

An Assessment of Donor Coordination
And External Financial Mobilization
For Health, Population and Nutrition
In Sub-Saharan Africa

Africa Regional IQC PDC--1406-1-7152-00
Delivery Order No. 10

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1993

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45

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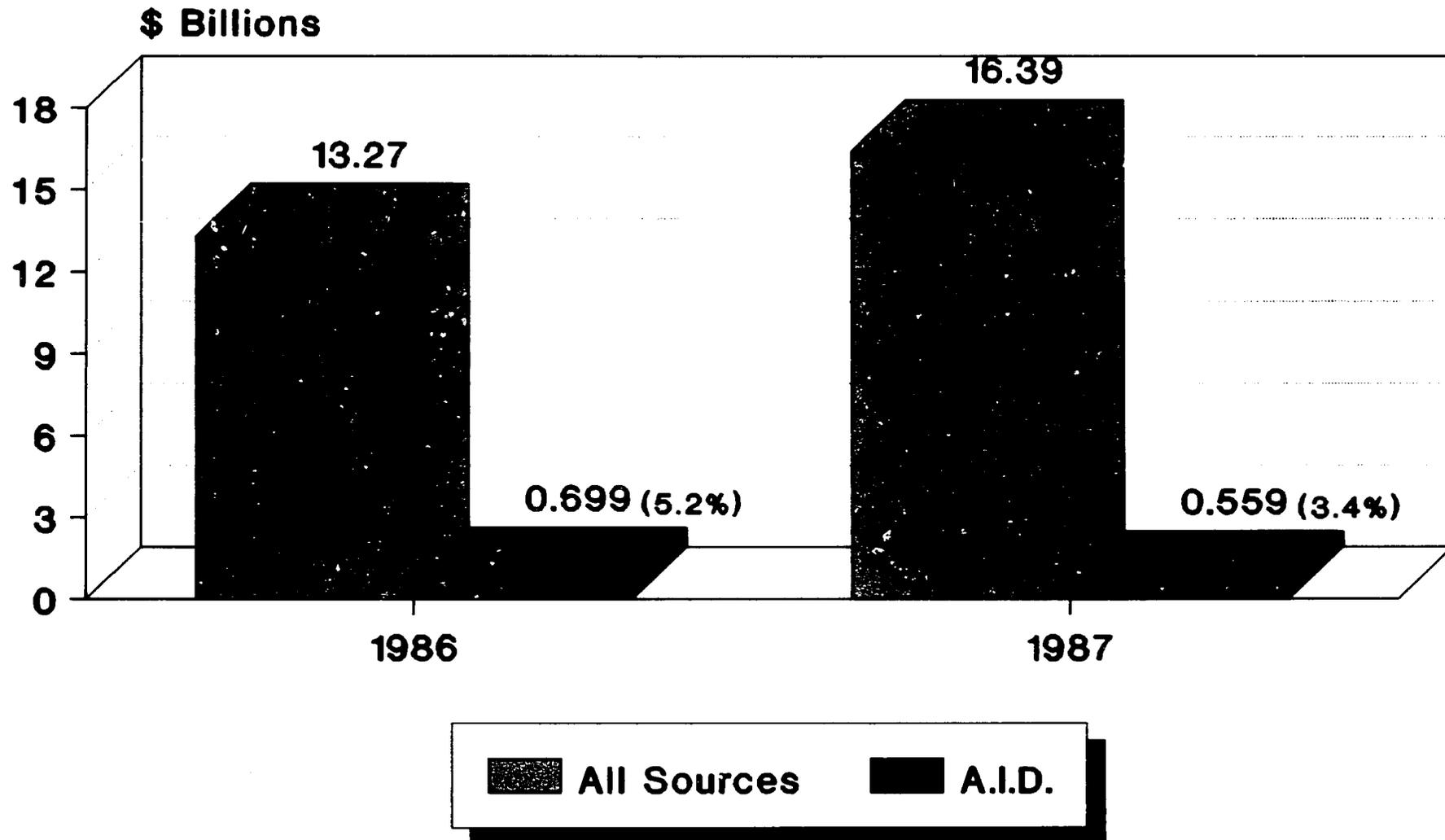


CHART I

Africa Health ODA: All Sources vs A.I.D.

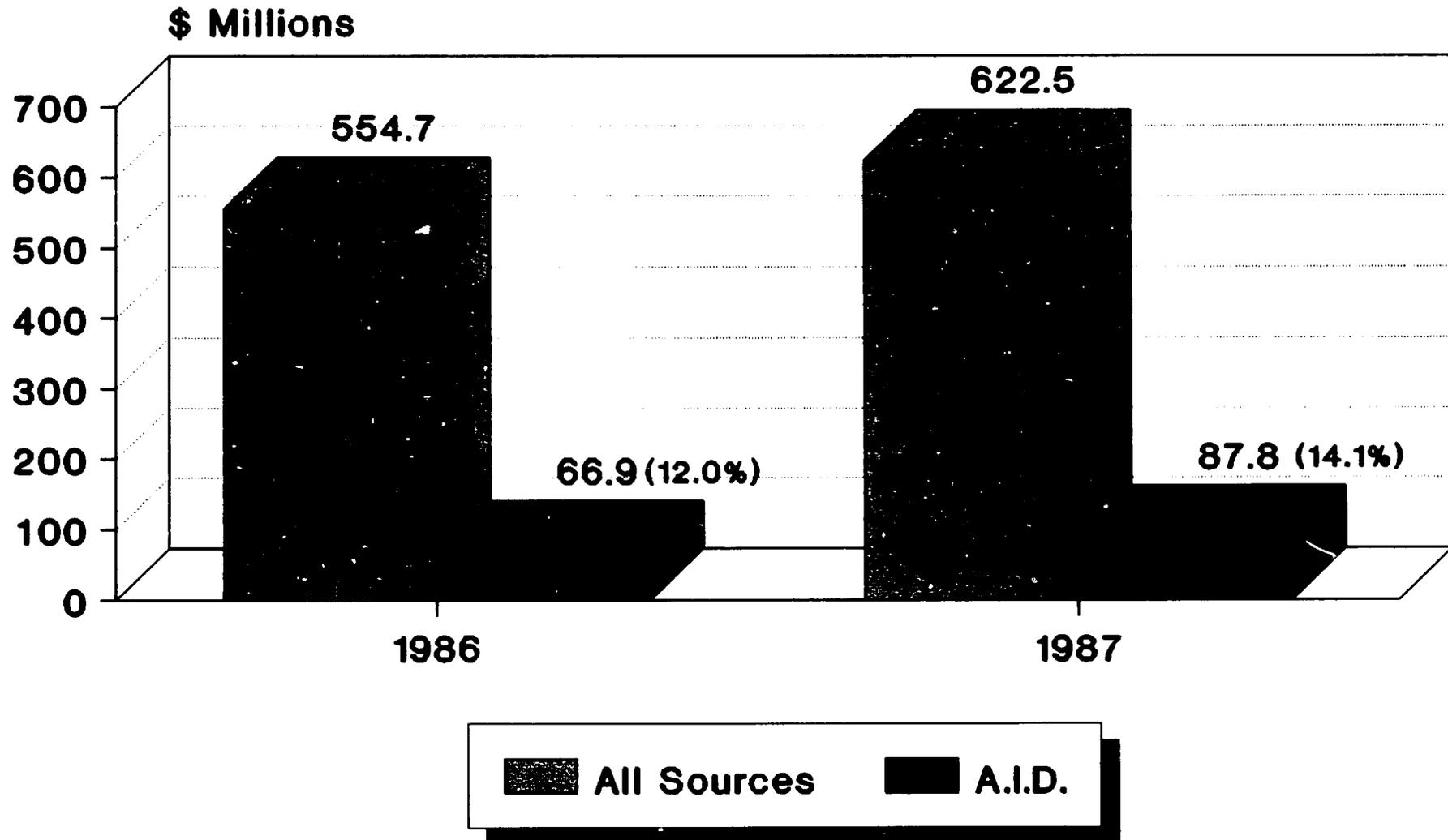


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Africa ODA, All Sources: Health vs Total

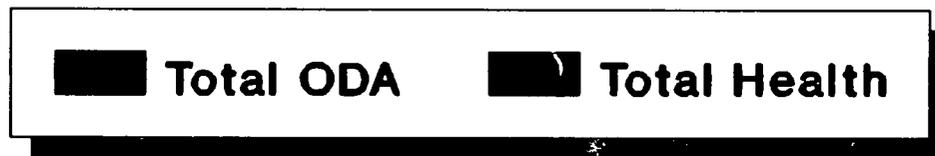
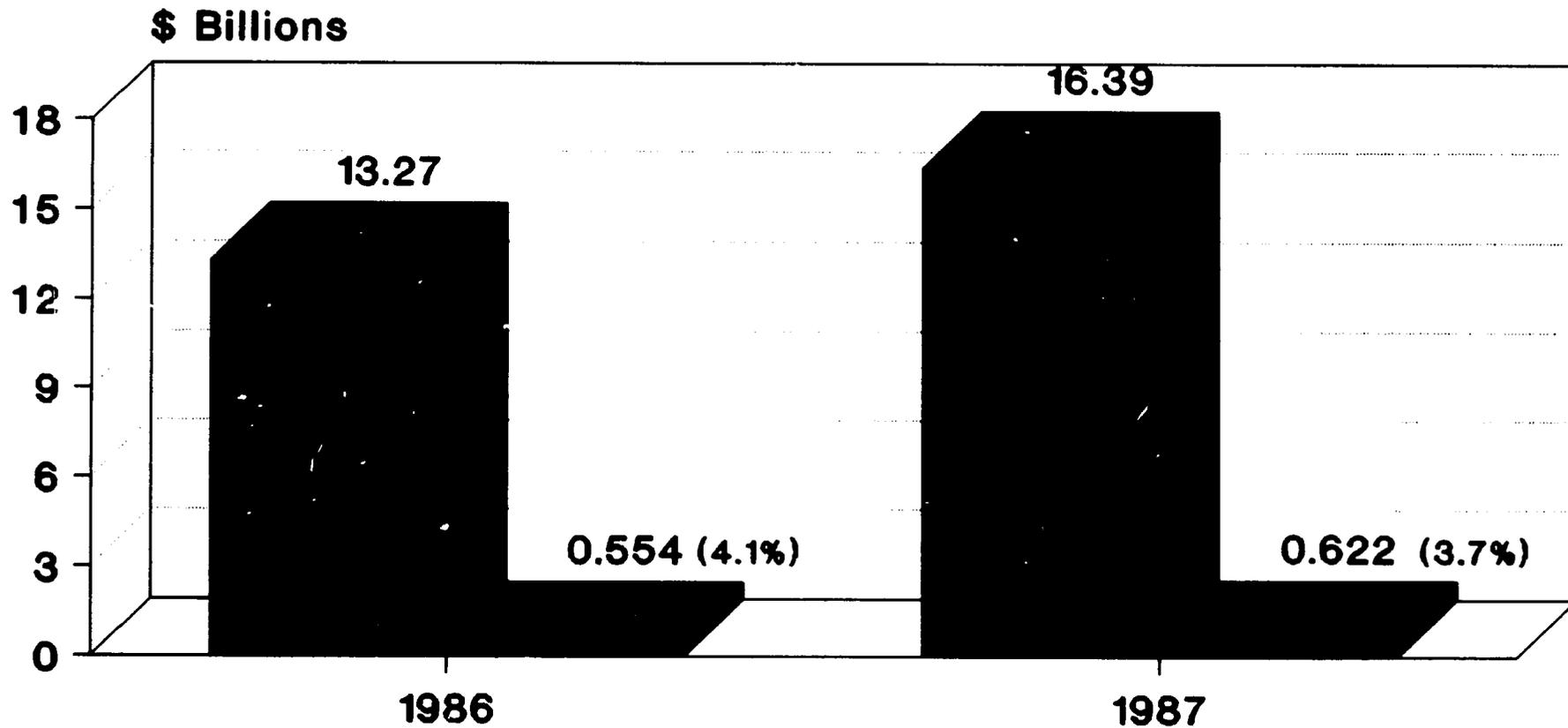


