



CHAPTER 5:

MULTILATERAL ORGANIZATIONS AND GLOBAL HEALTH INITIATIVES

A variety of international organizations are involved in mobilizing resources from both public and private sources and using them to extend development assistance to low-and middle-income countries around the world. They provide country-focused financial and technical assistance to developing countries, and contribute to the generation of global public goods, such as disease surveillance, norms and standards, data and knowledge, and aid coordination. Some of these international institutions, such as UN agencies and development banks, have been active in the sphere of development assistance for nearly six decades. In contrast, international public-private initiatives for global health like the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and the Global Alliance for Vaccines and Immunization (GAVI) are less than a decade old, but have emerged as significant actors in the global health landscape.

In this chapter, we review the health contributions of the UN agencies, development banks, and global health initiatives. In the three sections below, we briefly describe their role in the global health arena, and summarize the data we have captured to track their resource flows.

United Nations agencies

Numerous UN agencies undertake activities that directly or indirectly impact health. For the purposes of our resource-tracking exercise, we focused on UN

agencies that either work entirely in the health field or undertake significant health expenditures – the World Health Organization (WHO), United Nations Children’s Fund (UNICEF), Joint United Nations Programme on HIV/AIDS (UNAIDS), and United Nations Population Fund (UNFPA).

WHO was established in 1948 as the nodal agency for health within the UN. Funded by member states, private donors, and other intergovernmental agencies, WHO seeks to improve health worldwide by providing leadership on health issues, setting norms and standards, coordinating health research, and extending technical assistance to countries. UNICEF was originally created by the UN in 1946 to provide emergency food and health care to children in countries affected by the Second World War. It now works to improve the lives of children in 190 countries around the world. Financed by governments, private sources, and other intergovernmental organizations, it works to deliver medical supplies and health services to promote child health. Its other areas of work include education, advocacy for children’s rights, research, and disaster relief. UNFPA was established in 1967 to improve reproductive and maternal health around the world. It currently works in 150 countries to achieve this goal by procuring and distributing reproductive health supplies, providing reproductive health services, and undertaking information dissemination and advocacy

campaigns. UNFPA receives funding from both governments and private donors. Created in 1996, UNAIDS works with numerous other UN agencies to help over 80 nations carry out country-level HIV/AIDS plans. In its focus countries, UNAIDS coordinates HIV/AIDS interventions such as treatment, counseling and testing, social safety nets, health sector strengthening, prevention, training, and technical support with financial support from its 10 partner organizations as well as donations.

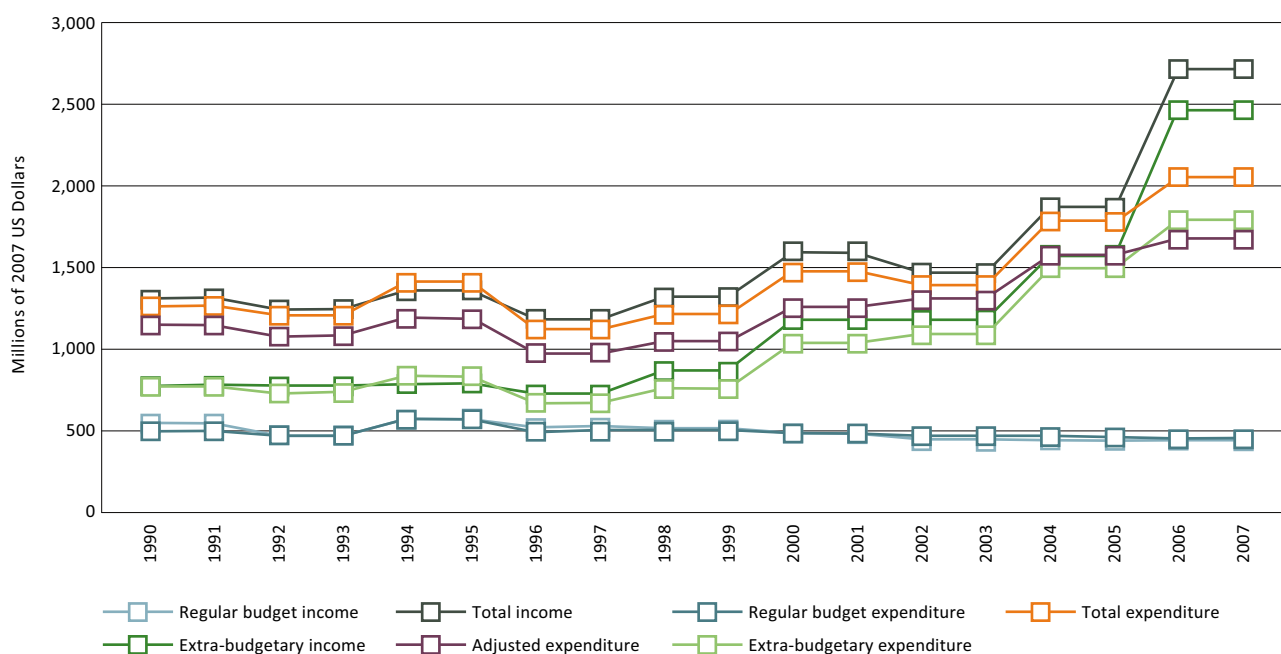
Several other UN agencies also work in the health sector, but their expenditures are relatively small in volume compared to the four UN agencies that we have included in our tracking exercise. We also excluded program expenditures associated with allied sectors like education, water and sanitation, food security, humanitarian assistance, economic development, and agriculture. While these programs undoubtedly affect health outcomes in developing countries, measuring health sector support is the goal of this study. For each of the UN agencies included in the study, we collected

