. They should be used to determine programme success or failure, objectively determined through comprehensive evaluations of performance. Because they are present in all programme countries and well connected to local counterparts, UN organisations should be used more extensively by vertical funds for purposes of implementation and oversight.

Programme orientation
There are serious programming distortions in both vertical funds and UN organisations. The former divert substantial funds into narrow, albeit critical, fields of health-care, drawing resources and personnel – and therefore capacity – in programme countries away from other areas. The operations of WHO and other UN organisations are driven in directions which reflect as much the priorities of donors as recipients. Correcting for these distortions would require closer collaboration between vertical funds and UN organisations in country programming, and a strengthening of the capacity of recipient countries in strategic sector planning.

Conclusions
As the development community moves into the era of the Sustainable Development Goals- incorporating lessons learned and updating the terms of how to partner- the UN should learn from the innovations and successes of the newer vertical funds. The vertical funds can, in turn, harness the vast network of UN actors and collaborators for support as they lack personnel in-country.

Concluding remarks

Interviews with GAVI, the Global Fund, Medicines for Malaria Venture, and the WHO revealed insights on the role of private donors in four global health organisations, changes in multilateralism, and lessons for multilateral organisations. The following elements influence the role of private donors in the four analysed global health organisations: (1) the historical and political context of its creation, (2) the composition of the governance structure of the organisation, (3) the clarity of the vision of the organisation, and (4) the dependency on the donor to function. Donors are usually not passive actors but want to shape the agenda and exercise power. They either directly or more subtly influence the organisation, both at operational and policy level. Consequently, organisational interests have to be balanced with the interests of the donors and compromises are often negotiated. Depending on the complexity of the organisation, its governance and funding structure, individual donors can position themselves within the organisation and influence its operations.

The creation of the vertical funds, namely GAVI and the Global Fund, was in part a response to the UN's operational shortcomings. GAVI and the Global Fund are new forms of multilateralism in the health sector that have become very influential in Africa and have made great strides in changing mechanisms of development assistance in health. Multilateral organisations have diversified their funding sources in order to maintain the scale and scope of their operations. The vertical funds have implemented innovative fundraising mechanisms that draw some lessons from the private sector. Overall, given the current distortions, the vertical funds conform at least as well as other organisations, inside and outside the UN, to multilateral principles. Yet, they represent a new organisational form that deserves further

study. Since UN operations in the health field are likely to continue, there are lessons to be learnt from the ways in which vertical funds are administered. Closer collaboration and complementarity between WHO and other UN organisations on one hand, and the vertical funds on the other would be beneficial to public health delivery in developing countries.

Interviews in Chad, Ghana, Mozambique, and Tanzania unveiled the reality of emerging donors in the health sector and highlighted concerns about managerial gaps at the country-level.

Overall, based on the interviews, BRICS do not contribute significantly to the public health sector in Chad, Ghana, Mozambique, and Tanzania. Interviewees see space for them in the landscape but acknowledge that myriad obstacles exist. They are not seen as a replacement, but rather as a supplement, for conventional aid. They are not foreseen to provide assistance that resembles conventional aid; they are primarily focused on investment opportunities. Though they reportedly interact directly with the government, they are not participating in donor coordination bodies (though the reasons vary by country).

In terms of perceptions of private assistance for health in the four case-study countries, there is currently little coordination between private *donors* and conventional development partners, therefore development partners know little about how, specifically, private actors are engaged in the health sector. Interviewees concluded that private donors can only be complementary to assistance coming from large bi- and multi-lateral agencies; they contribute to fragmentation due to their narrowly-projectised focus. Additionally, these unconventional donors are not held to the same standards as conventional donors in terms of regulation, policies (ex. "Submitting reports to the Ministry of Finance is mandatory for conventional donors, but is voluntary for unconventional sources), but perhaps the greatest contribution that could come from the corporate sector is to pay fair tax.

There are country-level gaps that are relevant to all donors, both conventional and unconventional. Low absorption capacity is a challenge for development assistance in many countries. An important element of this challenge is the managerial gaps at local level. Systems' strengthening must be pursued as an integral part of technical projects, not only in the capital, but also at provincial levels. Additionally, donors should pay attention to promoting the creation of too many coordinating bodies that –although well-intentioned— may distract from actual implementation and generate high transaction costs.

This study highlighted existing gaps in donor-donor coordination and recipient-donor coordination, despite the proliferation of coordinating bodies. There also appears to be a lack of understanding about emerging donors overall influence on communities' health through investments affecting the social determinants of health. The themes of this project could be further pursued through interviewing and exploring selected relevant emerging donors- both BRICS and non-BRICS countries, philanthropic foundations, and corporations with active corporate social responsibility programmes in each of the case-study countries.

We found that studies on private finance for development need to find a different entry point to quantify and qualify contributions. Interviews and document review are insufficient. Funds from philanthropic foundations often enter recipient countries through non-governmental organisations obfuscating their contributions. There is a lack of disaggregated data on websites and annual reports. Additionally many private financiers are part of complex networks of other donors, recipient organisations, and implementing bodies; this prevents monitors from teasing apart flows without proper network analyses.

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