CHART III

EXECUTIVE SUMMARY

1. Title:

Donor coordination and financial resource mobilization for health, population, and nutrition in Sub-Saharan Africa.

2. Contract:

Africa Regional IQC PDC-1406-I-7152-00, Delivery Order No.10

3. Objective:

To conduct an assessment of donor coordination and financing for the HPN sector in Africa.

The intent is to review current trends and the potential for increased mobilization of external financing for HPN. The context is that the feasibility of any future Bureau strategy in this sector will be necessarily linked to the outlook for Bureau financing in relation to the collective efforts of other donors with similar HPN objectives.

4. Scope of Work:

For the HPN sector in African Region:

- Summarize trends of major official and nongovernmental financial sources by country
- Identify major existing and potential sources of financial assistance by country of preference
- Identify current and projected demand for HPN financing by country and constraints to demand, to the extent data permits
- Identify major opportunities for financial mobilization, including matching, negotiating and project development
- Identify training requirements for better utilization and coordination of donor resources
- Identify the practical components of a donor coordination and financial resource mobilization system which is acceptable to African governments and external cooperating agencies. Who should implement the system?

5. Methodology:

The study was carried out during the four month period, January 27 to May 28, 1989 by a two-man team. Dr. Lee Howard reviewed 21 major donor information sources in North America and Europe including the World Health Organization headquarters, Geneva and the Organization for Economic Cooperation and Development, Paris. Mr. Patrick Morris visited WHO Regional Headquarters in Brazzaville and Ministries of Health and A.I.D. Missions in Kenya, Malawi, Niger, and Zaire. Supplemental data was gathered through Pragma contacts in Benin, Burkina Faso and Liberia.

Data quality for HPN purposes is highly variable. DAC/OECD provides annual data on gross development financing trends to developing countries, but limited sectoral data. The OECD Creditor Reporting System excludes financial contributions by the UN system as well as sector specific information on technical cooperation. Data is normally a year late by the time it is published.

The WHO/Geneva has attempted periodic data gathering from donors. Current reviews are not regularly updated and often exclude country-specific distribution of financing. The result is useful for WHO itself, but less so for developing countries who desire convenient access to policy, program and financing information on external financial sources.

The UNDP annually gathers country-level information from all existing official donors without identifying potential financing from non-represented official and nongovernmental sources.

The World Bank accumulates fiscal data on all countries without special efforts to identify concessional financing for the HPN sector.

Bilateral donors maintain geographically-oriented fiscal data which is reported annually to OECD, but many donors do not retain HPN sectoral information on a routine basis.

To summarize, there exists no international source or system which is organized for the purpose of gathering and distributing timely reliable sector-wide HPN donor financing on a global scale. Criteria and definitions for "health sector" activities vary among sources. The effects of this status are two-fold:

- Developing countries have limited access to timely knowledge of the potential sources of concessional financing for HPN.

- Donors themselves have limited access to reliable sectoral information on which to rationally base future coordination of external health financing for common objectives.

6. Problem:

Future financial options for the support of the AID/HPN sector in Africa will be influenced by cross-cutting technical and financial issues:

- Sub-saharan Africa, including the A.I.D.-emphasis countries, has the world's highest rate of population growth, malnutrition, endemic tropical disease, infant and maternal mortality.
- A.I.D. Regional population, child survival, primary health care, tropical disease efforts are part of a collective Regional effort by all donors, particularly since the Alma Ata Conference in 1978, to assist developing countries achieve at least minimal access to the most basic health requirements.
- International consensus on the major HPN goals for Region have required financing to support major extension of services at a time of regional economic crises, debt and famine.
- In the face of expanding sector goals and severe economic constraints, major attention has been paid to improvement of effectiveness of health care financing at the country level ("health care financing"). Less formal attention has been paid to the mobilization of external financing for HPN sector common objectives.
- Volume of external flows is not the sole measure of donor effectiveness. It does serve as a tangible measure of donor intent. In this sense:
 - o External concessional financing (ODA) from all donors to Sub-Saharan Africa has increased from \$10 billion in 1981 to \$16 billion in 1987 (See Table 1)
 - o U.S. official concessional assistance (ODA) represented only 8.2 percent of all bilateral and multilateral ODA flows in 1987 (See Table 2). A.I.D.-administered development flows to the Region, as a percentage of total all-sources development commitment, represented only 5.2 percent in 1986 and 3.4 percent in 1987 (See Chart I and Table 7)

- o While the relative contributions of A.I.D. regional financing vary with A.I.D. emphasis countries, the Bureau has faced a decline in total development financing since 1985 and continues to be at risk of further reduction from the Gramm-Rudman-Hollings legislation.

Given these foregoing constraints, key financial issues for the Bureau's HPN sector may be stated as follows:

- Is there a financing strategy to support the Africa Bureau's long-term HPN objectives?
- If the Bureau's priority HPN objectives are shared by other major donors, by what mechanism can the Bureau assure maximum coordination with these sources?
- How can the Bureau's HPN budget be justified without access to a practical operational system through which the Bureau is able to identify alternate sources of financing, opportunities for donor collaboration, and mechanisms to strengthen the ability of African countries to increase official demand for external financing?
- Since Foreign Assistance Legislation, the Agency's Blueprint for Development and the Bureau's draft HPN strategy emphasize the importance of donor coordination, what are the practical alternatives for an effective system of Regional HPN donor coordination and external financial mobilization?

7. Background

At a general macro-economic level, donor coordination is receiving major attention both in Africa and through international mechanisms such as DAC/OECD. By contrast, mechanisms for sectoral HPN coordination have received far less formal attention. While acknowledging continuing ad-hoc coordination among existing donors in some A.I.D.-assisted countries, limited regional efforts such as the OCP and Club du Sahel, and selected efforts at global coordination (e.g. AIDS), there are components of financial coordination and planning for HPN which have received limited attention, for example:

- Regional or country external financial planning prior to sectoral investment
- Mobilization of collaborative external financing for global, regional or country program priorities (in contrast to routine internal donor budgeting or co-financing for donor-specific projects)

- Strengthening the capability of developing countries to articulate sectoral demand for financing from alternative sources
- Evaluation and monitoring of external financial supply and demand

Traditionally, "donor coordination" encompasses cooperation among regional and country resident donors who are already committed to a specific project.

Prevailing mechanisms of coordination have their limitations as applied to the HPN sector. The DAC/OECD has no formal continuing effort to coordinate or analyze the HPN sector. DAC/OECD relates to donor member countries, not directly to recipient countries. WHO has a constitutional mandate to serve as a "supreme coordinating authority" in health and serves this function well in its technical dimension. Financially, WHO has been able to play only a minor role since HPN financing originates primarily from development organizations, not health organizations. The World Bank serves to secure co-financing for defined priority projects negotiated with developing countries, but not for the HPN sector as a whole. The UNDP supports efforts to secure financing for HPN projects submitted through its Roundtable process, but there is no UNDP mechanism specifically designed to attract financing for the HPN sector as a whole.

8. Prior A.I.D. Experience in External Financial Mobilization

The first study on global donor financing for the HPN sector was carried out by the author in 1980 in cooperation with WHO. The initial study documented the weak competitive position of the sector in articulating proposals, the excess of financial supply over expressed demand, the absence of training or guidelines, and the relatively small role of A.I.D. on a global scale (ten percent).

In cooperation with the Pan American Health Organization (the WHO Regional Office for the Americas), a six-year effort (1981-1987) was made through an new office of financial resource mobilization to identify potential sources of official and nongovernmental finance, to provide Latin American and Caribbean countries with usable information on sources, the documentation and development of demand, the identification of constraints to demand, analysis of supply in relation to demand, provision of technical guidance in mobilization of financing, provision of training, and the issuance of guidelines on external financing. The consequence has been a documentable increase in multiple-source financing and the continuation of a full time effort at PAHO, supported from its own budget.

In the absence of comparable experience in other WHO regions, and particularly in Africa, experience in the Americas serves as a tested model for trial and adaptation.

9. Trends of Major Official and Nongovernmental Financial Sources for the HPN Sector in Sub-Saharan Africa

Since 1980, studies by the author have shown that approximately 80 percent of all concessional flows for health to developing countries originate from development organizations rather than agencies having a primarily health function (See Figure 1). For this reason, Official Development Assistance trends in Sub-Saharan Africa are shown in Table 1 and 2. Attention is drawn to the formal policies of all major donors which accept health as an eligible component for financing providing national development authorities consider health to be priority issue. There are less formal restrictions for approval of HPN financing within the health-related UN agencies and among nongovernmental organizations.