data on their income and expenditure from audited financial reports. In all cases, the institutions differentiate between regular budgetary income, which reflects core or assessed contributions received from donors per previously agreed upon arrangements, and extra-budgetary income, which reflects voluntary contributions from donors. They each disaggregate their income and expenditure according to these two revenue streams. We collected data on both revenue streams.

For WHO, UNFPA and UNAIDS, we counted their total expenditure as DAH after adjusting for any transfers to other channels tracked by IHME. Since UNICEF's activities are not limited to the health sector alone, we estimated the fraction of its total expenditure that was for health. The methods annex explains these corrections and includes references to data sources used.

Figure 21 shows WHO's regular budgetary and extra-budgetary income and expenditure. It also shows the amount of its expenditure that we counted as DAH after adjusting for transfers to other institutions

FIGURE 21
Income and expenditure for WHO



Source: IHME DAH Database

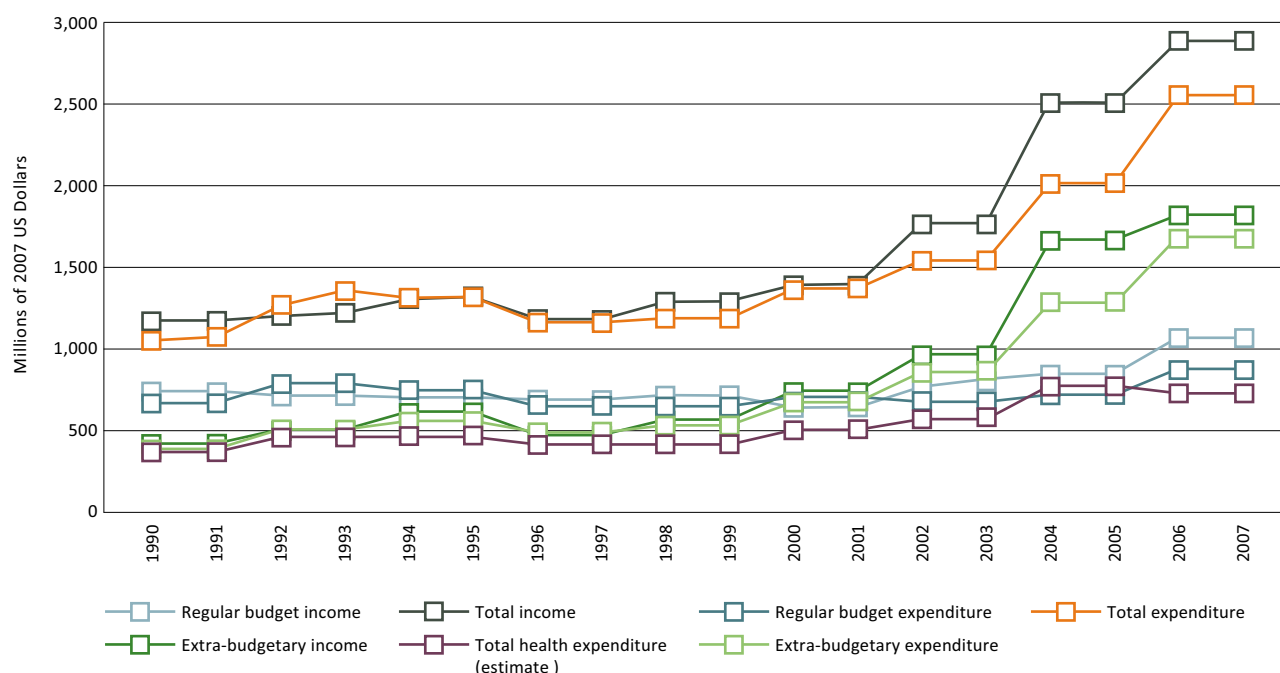
tracked in the study. It is worth noting that the total income of WHO, shown in black in the graph, has increased dramatically since 2003. While the regular budgetary income and expenditure, shown in shades of blue, have remained stable over the entire duration of the study, the extra-budgetary income of WHO doubled between 2003 and 2007, mostly due to the representation of trust fund income from GFATM in its financial accounts. Consequently, the extra-budgetary expenditure of WHO also increased during those years, but not as much as its income. WHO's extra-budgetary income and total income exceeded its extra-budgetary expenditure and total expenditure by \$669 million and \$659 million respectively in 2007.

