Trends and influence of private finance on global health initiatives and development goals in resource-constrained countries

Executive Summary

31 September 2012 to 30 April 2015

v1.0
16 September 2015

Research Plan

Problem statement

Development Assistance for Health (DAH)[i] in resource-constrained countries is at a crossroads and on the verge of crisis. This situation is evolving after a decade of increasing complexity in global health architecture with the arrival of new actors, particularly from the private sector, philanthropic groups, and emerging economies. This is coupled with the decline in influence from the conventional global health leadership of the United Nations System. Global monitoring of financial flows for DAH as part of Official Development Assistance (ODA) continues to focus only on conventional OECD (Organisation for Economic Co-operation and Development) sources and fails to include these pivotal new actors, their programme activities, and their influence. In 2011, for the first time in 15 years according to OECD data, ODA declined in real terms.

General objective

1. What is the nature and emerging dynamics in alternative financing and structural approaches in global health initiatives?

2. How are the governance structure and mechanisms of the new and emerging private financing mechanisms in the national or trans-national domain, ensuring national and international support and sustainability in funding and translating evidence and policy into global health action?

3. How effectively are the various new and emerging private financing flows contributing to global health goals and health development processes?

4. What are the likely future scenarios for private financing as a share of DAH, and its influence on global health governance and development?

Research methods

Semi-structured and key informant interviews with the staff and leaders of the Geneva-based organisations concerned were complemented by discussions with leaders and stakeholders in Chad, Ghana, Mozambique, and Tanzania. In addition, document review including evaluation reports of the last four years and routine data of the respective programmes were collected for comparison. Data was collected through desk reviews and interviews of key informants concerning the engagement patterns of emerging economies at the global health policy level and their respective influence.

Primary sources of information include the Ministries of Finance and Health and Commissions of Science and Technology (regarding unconventional financing flows). Secondary desk sources include National Health Accounts, Performance Expenditure Reviews, and UN statistics for classical ODA and DAH. The database created through recent global initiative of the aid transparency, “Publish What You Fund”, was reviewed to capture

[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).

the official statistics from the participating donor countries and private business when relevant.

Primary data collection

International organisations

Members of the research team conducted semi-structured in-depth interviews with 17 key informants from the GAVI Alliance, the Global Fund to Fight AIDS, Tuberculosis, and Malaria, Medicines from Malaria Venture, and the WHO. Interviewees were selected from the Board and Senior Management of each organisation. Invitations for interview were sent by email. Six interviews were conducted by phone with the remaining face-to-face. All interviews were conducted in English by one to three team members. All interviewees agreed to have their interviews recorded. Audio recordings were transcribed verbatim and uploaded into NVIVO software for analysis.

Case-study countries

The investigators conducted face-to-face semi-structured in-depth interviews with 86 key informants from the Ministry of Health, Ministry of Finance, health or development attachés of partner embassies in-country, selected UN agencies, local research institutions, the African Development Bank, and independent consultants. Interviews were held in the offices of key informants in N'Djamena, Chad; Accra, Ghana; Maputo, Mozambique; and Dar es Salaam, Tanzania. One in-depth interview was conducted by Skype. Interviews typically lasted approximately one hour but ranged from 45 minutes to three hours. An additional nine brief discussions were held with relevant experts for country and/or development context. In N'Djamena investigators were invited to, and attended a meeting hosted by the Country Coordinating Mechanism (the partnership of local stakeholders responsible for Global Fund grant development, submission, and, upon approval, oversight).

In Chad 16 interviews were conducted with 21 interviewees. One investigator is a Francophone and the other an Anglophone with a local translator. Ten interviews were conducted in French and six in English. The meeting of the Country Coordinating Mechanism was held in French. Fourteen interviews were conducted in Ghana with 17 interviewees. All interviews were conducted fully in English. In Mozambique 23 interviews were conducted with 24 interviewees. The discussions were held primarily in English with periodic clarifications in Portuguese as one investigator is a Lusophone. All 19 interviews in Tanzania with 25 interviewees were conducted fully in English. Investigators took detailed notes in English during the discussion. When more than investigator was present for an interview, notes were compared after transcription.

Follow-up emails were sent to key informants from Tanzania 11 months post-interview to ascertain relevant changes in the donor landscape. Eleven interviewees responded and two referred the investigators to new respondents. Key informants in Mozambique received follow-up emails nine months after the initial interview. Of the 24 interviewees, eleven responded and two referred the investigators to new respondents who provided input.

Schedule

Activity	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10
Case research reports and profiles (WHO, Global Fund, GAVI, and MMV).	■	■	■							
Map programmes and activities for the neglected diseases (WHO, Global Fund, GAVI, and MMV).		■	■							
Case assessments (WHO, Global Fund, GAVI, and MMV).			■	■						
Review of BRICS engagement (WHO, Global Fund, GAVI, and MMV).			■	■						
Conduct Geneva-based interviews with WHO, Global Fund, GAVI Alliance, and MMV			■	■	■	■	■	■	■	
Conduct interviews in Chad, Ghana, Mozambique, and Tanzania				■	■		■			
Case-studies: impact of private financing and BRICS influence (Chad, Ghana, Mozambique, Tanzania).						■	■			
Manuscript preparation						■	■	■	■	■
Participation in events shaping post 2015 (post MDG) sustainable development goals.						■	■	■	■	■
“Zenith Meeting”										■

Results

International organisations

Interviews with the GAVI Alliance, 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 Alliance and the Global Fund, was in part a response to the UN’s operational shortcomings. The GAVI Alliance 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.