Disbursements from all external sources for health as a percentage of total development aid (ODA) were 4.1 and 3.7 percent respectively for 1986 and 1987 (See Table 7, Chart III).

The average percentage US ODA flow (1987) was 3.4 percent of total development ODA, although individual donor health ODA varies. AID/Africa HPN financing totalled 26 percent of bilateral HPN financing and 15.7 percent of all bilateral and multilateral financing. The level of support is approximately four times higher than the regional average for bilateral donors. (U.S. ODA is higher than A.I.D. ODA for purposes of reporting to OECD - See Table 5).

Multilateral donors, including WHO and UNICEF, provide approximately 4.5 percent of total multilateral ODA to the sector. There is a slight decline in the percentage of 1987 HPN ODA although the outlook for increase beyond 1987 is favorable (See Table 7).

Increase in A.I.D. HPN disbursements from 9.5 to 15.6 percent of A.I.D. ODA represents a level three times higher than all-source averages in 1986 and four times higher than all-source 1987 levels (See Table 7). The A.I.D. percentage of all-sources HPN ODA was 12.0 and 14.1 percent for 1986 and 1987 (See Table 7 and Chart II).

The outlook for HPN financing in Africa is particularly favorable through Italy, Japan, World Bank, WHO, and UNICEF. (Although WHO is considered as a major technical, not financial resource, the financed personnel resources are large, approximately 3500 professional personnel on a global scale). Data limitations on donor resources preclude a more detailed picture of trends.

In spite of declines in the A.I.D. regional development totals between 1985 and 1987, A.I.D. remained the largest single HPN donor as of 1987 (14.1 percent of total ODA flows). In spite of this favorable performance, what is the outlook for sustaining levels four times higher than the donor average in the face the major gap which remains to be covered in HPN objectives, and with the outlook for continued Congressional restraints and pending restrictions?

In terms of A.I.D.'s own priorities in population, child survival, nutrition, primary health care and tropical disease control, goals which are shared by other major donors, an assumption is made that A.I.D. development objectives (agreed HPN goals) are more important to achieve than increase in HPN financing by any single donor, including A.I.D. Therefore, while A.I.D. should continue to justify a maximum effort, it is clear that A.I.D. is not likely to become the predominant or majority donor in the foreseeable future. Achievement of goals makes it mandatory to develop more efficient mechanisms for mobilizing global resources for Africa.

It is a major conclusion that a sustained, effective external financing strategy for the next decade will depend, at minimum, on the most efficient utilization of all potential donor resources. It is in the interest of the Regional Bureau to encourage the development of a new mechanism to bring about an increase in total resources, even in the absence of any predictable certainty that A.I.D. itself will be able to significantly increase its own resources.

10. Major Existing and Potential Sources of External Financing Assistance by Country of Preference

In view of the stated agreement among major bilateral and multilateral sources that HPN is eligible for support in the development context, Annex I presents OECD data showing the magnitude of support for each recipient country South of Sahara (1987). The list defines eligibility on a country specific basis. Except for agencies which have a historical requirement to earmark or justify programming in advance of an operational year (e.g. A.I.D.), most external sources program in response to official requests. In this sense, the level of financing reflects country demand and not pre-allocation by the donor.

Annex II illustrates current trends in allocation of total aid by individual donors to current emphasis countries.

Section VII of the main report lists the major official international sources which provide HPN assistance beyond the 18 bilateral DAC/OECD sources and 18 major multilateral sources. This study does not list an estimated 3000 international NGOs,

approximately half of whom offer health related support. The text notes the importance of private commercial organizations, particularly pharmaceutical companies, who have cooperated actively in providing medicines at concessional rates.

The review of sources illustrates the large total number of concessional sources, very few of which are known to recipient countries. Even allowing for a few countries which have had long exposure to donors, it is infrequent that the majority of countries at the level of the Ministries of Health are aware of the financing potential. More importantly, there now exists no functioning global or regional mechanism to provide ministries of health with updated information on the array of donor programs, policies and financing. At the country level, ministries of health are not yet organized to track global financing.

From direct interviews with the 21 development financing sources and with countries in Africa, there is confirmation that the financing potential is not fully explored. It is also confirmed that the articulated demand in the form of proposals is far short of the potential supply of available financing.

11. Current and Projected Demand for HPN Financing

In the absence of any regional data base which maintains a current file on HPN proposals for external financing, indirect means are examined except for data available by direct interview with selected African countries

The magnitude of approved HPN financing is shown in Tables 5-7 and in Chart III. This data is interpreted to mean that effective demand for HPN averages 3.7 percent from all external sources (1987). This level is below worldwide averages of 5.2 percent for bilateral and 7.8 percent for multilateral aid.

The demand is higher from A.I.D. (15.6 percent), France and from readily available United Nations funds through WHO, UNFPA, and UNICEF. The explanation is largely related to the on-site availability of resident health personnel or health offices for dialogue and negotiation. It is not generally appreciated that most donors such as Canada, West Germany, United Kingdom, Scandinavian countries and the international banks do not retain resident health representatives or health offices, although technical personnel may be assigned to approved projects.

At the level of the ministry of health, planning and financial offices are at a very early stage of development. Consequently, countries find it easier to respond to external offers of cooperation rather than carry out the more difficult function of identifying national health priorities and translating these priorities into fundable proposals. The Morris Report (attachment) provides examples in the following nations:

- Malawi: A strong central development planning office, but a MOH planning unit which has been criticized for being unable to realistically plan recurring costs for external proposals
- Niger: Cooperating donors such as France, World Bank, and A.I.D. have detailed health sector plans, but the government itself has no costed plan for health sector development.
- Zaire: Central health planning, programming and resource allocation is weak, although Health Zone Financing is functioning well.
- Kenya: A long-term emphasis country retains stronger planning capabilities

A major consequence of the early stage of planning and financing experience is not only limited preparation of official requests but inundation with the workload of externally approved programs. European donors refer to "distortion" of national effort which limits the ability of existing personnel to effectively plan their own HPN priorities. WHO has documented (1988) that 90 percent of 29 reporting African countries are spending less than five percent of GNP on public sector health expenditures.

Formal expressions of regional HPN demand have been approved since 1978 by African countries (Alma Ata, 1978; Declaration of Heads of State, 1987; and the recent Bamako Initiative), but these declarations have not been consistently translated into official country-level proposals.

In a largely experimental effort, WHO/Geneva has sponsored 16 Country Resource Utilization Reviews (CRUs) during the past nine years. The effort has tended to be a one-time (five revisions) mini-health sector analysis resulting in brief costed proposals. The donor response has been favorable in one country (Guinea-Bissau) and less so for two other countries (The Gambia and Benin). Partial response for the remainder in part reflects the absence of an established institutional base within a Ministry of Health with the capability for planning and attracting financing.

12. Constraints to Demand

While financial, technical, administrative limits apply to all development sectors, the current operational limits to the expression of demand are consistent with problems encountered in Latin America and the Caribbean:

- Limited training and staff capacity to undertake national health planning, including health sector analysis and financial planning.
- Unfamiliarity with potential sources and requirements for external planning.
- Weakness in proposal justification within the context of national development priorities.
- Unfamiliarity with proposal development or negotiation with the four major categories of financing: Bilateral, multilateral, United Nations, and nongovernmental agencies.
- Reluctance of national development planning authorities to approve social sector programs during periods of structural adjustment.
- Absence of a functioning regional or international financial resource mobilization system through which African countries may obtain convenient access to country-specific donor information, training, and technical guidance

13. Major Regional Opportunities for External Financial Mobilization in Africa

Opportunities are defined in terms of two operational cycles described in Figures 2 and 3. Figure 2 describes the basic cycles of programming for processing proposals and negotiating with four external categories of financial sources. Figure 3 outlines the specific stages for financial mobilization as it relates to a Ministry of Health.

In the absence of an organized regional effort to train or orient ministries of health in the external financing cycles, the opportunities for strengthening national capability exist at multiple points within the cycle:

- Development of a national plan which includes appropriate analysis of technical, financial, economic, institutional and social feasibility
- Identification of national program priorities, and their specific national and external financial requirements
- Tentative clearance of programs by national development authorities (except for NGO programs)
- Identification of potential external sources

- Matching, dialogue, proposal development and negotiation.

To strengthen and support this process, the Regional Director of the WHO Regional Office in Brazzaville has expressed his interest in providing full support. WHO is making an early attempt to develop a resource mobilization office and could build on early experience. There is advantage in cooperating with a permanent African regional organization which is not basically dependent on external financing for its principle functions.

The World Bank has the advantage of being a primarily development organization, unlike WHO, with the capability to support sector financing and strength financial discipline. A.I.D. has already demonstrated one pattern of cooperation with the Bank through the Onchocerciasis Control Program where the Bank serves as the financing agent for cooperating donors.

The African Development Bank, UNDP, UNFPA, UNICEF also contribute to the HPN coordination process although none offer the potential for regional strengthening of financial mobilization for the HPN sector as a whole.

It is a major characteristic, however, that the primary preoccupation among donors is understandably focussed on financing their own project agreements. What is required for the development of a regional financial mobilization system is a donor which is prepared to invest in the development of a system which attracts multiple alternative financing for common HPN objectives. Just as A.I.D. provided catalytic staff financing for the first program through PAHO, the more complex problems of Africa and the relatively small total financial HPN input by A.I.D. suggests the opportunity for A.I.D. to contribute "start-up" funds. As one among many donors, regional financial mobilization would be difficult to administer an exclusively A.I.D. project. Cooperation with existing structures such as WHO and the World Bank would permit initiation of an activity which should eventually justify participation by other major external sources.

14. Training Requirements for a Regional Financial Resource Mobilization System

With the lack of competitiveness within the HPN sector, in comparison with other development sectors, and the low familiarity of many HPN personnel with development financing, the target groups for training should include not only Ministry of Health personnel but professional staff within WHO and resident donor agencies, including A.I.D. HPN staff.

Training curriculum should cover all points in the cycles described in Figures 2 and 3.

The mechanisms, as successfully applied in the Americas, are the on-site country or regional workshop with experienced trainers, including representatives of the WHO Regional Office and regional donor representatives.