Figure 22 shows comparable numbers for UNICEF. Much like WHO, UNICEF's income and expenditure have shown marked increases since 2003 and the gap between its total income and expenditure in 2007 was substantial. Figures 23 and 24 track UNFPA and UNAIDS. In magnitude, these organizations account for much smaller health expenditures than either WHO or UNICEF.

International development banks

International development banks are financial institutions that extend grants, loans, and technical assistance to low- and middle-income countries for development purposes. The most well-known among them is the World Bank, which is comprised of the International Development Association (IDA) and the International Bank for Reconstruction and Development (IBRD). When IBRD was established in 1944, its primary purpose was to assist European countries in their post-war reconstruction effort. Over time, IBRD's focus shifted to aiding development efforts in middle-income and certain low-income countries through low-interest loans and technical assistance. Financed through revenue from capital markets and loan repayments, IBRD helps client nations finance projects in several development-related sectors including health. Founded in 1960, IDA provides grants and zero-interest loans to low-income countries for development projects. The aid IDA extends is financed through contributions from member countries, as well as revenue from financial markets and transfers from IBRD.

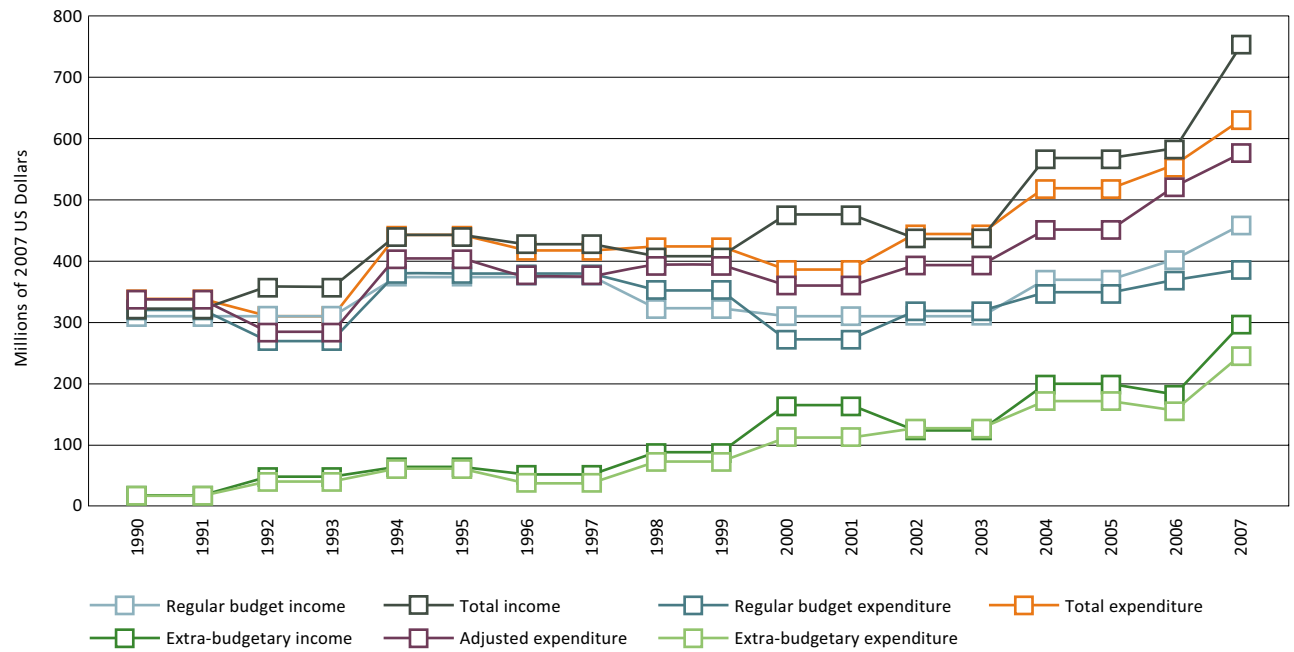
FIGURE 22
Income and expenditure for UNICEF