Case-study countries

Interviews in Chad, Ghana, Mozambique, and Tanzania unveiled the reality of emerging donors in the health sector, provided insights on the perceptions of the Global Fund's New Funding Model in Mozambique, 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.

Summary indicating whether the results obtained correspond to those expected at the beginning of the research

We expected to unearth more quantitative data on financial flows for the four case-study countries. No interviewees, including those from the Ministries of Health, could, or would, provide exact figures. Chad's Ministry of Finance was the only governing body that provided budgetary data; unfortunately, no donor funds go through the public sector, so it was not useful in our study. This unexpected result illuminates the lack of transparency, or country-level awareness, of newer sources of external finance.

We also expected conventional development partners to be more aware of the presence and activities of emerging donors. It is difficult to gauge whether or not this is a pitfall in current donor coordination efforts (both amongst themselves but also with the recipient governments) or because the emerging donors provide more support for social determinants of health rather than development assistance directly for health, etc.

Further research

- **Emerging donor engagement from their perspective.** Our study was interested in understanding how new partners are engaged with recipients from the country-level perspective. This study highlighted gaps in donor-donor coordination and recipient-donor coordination and potentially gaps in 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.

- **Network analysis / partner mapping.** Recipient countries have increasingly complicated partnership landscapes. In Mozambique, there are 38 members in NAIMA+, the NGO coordination body. Between these 38 members there are more than 90 unique sources of funding and more than 190 unique operating partners. It is impossible to understand such complex interactions of donors, recipients, and operational partners without a proper network analysis to understand where money goes.

- **Agenda-setting with new donors.** How are agendas set between recipient governments and emerging donors? Conventional donors have long-standing relationships with the countries in which they operate and therefore have "institutional memory" for agenda-setting. How are new partnerships formed and finalised? How are agendas and priorities set? Who approaches whom for investment?

- **Policy analysis of changes associated with bilateral aid agencies' shift to Ministries of Trade.** The international community expressed concern about Canada and Australia's recent re-structuring of their Department/Ministry of Foreign Affairs. CIDA and AusAID were reorganised and housed within their countries' Ministry of Trade. Concerns focus on how this will affect central-level resource allocation and to what extent priority setting for development assistance will be overtly linked to trade interests. Norway, the Netherlands, and Denmark have all alternated between having independent aid agencies and aid agencies housed within the Ministries of Trade. What actually changes besides politics and internal re-structuring? Were these organisational changes accompanied by significant changes in development policy?

Practical and policy recommendations

- 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.

- National Health Accounts[ii] are an internationally accepted framework to track expenditure on health to guide policy-making. They primarily focus on financial flows for health services and break down domestic sources into public and private and also include development assistance for health. Unfortunately, many countries do not yet produce NHAs and those that do only publish every three to five years (when a country publishes them at all). In terms of development assistance for health, the data presented is aggregated and is not broken down by donor, nor do they include external sources of private finance or the emerging economies. NHAs should be modified to include emerging sources of finance and should be updated on a more regular basis to be a more useful tool of who is contributing to health in any given country.

- In an ideal world, emerging donors would publish their aid data with the International Aid Transparency Initiative (IATI)[iii], a voluntary, multi-stakeholder initiative that aims to increase aid effectiveness through increasing aid transparency. Government donors, private organisations, and NGOs are called to report their aid data in a standardised framework. There are currently 338 publishers on IATI. Of these, seven are foundations, 12 are classified as "private sector", two are public private partnerships (the Global Fund is classified as a multilateral organisation), and none are emerging economy bilateral donors.

  Unfortunately only 16 of 34 OECD countries report to IATI, so putting international pressure on emerging donors would be ineffective if conventional donors are not complying. At the very least emerging donors should be encouraged to report against global standards like the OECD-DAC. Additionally, the OECD-DAC databases would be more useful for understanding aid flows, if donors were required to submit data with a lower level of aggregation.

  As of yet there are no real incentives for donors to increase their transparency or accountability. Perhaps the most effective approach would be for the international development community to design a standardised rubric to be included in routine auditing of bilateral donors- a separate section dedicated to aid effectiveness. In light of ongoing economic volatility, it is also in the best interest of donor governments and tax-payers to ensure that their aid agencies avoid internal duplication and non-evidence-based programming.

[ii] http://www.who.int/health-accounts/en/
[iii] http://www.aidtransparency.net/

Publications and activities

Research Questions
Question 1: Nature and emerging dynamics in alternative financing
Question 2: Governance structure and mechanisms
Question 3: Effectiveness of private financing
Question 4: Future scenarios for private financing and its influence on global health governance and development

#	*Publication Topic*	*Lead Institution*	*Related Research Question(s)*
1	High-profile overview paper summarizing main conclusions and messages	IHEID	
2	Emerging economies' engagement in health as a political tool and as a reflection of global political shifts	Swiss TPH	1
3	Perceptions of private assistance for health at the country-level	Swiss TPH	1
4	New Funding Model of GF in Mozambique	Swiss TPH	3
5	Changing discourse in health aid management	Swiss TPH	3

6	New politics of health assistance	IHEID	1, 2
7	Vertical funds: what lessons for multilateralism and the UN?	FUNDS	2
8	The role of private donors in four global health organisations	IHEID	3, 4
9	BRICS in the global health agenda – a perspective from the inside of international health organisations	IHEID	2
10	Managerial gaps and financing decisions in Mozambique	Franklin University	2
11	Changing multilateralism – lessons from four African countries	FUNDS	1
12	Challenges of global health research in a rapidly changing aid landscape	Swiss TPH	
13	Monitoring, Transparency and Accountability Framework within Global Partnerships in the global health sector: Including member organisations, philanthropic foundations and business partners	CSEND	2, 4