As a basis for training, a manual or guideline--as developed in the Americas--is essential.

15. Recommendations: The Practical Components of a Donor Coordination and External Resource Mobilization System for Sub-Saharan Africa

Taking into account the limited outlook for A.I.D. sectoral financing over the next several years, pending Congressional budget restraints, the stated A.I.D. Africa Bureau HPN priorities and the congruence between these priorities and those of other major donors in Africa, it is proposed that the Bureau apply an adaptation of the financial mobilization system tested in Latin America and the Caribbean over the past six years.

In cooperation with the WHO Regional Office for Africa in Brazzaville, with the World Bank, and with other regional institutions as appropriate (e.g. UNDP), the A.I.D. Bureau should provide the "start-up" costs for a five-year trial program to establish an external financial resource mobilization system for Africa. The components are as follows:

- Identification of major global official and NGO sources of financing for Africa, including:
 - o Liaison with sources
 - o Preparation and distribution of updated profiles to all African countries
- Preparation of a Guideline on External Financing specific to the region, following the tested PAHO pattern, and distributed in French and English.
- Identification of potential demand and constraints to demand at country and regional levels
- Analysis of identified demand with potential external financial supply
- Mobilization of external financing, including:
 - o Source selection
 - o Matching of demand with potential sources

- o Preparation of short preliminary proposals following the PAHO Model
 - o Preliminary dialogue and negotiation with sources
 - o Final project preparation and negotiation
 - Provision of training for ministries of HPN and for international personnel
 - Monitoring of financial flows and evaluation of mobilization efforts.
16. Level of Effort for an A.I.D.-Sponsored Five-Year Project to Initiate a Cooperative Regional System for External Financial Resource Mobilization
- o Identification of external financial supply:
 - One full time U.S.-based project officer to identify and provide liaison with global sources
 - One full time development economist stationed in Brazzaville
 - Travel and per diem for maintaining liaison within or outside Africa
 - o Preparation of updated Regional External Financial Guidelines:
 - One full time program officer based in Brazzaville
 - Financing for guideline preparation, translation into French, editing, publishing, distribution
 - o Identification of potential demand and constraints to demand at the country level
 - 2 full-time technical advisors (1 French speaking; 1 English speaking)
 - Travel and per diem
 - o Analysis of financial supply with official demand
 - To be carried out by assigned officers noted above
 - o Training
 - Listed staff should carry out training in cooperation with World Bank and other donors. Costs would encompass an estimated 6 one-week workshops at country-level per year, one regional workshop in French and one Regional Workshop in English.

- Costs should cover curriculum and material preparation, participant stipends, travel within the region, teaching equipment
- o Mobilization of external financing
 - 12 A.I.D.-sponsored consultant man-months per year for the purpose of assisting governments in preparation of short preliminary proposals after the PAHO model.
 - Maximum effort should be made to solicit non-project funded support from regional donors, including World Bank, African Development Bank.
- o Evaluation and monitoring
 - Responsibility of A.I.D. contractor in cooperation with WHO/Brazzaville. Limited travel and per diem for once annual review.
- o Fourth year independent evaluation to include consultant, travel and per diem costs - Two weeks.
- o A.I.D. Contract Management
 - One full time health/development professional
 - One staff assistant

I. OBJECTIVE

To "conduct an assessment of donor coordination and donor financing of the HPN sector in Africa" (contract language).

II. SCOPE OF WORK

1. Summarize the trends of major official and nongovernmental financial sources for HPN in sub-Saharan Africa by country.
2. Identify the major existing and potential sources of financial assistance by country of preference.
3. Identify current and projected demand for HPN activities by country and the constraints to such demand, to the extent current data permits.
4. Identify the major opportunities for financial mobilization, including matching, negotiating and project development, taking into account the specific program interests of the A.I.D. African Bureau.
5. Identify the training requirements (personnel, participants, curriculum content, preparation of guidance materials) necessary for government to better utilize and coordinate donor resources.
6. Identify the practical components of a donor coordination and resource mobilization system which is acceptable to African governments and external cooperating agencies. Who should implement the system?

III. METHODOLOGY

The study was carried out over a period of four months, from January 27 to May 28, 1989. In order to interview and study donor sources as well as African countries and A.I.D. Missions within the assigned time period, Pragma assigned a two-member team, Dr. Lee M. Howard and Mr. Patrick F. Morris, to carry out the two components of the study: Donor Information Sources and African Regional Information Sources.

A. Donor Information Sources

Taking advantage of an overlapping assignment for the World Bank in Europe and North America, Dr. Lee Howard focused on the Africa HPN flows and policies of 21 bilateral and multilateral organizations, with special attention to donor information at the World Health Organization (WHO) Headquarters, Geneva, and at the

Organization for Economic Cooperation and Development (OECD) in Paris. Seventy-three staff officers in 23 donor agencies or international organizations in the following countries were interviewed, with the exception of Canada and Japan, which were contacted by mail:

Austria	OECD
Belgium	OPEC Fund
Canada	Sweden
Denmark	Switzerland
European Community	United Kingdom
Finland	UNDP
Germany, Fed. Rep.(2)	UNICEF
France	UNFPA
Italy	USAID
Japan	WHO
The Netherlands	World Bank

1. Quality of Donor HPN Sectoral Financial Data

Statistical sources on financial flows for general development, as reported by OECD/Paris, are readily identifiable with caveats on the limitations of the OECD Creditor Reporting System. Data are published annually, but the data are at least a year old (current 1989 publications include 1987 data). Reporting completeness varies with the cooperation of the reporting source. Gross flows for concessional assistance, however, are far better an indicator than sectoral flows. Annual data on health and population varies with the definition of the reporting country. Statistical offices within donor agencies most often have the responsibility for reporting, not the offices technically responsible for health and population activities. In direct interview with technical staff, it is difficult to obtain comparable (between donors) HPN data, largely because most development sources are geographical rather than sectoral in orientation. In this context, it is easier to obtain a clear picture of health financing from an international bank (due to loan content), from an international health-oriented organization (UNFPA,WHO), or from USAID, which has functional accounts. The Netherlands, for example, which contributes approximately \$190 million year to health, says that the government does not have a "health program" but rather an integrated development activity in cooperating countries where health may be a component.

Unfortunately, there is no international organization or cooperative system now in place which provides an updated, timely, and complete picture of concessional HPN flows developing countries. OECD has not pursued the detail of sectoral reporting to permit comprehensive global flows. WHO/Geneva has made periodic attempts to collect donor information, without current efforts to monitor an updated

status. The format does not provide sectoral information which would be of practical value to a geographic regional such as Africa, and no financial information of value to a specific developing country.

While donor organizations are cooperative, there is a clear need for substantial improvement in cooperative international mechanisms which can identify donor health financing on a timely basis for the benefit not only of the donor community, but for the ultimate "user," the developing countries.

B. African Regional Information Sources

Mr. Patrick Morris visited WHO African Regional Headquarters in Brazzaville, Congo as well as Government and USAID Mission Offices in Kenya, Malawi, Niger and Zaire.

A concurrent but nonproject-related visit to Benin, Burkina Faso and Liberia by Pragma Health Division Director, Richard Killian, provided further insight into the status of coordination and financial mobilization.

Other than on-site data-gathering in Africa, information on coordination and financing for health in Africa was gathered through the donor representatives and international organizations, as noted above, with special mention of WHO Offices in Geneva and Brazzaville, the OECD in Paris, the A.I.D. Office of Technical Resources, Division of Health, Population and Nutrition, and the A.I.D. Office of Donor Coordination.

1. Quality of African Regional Country HPN Financial Data

For the purpose of this study, there is no readily available comprehensive information source on HPN financial flows to Sub-Saharan Africa. Neither the Geneva nor Brazzaville WHO offices maintain updated annual information on financial flows to African countries. There are periodic studies of individual countries, monitoring by Geneva for annual progress reports of progress towards Health for All (35 percent non-response rate), and limited efforts to prepare Country Resource Utilization (CRU) Reports (17 countries in nine years). The CRUs are not annually updated.

The UNDP has the responsibility for producing annual reports of all donor flows, a good source except for difficulty in accessing a complete set for Africa. UNDP in New York itself does not have a complete set of current reports. Sample reports indicate data as of 1987.

Ministries of Health in Africa, the primary end-user of donor information, maintain highly varying levels of donor information for reasons (discussed under the section on constraints to project demand) which relate to current governmental practices of recording responsibility, training and financial accounting.

Clearly, non-availability of reliable comprehensive HPN financial information for Africa is a problem, not only for the purposes of this report but for the design of any recommendation on improving and monitoring HPN flows to Africa.

IV. PROBLEM

Future financial options open to the A.I.D. Africa Bureau for support of its health, population and nutrition programs are influenced by a number of cross-cutting technical and financial issues:

1. Technically, it is recognized that Sub-Saharan Africa, as a geographical region, has the world's highest rates of population growth and infant and child mortality; the highest maternal mortality; and the largest remaining focus of endemic malaria, sleeping sickness, onchocerciasis, filariasis and schistosomiasis.
2. During the last ten years, particularly since the 1978 International Conference on Primary Health Care (Alma Ata), major policy agreement has been reached among all members of WHO, including the donor countries and multilateral organizations, on achieving global health coverage with first emphasis on the most basic and essential health requirements (primary health care). A.I.D. regional population and Child Survival programs have been extensions of this effort.
3. Historically concurrent with international consensus on health program goals (during the past ten years), major economic crises, inflation, debt and famine have effectively constrained progress towards the reduction of the African population and disease patterns.
4. Against the increasing conflict between expanding international HPN program objectives and declining national financial resource availability in Sub-Saharan Africa, what has been the strategic approach of A.I.D. to strengthen regional financing for HPN objectives? Two principal approaches are noted:

- o First, major emphasis has been given to the use of national resources for health care financing. Studies and program support are based on the

economic reality that, in the long term, developing countries must finance their own public sector programs. This approach focuses on new or innovative methods such as self-financing, cost-recovery, private enterprise and insurance. In current A.I.D. program strategy, the term "Health Care Financing" refers predominantly to this dimension of support for national financing.