Source: IHME DAH Database

FIGURE 23

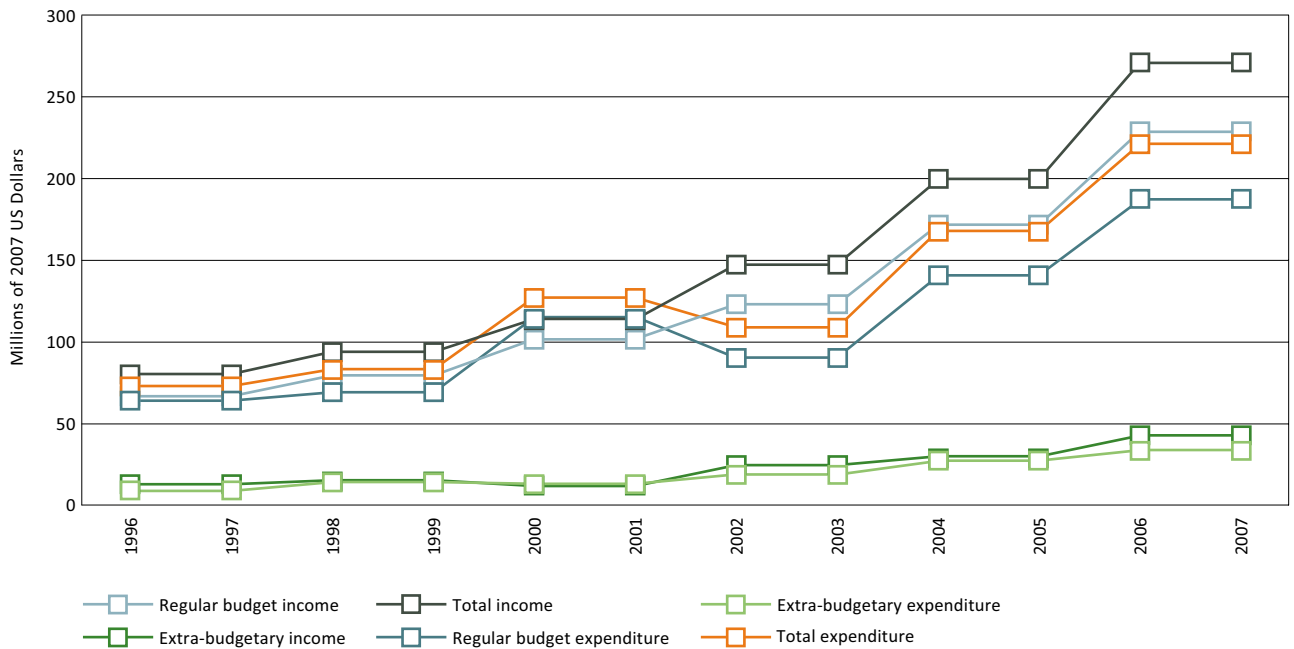
Income and expenditure for UNFPA



Source: IHME DAH Database

FIGURE 24

Income and expenditure for UNAIDS



Source: IHME DAH Database

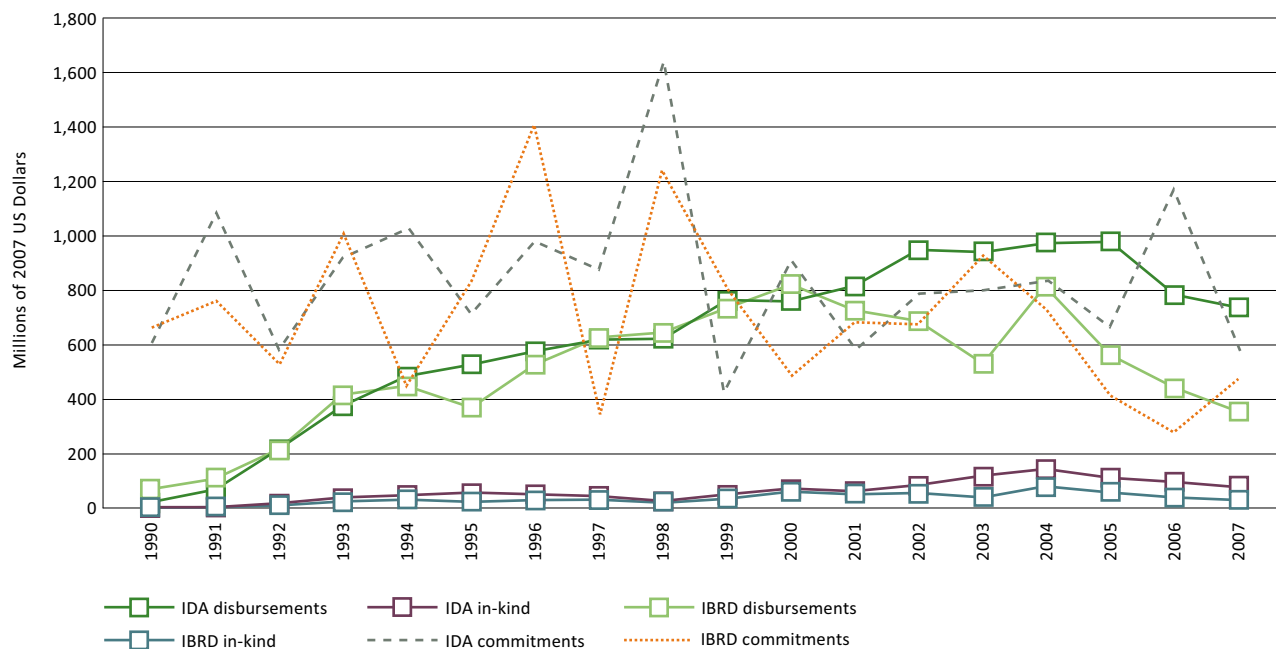
Several other regional development banks also provide targeted financial and technical assistance to developing countries within their region of focus. In this study, we tracked health contributions from the Asian Development Bank (ADB), the African Development Bank (AfDB), and the Inter-American Development Bank (IDB). Established in 1966, ADB uses revenue from member country governments, debt repayments, and financial investments to provide grants and technical assistance to governments and the private sector in 44 developing countries in Asia and the Pacific. Created in 1959, IDB's clients include governments and private sector institutions in 26 Latin American and Caribbean countries. Established by African governments in 1964, AfDB provides loans and grants to private companies, financial institutions, and governments in 53 African member countries.