- o Secondly, less formal program emphasis has been made to improve mobilization of external financing through donor coordination for sectoral objectives even though the issues of national and external financing are closely interrelated. While it is well accepted that sustained public sector financing is dependent on efficient utilization of national resources, external financing serves as the catalytic agent for change in current models of development. The rate of development progress in Africa, as elsewhere in the developing world, depends on multiple policy, technical and financial decisions. But the ability of developed countries to cooperate in the development process is dependent to a large extent on well-financed strategies which cooperatively support governments to achieve their own priorities. External financial volume is not the sole measure of donor effectiveness, but volume trends do represent one of the few tangible measures of donor intent.

For Africa, regional trends in general development support from all external global sources are illustrated in Tables 1 and 2. As the principal focus of this report, HPN trends are explored in Section VII.

Table 1 illustrates commitments of official development assistance (ODA) from all sources to individual countries south of Sahara, 1981-1987. In current dollars, the trend shows a net increase from \$10 billion in 1981 to \$16.29 billion in 1987.

Table 2 illustrates bilateral and multilateral disbursements and commitments by donor source, South of Sahara. 1984-1987. U.S. commitments in 1987 were only 8.5 percent of total bilateral commitments and only 5 percent of total ODA commitments, bilateral and multilateral. Excluding U.S. multilateral commitments, the A.I.D. 1987 appropriation represented only 3.4 percent of the total all-sources development commitment (See Tables 2 & 7 and Chart I).

5. Although the proportion of A.I.D. support as a percentage of total donor support varies between countries, the total

Table 1

ODA Commitments From All Sources Combined To Individual Recipients
South of Sahara, 1981 - 1987

	1981	1982	1983	1984	1985	1986	1987
Angola	62.9	103.0	92.2	104.3	113.9	138.2	157.0
Benin	132.6	154.5	71.1	165.1	95.5	127.0	205.0
Botswana	117.1	125.2	101.7	110.1	113.1	144.1	135.0
Burkina Faso	334.1	289.0	252.7	246.2	249.5	263.1	320.0
Burundi	252.5	121.3	172.3	123.5	199.7	159.1	202.0
Cameroon	231.1	234.3	198.8	304.3	167.3	270.5	346.0
Cape Verde	73.6	62.0	96.3	94.1	61.6	89.8	93.0
Central African Rep.	88.0	155.9	147.8	96.8	117.5	173.9	213.0
Chad	98.2	67.9	109.8	144.5	210.0	254.8	332.0
Comoros	80.6	73.9	39.3	50.5	26.3	34.6	55.0
Congo	130.5	73.6	112.1	71.2	58.1	165.2	144.0
Cote d'Ivoire	209.1	169.9	172.9	169.4	115.7	338.7	270.0
Djibouti	96.1	123.9	89.5	111.0	76.1	152.8	103.0
Equatorial Guinea	19.5	13.6	21.9	26.9	41.0	41.9	41.0
Ethiopia	315.3	295.8	498.4	603.6	626.8	808.3	784.0
Gabon	42.7	99.8	76.6	92.1	67.0	68.0	100.0
Gambia	79.0	50.8	66.4	82.1	33.2	113.6	90.0
Ghana	156.9	109.5	291.7	287.2	419.6	361.6	724.0
Guinea	121.3	130.4	141.9	237.2	176.7	209.2	364.0
Guinea-Bissau	63.4	62.4	122.6	76.1	62.1	62.8	169.0
Kenya	399.1	715.7	398.4	659.8	399.3	623.2	659.0
Lesotho	115.4	71.6	101.8	125.2	91.9	139.6	94.0
Liberia	98.0	174.3	90.9	145.2	86.3	100.3	159.0
Madagascar	271.9	218.2	248.1	235.0	263.2	341.5	439.0
Malawi	211.8	84.1	270.3	143.9	222.0	265.0	316.0
Mali	303.0	354.1	300.5	411.4	438.1	361.5	368.0
Mauritania	279.0	225.3	163.4	191.5	250.2	200.9	250.0
Mauritius	58.7	86.0	36.5	40.9	30.0	59.3	80.0
Mayotte	12.8	9.4	14.6	13.5	19.9	20.7	42.0
Mozambique	188.4	254.9	262.2	308.1	357.1	541.6	833.0
Namibia	--	--	0.0	--	13.7	11.3	8.0
Niger	345.9	250.3	254.3	346.0	261.0	457.3	464.0
Nigeria	156.9	47.6	63.1	55.3	59.4	66.2	86.0
Reunion	670.2	648.7	708.8	528.9	387.1	353.5	588.0
Rwanda	217.1	240.8	197.0	161.0	199.1	229.5	340.0
St. Helena	7.3	10.2	9.9	10.0	12.2	13.5	48.0
Sao Tome & Principe	8.9	7.4	10.7	15.2	13.9	40.9	45.0
Senegal	381.3	481.5	428.2	445.8	312.9	637.8	892.0
Seychelles	33.0	11.8	22.5	14.0	23.1	25.2	26.0
Sierra Leone	121.9	81.6	59.5	84.9	110.9	90.7	124.0
Somalia	562.4	513.2	352.4	417.2	389.5	786.0	693.0
Sudan	655.9	620.3	1245.2	720.4	1301.9	1303.4	1018.0
Swaziland	36.2	45.8	54.7	39.3	28.0	53.8	51.0
Tanzania	703.5	729.8	516.3	516.3	464.9	887.2	1173.0
Togo	87.8	111.7	169.5	125.8	234.2	177.4	149.0
Uganda	206.1	215.7	295.5	308.8	150.3	215.9	435.0
Zaire	367.3	445.1	378.4	376.1	386.6	600.3	823.0
Zambia	343.7	406.3	256.9	343.3	450.4	463.2	483.0
Zimbabwe	346.7	402.2	294.9	315.0	161.5	279.2	265.0
East African Community	5.5	7.5	5.3	7.1	11.6	2.8	1.0
DOM/TOM Unallocated	--	--	--	--	--	--	--
EAMA Unallocated	2.0	18.1	--	73.6	--	--	--
South of Sahara Unall.	179.4	312.7	256.1	399.7	352.1	383.8	472.0
TOTAL	10081.6	10282.6	10342.0	10774.5	10512.9	13709.6	16293.0

Source: OECD, Geographical Distribution of Financial Flows to Developing Countries, 1989, p. 32

Table 2

**Global Trends in ODA Disbursements and Commitments
South of Sahara, 1984 - 1987
(\$ Million)**

Donor Source

DAC COUNTRIES	1984	1985	1986	1987	1984	1985	1986	1987
	TOTAL ODA NET (disbursement)				ODA COMMITMENTS			
Australia	43.5	33.3	26.1	35.0	46.7	29.1	21.7	47.0
Austria	13.1	15.1	12.5	13.7	10.9	15.0	26.4	28.9
Belgium	164.9	184.8	251.6	272.2	111.3	86.4	240.1	251.6
Canada	349.3	334.9	291.0	364.8	593.9	349.4	299.0	487.7
Denmark	121.7	113.3	201.7	233.4	110.5	161.6	292.3	265.9
Finland	63.5	69.9	102.4	145.1	77.2	126.0	167.2	118.7
France	1414.4	1463.5	1961.2	2420.6	1829.5	1679.1	2077.5	2515.3
Germany, Fed. Rep.	560.3	590.3	771.7	943.1	689.7	780.4	883.1	1063.0
Ireland	9.1	11.0	13.9	16.6	9.1	11.0	13.9	16.6
Italy	368.6	449.2	946.0	1148.1	413.1	561.5	1630.5	1844.5
Japan	239.2	277.5	451.1	592.8	287.2	259.3	532.1	680.3
Netherlands	290.1	251.2	440.1	510.9	289.3	222.9	471.2	581.1
New Zealand	0.2	0.6	0.5	0.5	0.2	0.8	0.6	1.0
Norway	164.3	179.9	268.3	306.6	209.7	188.4	325.1	267.4
Sweden	224.3	259.4	387.8	380.1	271.4	261.6	387.8	14.5
Switzerland	90.3	95.3	159.9	147.2	71.1	140.1	128.0	158.9
United Kingdom	242.5	302.1	307.0	381.3	250.7	275.7	365.9	504.5
United States	857.0	1318.0	882.0	783.0	1316.5	1226.5	1040.1	826.0
TOTAL BILATERAL	5216.1	5949.1	7474.5	8695.0	6587.9	6374.7	8902.4	9672.9
MULTILATERAL								
F.D.F.	105.4	206.3	261.8	369.1	355.8	408.4	570.6	724.5
F.D.B.	--	--	--	--	--	--	--	--
S.D.B.	--	--	--	--	--	--	--	--
AR.D.B.	--	--	--	--	--	--	--	--
E.C.	692.4	739.3	868.4	816.6	848.6	661.2	877.5	2360.2
BRD	9.1	6.1	1.1	0.4	--	--	--	--
IDA	757.2	860.6	1372.6	1630.7	1116.2	1265.1	1635.6	1915.0
I.D.B.	--	--	--	--	--	--	--	--
FAD	42.9	77.0	94.2	129.7	77.2	73.7	74.1	123.4
I.F.C.	--	--	--	--	--	--	--	--
IF TRUST FUND	--	--	--	--	--	--	--	--
U.N. AGENCIES-WHO	--	--	--	--	--	--	--	--
IDP	197.2	225.0	258.6	262.2	841.6	1036.6	929.4	993.4
ITA	34.9	49.2	47.3	56.7	--	--	--	--
UNICEF	76.6	100.8	111.6	129.5	--	--	--	--
IRWA	--	--	--	--	--	--	--	--
TOTAL MULTILATERAL	2523.8	2976.6	3614.0	3997.4	3485.9	3549.8	4263.4	6224.1
TOTAL, ALL SOURCES	8227.5	9525.4	11530.3	13025.3	10774.5	10512.9	13709.6	16293.1

Source: OECD, Geographical Distribution of Financial Flows to Developing Countries, 1989, p. 322

volume of A.I.D. regional development assistance is comparatively small. With declines in the regional obligation level since 1985 and the Agency's risk of further retrenchment from Gramm-Rudman budget reduction, the issue of donor coordination and mobilization of alternate sources of external finance take on greater importance than at any time in recent A.I.D. history.

6. Given the financial constraints which face A.I.D., key problems for the HPN sector may be stated as follows:
 - o Is there a financing strategy to support the Africa Bureau's long-term HPN objectives?
 - o If bureau objectives in population, nutrition, child survival, primary health care and disease control are shared by other major donors, by what mechanism can the bureau assure maximum participation by these sources?
 - o Can the bureau's HPN budget be justified without access to a practical operational system through which it can identify alternate sources of financing and opportunities for improving African regional demand for alternate financing?

7. Foreign Assistance Legislation, the Agency's Blueprint for Development as well as the Bureaus H, N, CS Status Report and Draft Strategy emphasize the critical importance of donor coordination. In the absence of any current organized system or pattern of HPN sector donor coordination in Africa, more need for specific guidance is indicated.
 - o What is intended by donor coordination?

Policy dialogue? At what level--country, region or headquarters? Is mobilization of new external financing central to the work of coordination? Is coordination primarily a headquarters, regional or country level action after resources have already been committed?
 - o What organizations have internationally recognized responsibility and accountability for HPN coordination in Africa?
 - o What are the practical alternatives for an effective system of regional HPN donor coordination and external financial mobilization?

Is there a potential mechanism of practical value to both donors and to developing countries? If so, what are the potential roles of organizations which now

serve in partial ways to influence sectoral programs and finance, e.g. DAC/OECD, WHO/Geneva, World Bank, WHO/Brazzaville, UNDP, UNICEF, individual donors?

- o Is there an opportunity for the A.I.D. Africa Regional Bureau to take initiative in exploring more effective mechanisms for financial and program coordination?

V. BACKGROUND

From a policy point of view, donor coordination has received major endorsement from Congress through the Foreign Assistance Act; from the A.I.D. Administrator through policy guidance; and through the establishment of the AID/PPC Office of Donor Coordination. A.I.D. staff are represented on the staff of the permanent U.S. Delegation to the OECD in Paris. A former A.I.D. Deputy Administrator, Joseph Wheeler, now serves as the Chairman of the Development Assistance Committee of OECD.

These positive directions have featured general economic and social development financial levels and policies. By contrast, specific actions to support priority functional sectors have been less than well organized.

Among the bilateral donors and their international secretariat, OECD, there is no specific effort to coordinate the health sector. There is data gathering, given the limitations of definition, participation and timeliness. A periodic meeting on some aspect of health such as the 1988 meeting on Primary Health Care is a positive step, but not one which represents an ongoing function of the DAC/OECD. This is not basically an OECD Secretariat problem but one of the unwillingness of OECD member states to request or support an ongoing sectoral coordination activity.

WHO, which has a constitutional mandate to serve as the "supreme coordinating authority" in health, has carried out this function effectively in many areas of technical coordination, but not for financial planning or donor coordination. At the country level, the UNDP has been according the mandate, among UN agencies, to coordinate donor resources.

WHO serves as the Secretariat of a World Health Assembly, at which countries are represented principally by Ministers of Health. WHO continues to support member governments at their request in varying range of coordination activities on behalf of the Ministry of Health. It is a paradox, however, that the 1948 WHO Constitution, in according WHO a "supreme coordinating authority," could not foresee that the very large proportion of external health financing today (an estimated 90 percent) is derived from development institutions, e.g. bilateral donors and

international banks, and not from health organizations. And the international community has not given WHO a constitutional mandate to coordinate development financing.

For HPN sectoral purposes, therefore, mechanisms for technical and financial coordination have been sporadic. Many of these periodic efforts have been excellent in themselves. The A.I.D. Regional Bureau has actively participated in financial and donor coordination efforts at the country or regional level, as for example in the West Africa Onchocerciasis Control Program.

More specifically, A.I.D. regional efforts today have focused on country level coordination, essentially following approval-in-principle of project commitment by a group of donors, that is, coordination of approved finance (level #4 below). One might illustrate the potential levels of effort which call for donor coordination:

1. Regional or country external financial planning prior to sectoral investment by any donor.
2. Attraction or mobilization of external financing for global, regional or country programs as a precondition for project implementation.
3. Strengthen the capability of developing countries to attract finances from alternate external sources.
4. Cooperation/coordination at global, regional and country levels among donors who are already committed to provide support for an activity.
5. Provision of coordination and financial support for an ongoing project.
6. Evaluation and monitoring of external financial supply and demand.

Coordination of financial and technical support has most often centered around level #4, primarily at country level. Efforts to undertake dialogue or develop mechanisms to deal with levels #1 and #2 are far less frequent, even though the most basic issues of long-term support for the HPN sector, particularly as applied to Africa, call for action in these first two levels.

A. Prior A.I.D. Experience in External Financial Mobilization

In 1979, the year after the International Conference on Primary Health Care (Alma Ata Conference)--and at a time when the knowledge of global financing in support of primary health care was of growing importance to A.I.D. health strategy--A.I.D. and

WHO jointly sponsored the first global study of global donor financing for health, nutrition and population.¹ This first study documented many of the organizational and statistical problems associated with external financing for the HPN sector. The study made the following key points:

- o The supply of finance greatly exceeded the demand for financing by developing countries.
- o The weak competitive position of the sector in identifying and articulating demand in the form of defensible proposals which could be justified in the context of a national development plan.
- o The dearth of training in external financial mobilization among personnel from developing countries as well as among expatriate technical advisors.
- o The US contribution to global health flows in developing countries was on the order of ten percent, a major downward shift in the proportion of health financing contributed by the U.S. in the 1960s and 1970s.

To determine if the principles recommended in the study might be applied to one geographic region, the author, on detail from A.I.D., accepted the responsibility as Director of a new Office of Resource Mobilization at the Pan American Health Organization (PAHO - the WHO Regional Office for the Americas). During a period of six years, a major new effort was made:

- o To identify all potential official and nongovernmental sources of HPN finances for the developing countries of Latin America and the Caribbean.
- o To provide this information in a form which was directly usable by each country within the region.
- o To identify the demand for external HPN financing in each country of the region, and the constraints to attraction of new financing.
- o To analyze the identified demand with potential supply and to suggest mechanisms for matching appropriate sources to demand.

¹ Howard, L.M., A New Look at Development Cooperation for Health, World Health Organization, Geneva, 1981.

- o To provide regional technical guidance² in the form of profiles on potential sources, strategies for attracting financing, prerequisite steps in technical and financial planning, and identification of major constraints to external financing.
- o To provide on-site and regional orientation and training in external financial planning and coordination.
- o To provide technical assistance as requested by countries in the preparation of initial proposals to potential alternative sources of external financing.

Between 1982 and 1986, the total flows of HPN financing to the region increased from \$400 million annually to over \$1.2 billion. While the experience is not credited for the full growth of resources, there did occur for the first time, under the formal sponsorship of the WHO Regional Office and with full endorsement of all Ministers of Health, an organized regional system for the mobilization of external financing for the HPN sector.

More importantly, there was confirmation of the small total A.I.D. input (ten percent) into regional HPN financing, although for some individual countries the proportion of A.I.D. financing was higher.

Among the constraints, it became apparent that individual donors were prepared to help governments with the preparation of donor-specific projects. No donors were supporting Ministries of Health in strengthening their capacity to attract financing from multiple alternate potential sources.

Major sources of bank financing such as the World Bank, Inter-American Development Bank and the Caribbean Development Bank were prepared to help governments look for alternative major financial sources for a previously-identified project, but none of the banks engaged in a specific activity to identify potential sources of concessional financing which would decrease dependence on borrowing.

The role of the WHO Regional Office in this instance has been well accepted by governments. PAHO has accepted the full financing responsibility for its Resource Mobilization Unit. Although the PAHO Office is very early in its efforts to support the region, the effort remains unique within the worldwide WHO system. In the absence of comparable mechanisms within the UN

² Guidelines on External Financial Resource Mobilization for Health in the Region of the Americas, Pan American Health Organization, 1983, 1984, 1986.

system or bilateral institutions, the PAHO offers early evidence of an operational system.

The primary weakness of the PAHO system, other than its small size and early stage of experience, is the lack of financial accountability or operational responsibility for the large proportion of HPN financing which is derived from development rather than health institutions. This suggests the possible need to explore joint operational mechanisms with an international bank (World Bank or Inter-American Development Bank) after the pattern of the West African OCP Program, in which the World Bank serves as the coordinating financial point, WHO provides the technical staff, and A.I.D. and other major bilateral donors serve regularly on the annual supervisory board to monitor progress.

B. What is the Appropriate Model For Africa?

Against this background of financial coordination and mobilization for the HPN sector, and in the context of A.I.D. regional developmental objectives and constraints, three questions summarize the intent and Scope of Work for this study:

1. What is the status of financial mobilization and coordination for the HPN sector in Africa?
2. What is an appropriate regional model for joint donor/developing country cooperation to strengthen the ability of African countries to mobilize external financing for the HPN sector?
3. What is an appropriate role for A.I.D., in cooperation with other donors and international organizations, to initiate the development of a new model for the region?

VI. TRENDS OF MAJOR OFFICIAL AND NONGOVERNMENTAL FINANCIAL SOURCES FOR THE HPN SECTOR IN SUB-SAHARAN AFRICA

Since 1980, studies by the author have demonstrated that external financing for the global HPN sector originates predominantly (on the order of 80 percent) from official development organization sources³ (See Figure 1). While comparable studies have not

³ Howard, L.M., A New Look At Development Cooperation for Health, World Health Organization, Geneva, 1981.

What are the Financial Resources for Health 2000?, World Health Forum, 2 (1): 1981

been carried out on a region-specific basis, the trends suggest that official sources also contribute on the order of half the funding for international nongovernmental programs, particularly those of Canada, Scandinavian countries, West Germany, the Netherlands, Italy and the United Kingdom. The magnitude of worldwide NGO financing is estimated to be \$3.5 billion, in comparison to an estimated total official concessional financing of \$48 billion (1987).⁴

For Sub-Saharan Africa, concessional financing trends (ODA) for all sectors (1981-1987) are shown in Table 1, indicating the progressive increase in the total availability of financing (\$10 - \$16 billion) as measured in current dollars. Table 2 disaggregates commitments and disbursements by donors in both bilateral and multilateral categories to show the increasing trends in the pool of financing.