For each of these international development banks, we extracted information on their income and project disbursements from audited financial statements, reports and online project databases. Since their

activities are not limited to health, we used their classification of projects by sectors and disaggregated sector-wise allocations to identify flows for health. In some instances, as was the case with the World Bank, identifying what was a health project required careful examination of the data and associated coding schema. The World Bank assigns a sector code as well as a theme code to each project. Sector codes represent economic, political or sociological subdivisions within society. Theme codes, on the other hand, indicate the goal of the activity. All projects coded to the health sector are also coded as having a health theme. The converse, however, is not true, since projects for allied sectors such as water and sanitation and education could also have health-related objectives. We included all projects coded as health in the sector field in the study and excluded any that were for other sectors but had health as a theme.

Where data on annual disbursements were not provided, we estimated them using information on project-wise cumulative disbursements and project

FIGURE 25
Health resource flows from IDA and IBRD



Source: IHME DAH Database

FIGURE 26

Health resource flows from ADB, IDB and AfDB

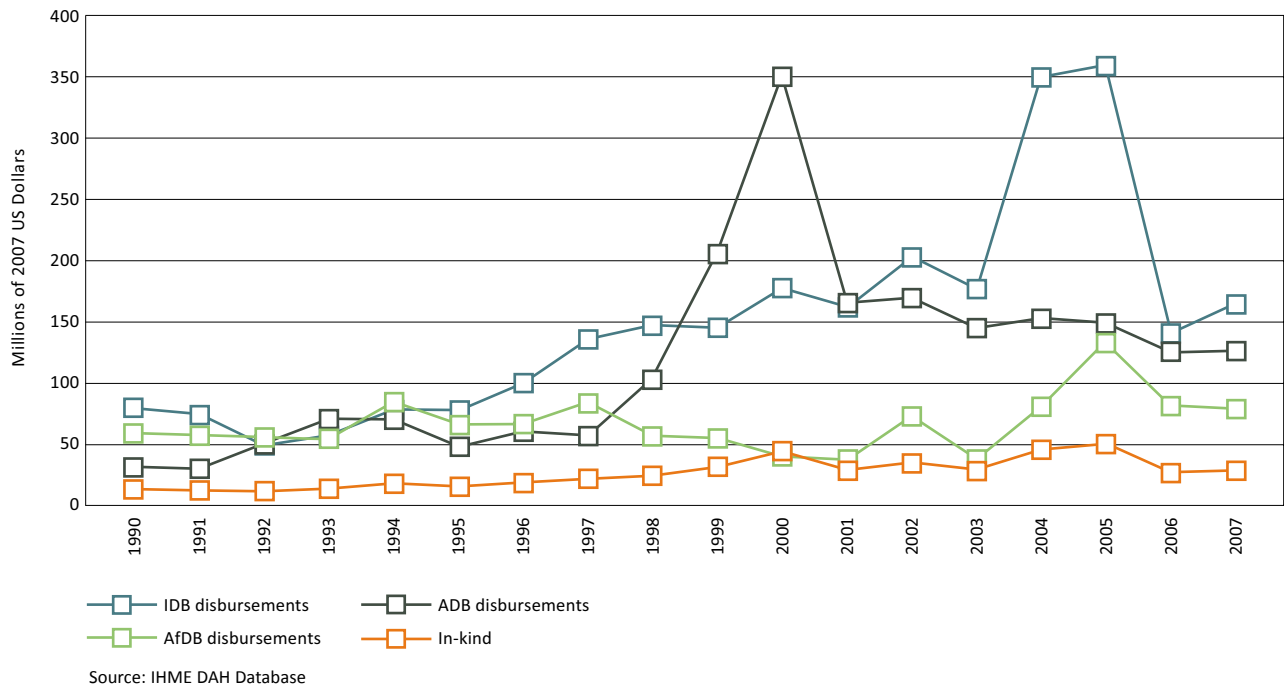
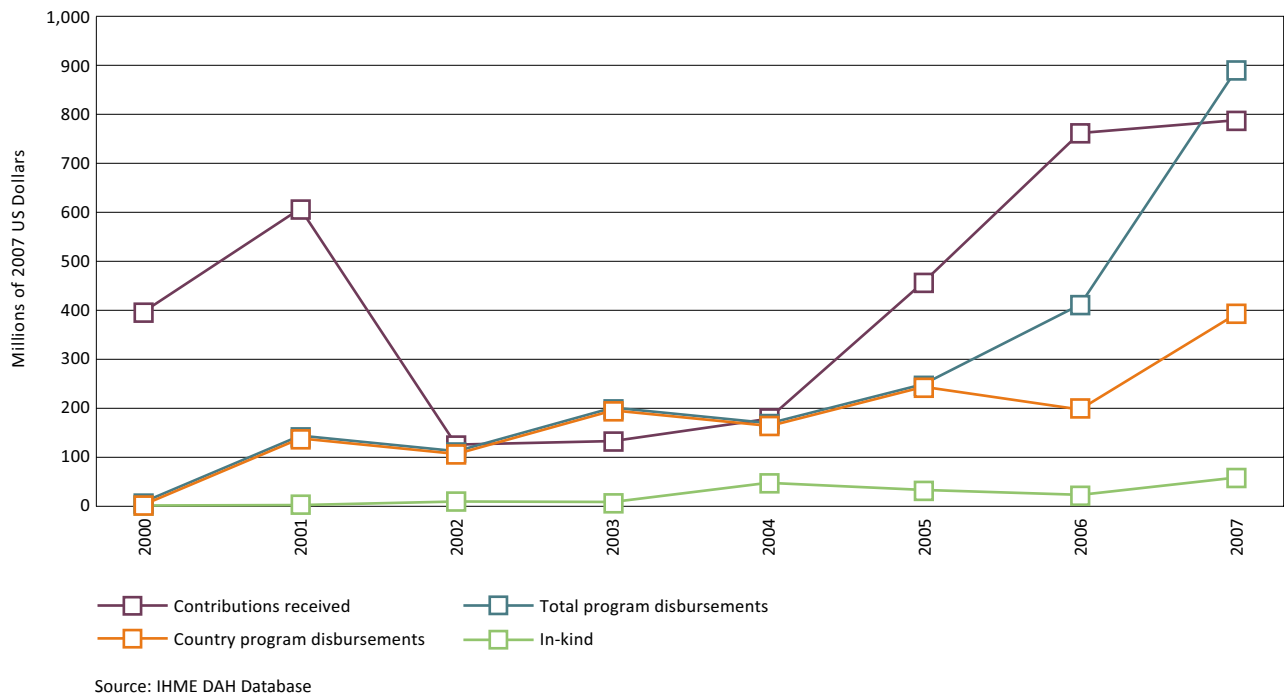