For sectoral availability, the gap between commitments and disbursements is of interest, particularly among bilateral agencies which are obliged to operate under rules of financial deobligation at the end of the year. Canada, Germany, Italy and Japan, for example, fall into this category. The gaps are even larger for the African Development Bank, European Community and IDA, where committed funds may not be lost but delayed in approval. The differences suggest the well-known problems of articulating and negotiating country-level demand, a problem of particular relevance to a competitively weak HPN sector.

International Sources of Financial Cooperation for Health in Developing Countries, PAHO Bulletin 17 (2) 1983.

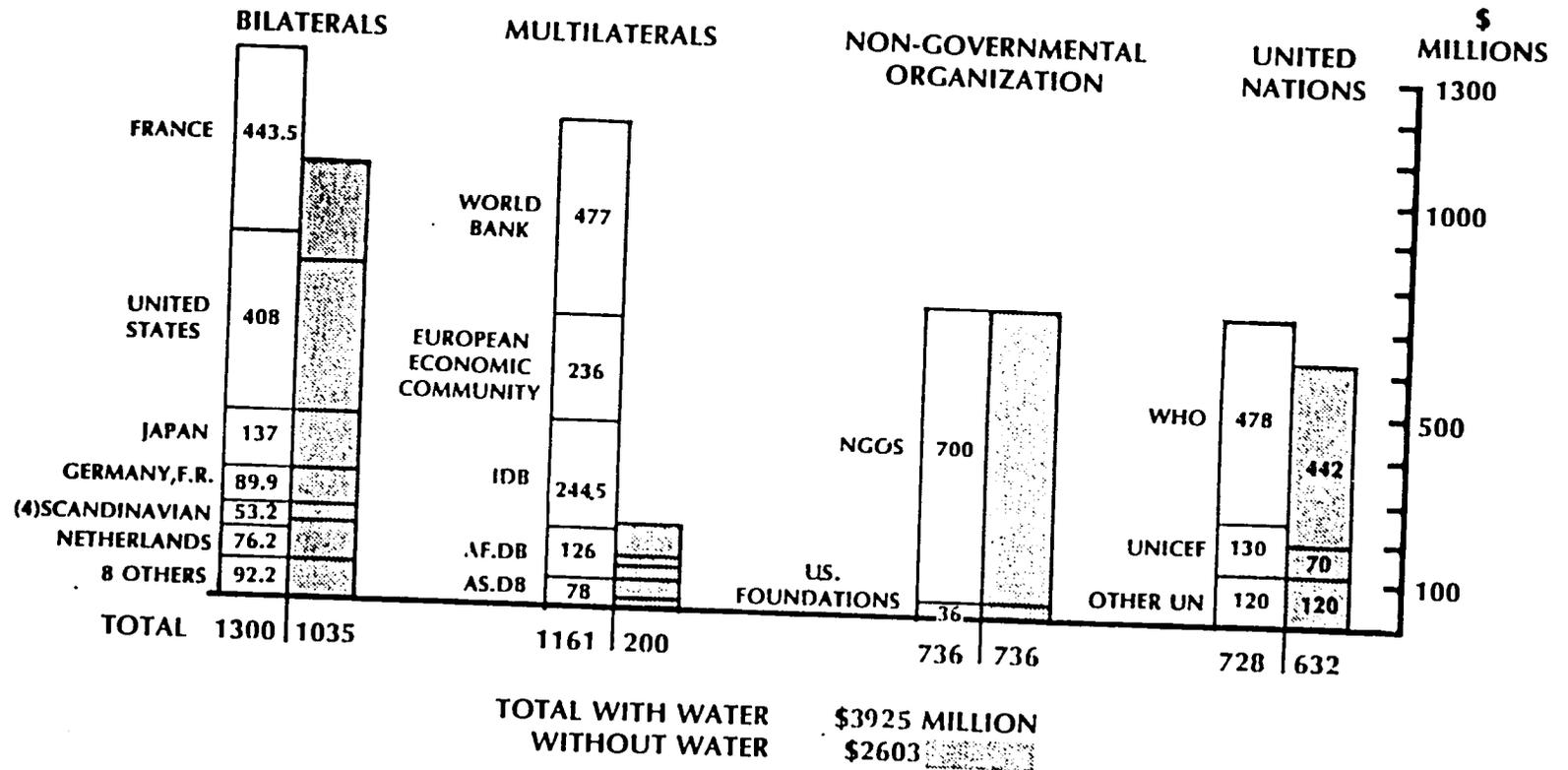
Where is the Money to come from? World Health Magazine, May, 1986

Trends in United States and International Financial Support for Health in Developing Countries, 1986: A Paper Prepared for the Colloquium on International Health and Development in the 1990s, convened by the Johns Hopkins University, April, 1988

The Evolution of International Cooperation for Health in Developing Countries: Bilateral and Multilateral: A Paper prepared for the Takemi Symposium, The Harvard University School of Public Health, Tokyo, Japan, July, 1988 (in publication).

⁴ OECD, Development Cooperation, 1988 Report, OECD, Paris. 1989

FIGURE 1
MAIN PARTICIPANTS IN EXTERNAL FINANCIAL COOPERATION, WORLD WIDE
1982



Tables 3 and 4 illustrate the trends in total development flows to specific countries according to magnitude and economic classification of recipient.

A. External Financing for the HPN Sector

Table 5 illustrates the estimated concessional disbursement for HPN by bilateral donor source for 1987, in view of the nonavailability of comprehensive data for 1988. The average percentage flow to health in Sub-Saharan Africa from bilateral sources is 3.4 percent of total concessional flows, although Austria, Belgium, Finland and the U.S. contributed ten percent or more of their total ODA. Combined HPN flows from A.I.D. represented an estimated 26 percent of all HPN bilateral financing for Africa and 15.7 percent of all A.I.D. regional flows, a level four times higher than the bilateral donor average.

Table 6 makes the equivalent comparison of commitments and disbursements among multilateral organizations in Sub-Saharan Africa. Except for health-oriented organizations such as UNICEF and WHO, the percentage of total ODA allocated to health is less than three percent (2.3 percent for the African Development Bank and 0.7 percent for the European Community). More notably, the total percentage disbursement for HPN including WHO and UNICEF is only 4.5 percent of all multilateral ODA commitments.

Data on the WHO Regional Office is presented as a major source of technical advisory assistance in Africa with a budget (\$85.6 million in 1987) comparable to that of A.I.D. (\$87.8 million). WHO is not a donor source in the sense that it makes only limited transfers of financing to developing countries. It is constitutionally an organization with membership from both developed and developing countries which deploys professional personnel for priority programs jointly approved by all member governments at the annual World Health Assembly.

UNICEF is properly defined as a financial and technical resource which allocates about 80 percent of its annual program budget to health.

Table 3

**NET DISBURSEMENTS OF ODA
FROM DAC, ARAB AND MULTILATERAL SOURCES
TO COUNTRIES IN SUB-SAHARAN AFRICA 1977, 1983-87**

\$ million at 1986 prices and exchange rates

Country	1977	1983	1984	1985	1986	1987
LICS*						
<i>Of which:</i>						
Ethiopia	197	476	643	1 023	786	600
Sudan	206	734	636	1 130	759	558
Tanzania	543	714	683	586	686	768
Mozambique	135	277	368	444	562	608
Senegal	195	333	384	315	534	532
Somalia	132	369	426	375	509	459
Zambia	177	269	301	403	464	368
Kenya	263	482	471	512	451	486
Zaire	421	381	387	399	448	532
Ghana	151	140	271	254	367	327
Mali	166	227	405	437	335	308
Madagascar	98	243	211	270	333	306
Niger	152	190	191	372	302	299
Burkina Faso	178	222	219	238	274	236
Rwanda	148	180	197	216	205	203
Malawi	128	142	197	139	198	235
Uganda	32	161	205	227	194	228
Burundi	77	171	157	165	177	154
Togo	104	133	134	129	166	102
Chad	134	115	142	223	165	173
Mauritania	100	158	156	183	162	150
Guinea	40	66	63	134	149	177
Benin	79	103	96	114	135	112
Central African Rep.	69	112	141	127	135	140
Cape Verde	42	72	78	85	110	74
Botswana	77	116	115	114	103	134
Gambia	32	50	65	61	102	89
Liberia	54	144	165	111	97	66
Lesotho	63	128	122	112	88	92
Sierra Leone	43	80	60	81	87	54
Djibouti	59	66	85	85	86	69
Guinea-Bissau	63	71	73	69	64	88
Comoros	15	39	45	53	44	46
Mayotte	11	18	17	26	28	34
Equatorial Guinea	1	14	19	21	22	37
St. Helena	7	12	12	15	14	18
Sao Tome & Principe	5	15	15	17	13	15
TOTAL	4 398	7 223	7 956	9 263	9 355	8 876

* Low Middle income countries

Source: OECD, 1988 Report; Development Co-operation, 1988
(Table 3.1, pp. 205-206)

**NEW DISBURSEMENTS OF ODA
FROM DAC, ARAB AND MULTILATERAL SOURCES
TO COUNTRIES IN SUB-SAHARAN AFRICA 1977, 1983-87**

\$ million at 1986 prices and exchange rates

Country	1977	1983	1984	1985	1986	1987
LMICS*						
<i>Of which:</i>						
Zimbabwe	11	255	369	295	227	255
Cameroon	269	164	222	192	222	178
Cote d'Ivoire	172	189	159	153	187	221
Angola	101	97	120	119	143	136
Congo	77	95	104	81	110	131
Nigeria	70	58	41	39	59	60
Mauritius	36	46	40	33	55	54
Swaziland	47	41	37	31	35	36
TOTAL	783	945	1091	943	1037	1072
UMICS**						
<i>Of which:</i>						
Reunion	515	499	430	471	506	501
Gabon	45	76	91	75	65	68
Seychelles	17	22	21	27	31	23
Namibia	-	0	-	7	16	15
TOTAL	578	598	542	580	617	606
South of Sahara Unallocated	78	207	178	425	392	451
TOTAL	5 837	8 973	9 768	11 211	11 401	11 006

* Low Middle income countries

** Upper Middle income countries

Source: OECD, 1988 Report; Development Co-operation, 1988.
(Table 3.1, pp. 205-206)

Table 5

Total ODA Development Commitments in Comparison with Estimated Health Disbursements by Major Bilateral Sources of Concessional Finance and Technical Assistance in Sub-Saharan Africa, 1987 (\$ Millions)

Bilateral Sources	Total ODA Commitments	Estimated Health ODA Disbursements	Health as Percent Of total ODA
Australia	47.0	--	--
Austria	28.9	4.3	14.8
Belgium	251.6	27.0	10.7
Canada	487.7	4.0	0.8
Denmark	265.9	12.6	4.7
Finland	118.7	18.0	15.2
France	2525.3	60.0	2.3
Germany, F.R.	1063.0	23.8	2.2
Ireland	16.6	--	--
Italy	1844.5	49.8	2.7
Japan	680.3	4.2	0.6
Netherlands	581.1	18.0	3.0
New Zealand	1.0	--	--
Norway	267.4	0.22	.08
Sweden ¹	380.1	18.0	4.7
Switzerland	158.9	--	--
United Kingdom	504.5	9.5	1.8
United States ²	826.0	87.8	10.6
Of which: US AID	559.3	87.8	15.7
US ODA % of Total ³	8.2%	26.0%	
Total ODA Bilateral	10038.0	337.22	3.4

Source note: Data obtained from donor reports to DAC/OECD, annual reports to DAC, and from direct interviews with donor sources. DAC may not fully represent donor contributions. Blank spaces indicate of information availability.