FIGURE 27

GAVI's health contributions



duration. Additionally, we separately estimated the in-kind component of the development banks' assistance, namely the costs associated with hiring staff to provide technical assistance and manage projects. The methods used for each institution as well as the in-kind calculations are described in detail in the methods appendix. Here, we highlight the main findings for this set of institutions.

Figure 25 shows aggregate health-related financial disbursements and in-kind contributions from IDA and IBRD. In the case of IDA, outlays for health programs increased steadily until 2005 but have declined over the past two years. Disbursements from IBRD for the health sector peaked in 2000 and appear to be in decline since then, with the exception of a sharp rise in 2004. These declines in disbursements mostly correspond to decreased health commitments, which are also shown in the figure for both IDA and IBRD. Funds committed for new health projects have been

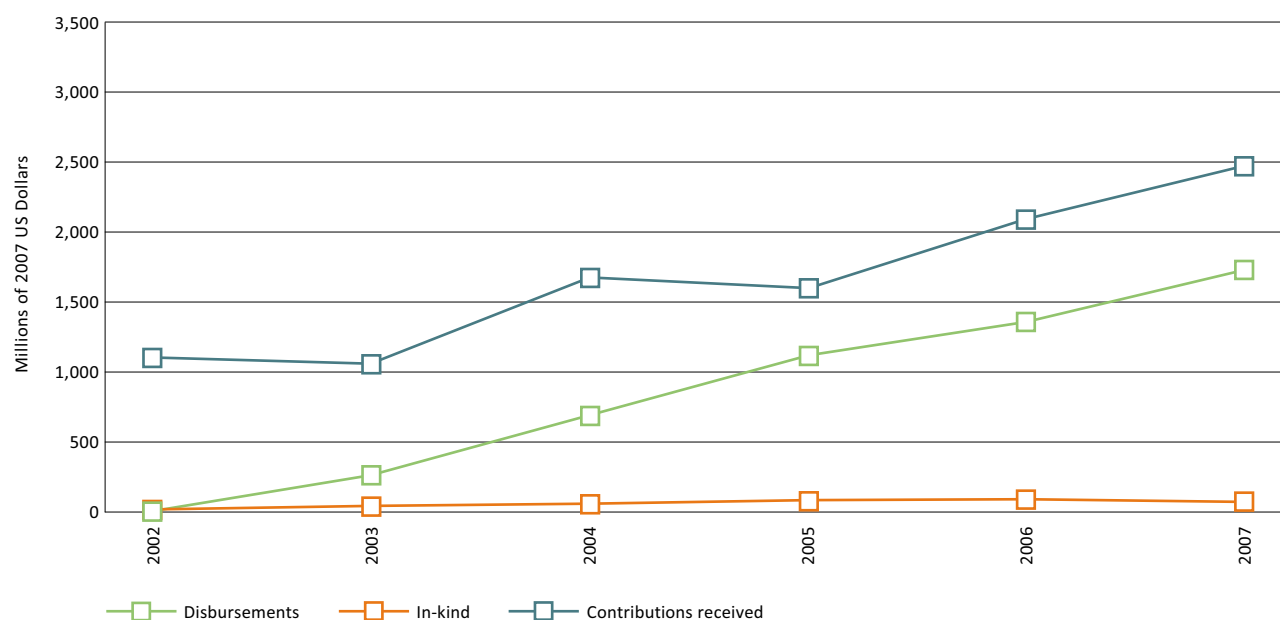
lower since 2000 than before for both organizations, though the drop is starker in the case of IBRD. IDA commitments spiked in 2006, which is likely to have led to higher disbursements in 2008 and 2009.

Figure 26 shows annual disbursements on health projects by the three regional banks included in the study, as well as their total in-kind contributions. ADB's outlays for health increased in the late 1990s but have declined steadily since then. In contrast, both AfDB's and IDB's investments in the health sector were higher post-2000 than before.

Global health initiatives

GFATM and GAVI have been heralded as new and innovative funding mechanisms for channeling health assistance to developing countries. Established in 2000 at the World Economic Forum, GAVI's goal is to increase vaccination coverage and reduce child mortality in developing countries by mobilizing

FIGURE 28
GFATM's health contributions



Source: IHME DAH Database

long-lasting funding, purchasing and distributing vaccines, providing technical assistance, and strengthening health systems. GAVI derives its funding from the International Finance Facility for Immunisation (IFFIm) and the Advanced Market Commitments (AMC), which are financed by governments and private donors. GFATM was founded in 2002 as a fund for increasing developing countries' access to new life-saving treatments for HIV/AIDS, tuberculosis, and malaria. Donations from governments and private donors have enabled GFATM to provide grants to governments, non-governmental organizations (NGOs), and multilateral institutions working in 140 countries for the prevention and treatment of these three diseases. Less than 10 years old, these global health initiatives have effectively mobilized resources from public and private sources and channeled them to disease-specific programs in developing countries. For both GFATM and GAVI, we extracted information about their revenue and global health contributions from project databases, audited financial statements, and project documents. We also calculated their administrative and management costs, which we count as in-kind support.

GAVI's country-based program expenditure, shown in orange in Figure 27, includes all grants for immunization services support (ISS), new and underused vaccines support (NVS), and health system strengthening (HSS), and has increased steadily since the inception of the organization. Total program disbursements, shown in blue, were the same as country program disbursements until 2005. In 2006 and 2007, total program disbursements rose sharply to more than double the volume of country program support. During this time, GAVI scaled up support to GAVI partners for new initiatives such as Global Polio Eradication and funding for pentavalent vaccine procurement using funds made available through IFFIm. We believe this explains the gap between total program expenditure and country-based expenditure in 2006 and 2007. GFATM's revenue as well as its program disbursements and in-kind assistance are shown in Figure 28. GFATM's health outlays have kept pace with its steadily increasing revenue since 2002.