¹ Sweden's disbursement is added to the bilateral commitment for the purposes of this table.

² ODA totals include bilateral flows as well as multilateral contributions. The A.I.D. FY 89 CP quotes \$559.3 million as the AID appropriation. The balance of \$826 million represents non-A.I.D. flows such as the Africa Development Bank, FFP, ESF, IBRD, IDA and voluntary contributions to UN organizations (e.g. UNICEF).

³ The 1987 data on A.I.D. health, population and child survival contributions totals \$87.8 million, which represents 15.7 percent of A.I.D. flows.

Table 6

Total ODA Development Commitments in Comparison with Estimated Health Disbursements by Major Multilateral Sources of Concessional Finance and Technical Assistance in Sub-Saharan Africa, 1987 (\$ Millions)

Multilateral Sources	Total ODA Commitments	Estimated Health ODA Disbursements	Health as Percent Of total ODA
AF.D.B.	724.5	16.59	2.3
EC	2360.2	17	0.7
IBRD	0	--	--
IDA ¹	1915	30.8	1.6
IFAD	123	--	--
UN Agencies	993.4		
Of which WHO/AFRO		85.6	
(Reg. Budget)		(49.4)	
(Vol. budget)		(36.2)	
UNFPA		30.4	
UNDP	262.2	1.3	0.5
UNTA	56.7	--	--
UNICEF ²	129.5	103.6	80.0
UNRWA	--	--	
WFP ³	--	--	
UNHCR	--	--	
Other Multi	--	--	
Arab agencies	107.7	--	
Total ODA Multilateral ⁴	6353.6	285.29	4.5

Source note: Data obtained from donor reports to DAC/OECD, annual donor reports to DAC, and from direct interviews with donor sources. DAC data may not fully represent donor contributions. Blank spaces indicate lack of information availability.

1 IDA records \$121.4 million in 1988.

2 UNICEF contributions are attributed 80 percent to health. Disbursement of \$129 million is used as "commitment" for the purpose of this table.

3 WFP obviously has major nutritional value which is difficult to quantify.

4 Includes UNICEF disbursement of \$129.4 million for purpose of this table.

Table 7 provides a comparison of ODA commitments and HPN disbursements from all development sources (bilateral and multilateral) in 1986 and 1987. The points to note are the following:

- o Average HPN disbursements are on the order of 3.4 percent of ODA in spite of an increase in total development ODA in 1987.
- o A slight decline in the estimated percent of 1987 multilateral health disbursements over 1986.
- o An increase in A.I.D. HPN disbursements from 9.5 to 15.6 percent of all ODA, a level which is approximately three times higher than the all-sources donor average for 1986 and four times higher than the 1987 average.
- o In comparison to the A.I.D. HPN contribution of 26 percent of all bilateral HPN flows, the A.I.D. contribution to combined bilateral and multilateral flows to Africa was an estimated 12 percent in 1986 and 14.1 percent in 1987.

The outlook for HPN financing in 1988 suggests bilateral increases for Italy and Japan, a marked known increase in World Bank IDA financing (\$ 90 million) and increasing trends for both WHO and UNICEF. It is anticipated that the 1988 A.I.D. HPN level, if the 1987 levels are maintained, will approximate only ten percent of the total ODA HPN flow.

The all-sources HPN percentage of 1988 total development flows will probably remain less than five percent. Estimates of total ODA flows is necessarily tentative due to incompleteness of 1988 data and fluctuations in loan approval levels.

B. Analysis and Conclusions

The progressive erosion of the A.I.D. development functional accounts over the past several years has influenced Africa regional efforts to support the HPN sector. Total A.I.D. regional ODA has declined from \$836 million in 1985 to a proposed (CP) level of \$591 million for 1989. For 1987, the combined health, population, nutrition, child survival and AIDS input represented around 15 percent of the regional A.I.D. ODA. At this level, the A.I.D. regional percentage contribution is four times higher than any other single donor with the exception of WHO and UNICEF. In current dollars, the A.I.D. regional HPN budget for 1987 (\$87.8 million) is slightly larger than the WHO regional budget (\$85.6 million) and larger than the actual UNICEF contribution to health (an estimated \$80 million out of the total UNICEF regional budget of \$103.6 million)

Table 7

Trends in Total ODA Development Commitments and Estimated Health Sector Disbursements from All Sources for Sub-Saharan Africa in Comparison with A.I.D. Financing, 1986-87 (\$ millions)

Category of Development Commitment	Total ODA Development Commitment		Total ODA Health Disbursement		Percent Health of Total ODA	
	1986	1987	1986	1987	1986	1987
All sources Bilateral	8902.2	10038.8	291.7	337.2	3.2%	3.4%
All sources Multilateral	4375.4	6353.6	263.0	285.3	6.0%	4.5%
Total all Sources	13277.6	16392.4	554.7	622.5	4.1%	3.7%
AID Bilateral and Percent AID Health of Total AID ODA	699.9	559.3	66.9	87.8	9.5%	15.6%
AID Percent of Total ODA	5.2%	3.4%				
AID Percent of Total Health ODA			12.0%	14.1%		

While the A.I.D. Africa Regional Bureau, as of 1987, was the largest single contributor (14.1 percent of total HPN flows), there is evidence which points to a decline in percentage contribution during 1988 and 1989 as the banks and other bilateral sources increase their contributions. Even if A.I.D. HPN levels are maintained in the coming years, Congressional constraints on the A.I.D. budget do not suggest an outlook for substantial increase in the availability of financing for the development accounts. The fact that the U.S. contributes the second lowest percentage of development aid in relation to GNP (0.21 percent) among all major industrial donors is not necessarily persuasive to Congress for an increase during a period of budget-restriction legislation (Gramm-Rudman).

In terms of the long-term nature of A.I.D. HPN objectives in Africa and the great gap which still remains to achieve access and equity in essential health, population and child survival services, what further increases in HPN financing be expected through A.I.D. regional resources? As noted:

- o A.I.D. is already the largest single HPN donor in the region (1987).
- o The percent contribution of A.I.D. is already four times larger than the average percentage of total ODA contributed to HPN by any other bilateral or multilateral donor, except for the special cases of UNICEF and WHO.
- o The contribution of A.I.D. is only 15 percent of the regional HPN total, with the probability of declines in 1988 and 1989.

In terms of A.I.D.'s own HPN priority objectives, regional budget support by itself is insufficient and without an assured prospect of sustained or major increases in the foreseeable future.

The major conclusion is that a sustained, effective external financing strategy for the next decade will depend, at minimum, on the most efficient utilization of all potential donor resources. And that it should be in the direct interest of the Regional Bureau, in terms of its own HPN objectives and financial outlook, to encourage the development of a new cooperative system which is designed to bring about the most effective utilization of global resources.

The issue here is not the already high level of A.I.D. financial leadership by comparison with other donors. Instead, it is the realization that the current level of A.I.D. input is inadequate as measured against projected regional HPN objectives for the coming decade. The issue is the requirement for new external

financing strategy to meet the formidable challenge of priority HPN objectives which A.I.D. holds in common with other donors and countries of the region, such as:

- o Measurable reduction in infant and child mortality
- o Reduction of high birth rates
- o Establishment of the low-cost delivery systems through which countries can provide the most essential basic health services to the population majority
- o Reduction in major tropical disease, particularly onchocerciasis and the all-pervasive malaria with its high impact on infant and child mortality
- o Measurable improvement in nutritional status
- o Reduction in high maternal morbidity and mortality
- o Control of AIDS.

Against these immensely difficult long-range development objectives in the world's least developed geographical region, the key problem may be phrased in another way:

Who is going to pay the bill?

VII. MAJOR EXISTING AND POTENTIAL SOURCES OF EXTERNAL FINANCIAL ASSISTANCE BY COUNTRY OF PREFERENCE

Given the formal policies of all major bilateral and multilateral organizations that health is an eligible component for development cooperation, Annex I presents DAC/OECD data⁵ showing annual magnitude of commitments from major sources to each individual recipient country in Sub-Saharan Africa (1987). The table lists the major sources of finance and, in principle, the major existing sources of potential HPN financing. The term "existing sources" is important, since not all potential sources report to OECD.

⁵ OECD, Geographical Distribution of Financial Flows to Developing Countries, Paris, 1989.

Annex II shows trends in percentage allocation of aid from each major donor to principal recipient countries.⁶ The allocations signify emphasis countries on a global scale. For Sub-Saharan recipient countries, comparison in magnitude of total external flows from DAC/OECD countries has been pointed out earlier in Tables 3 and 4.

Beyond the list of 18 industrial bilateral donors and the 18 listed multilateral sources, there are additional HPN financing sources operational in selected countries of Africa or other developed countries. These include:

- o Nonlisted UN agencies, specifically:

- WHO Headquarters, Geneva
 - WHO Regional Office, Brazzaville, Congo
 - UNFPA
 - UNEP

- o OECD members which are not members of the DAC (Development Assistance Committee):

- Greece
 - Iceland
 - Luxembourg
 - Portugal
 - Spain

- o Special Funds supported by OPEC countries:

- Abu Dhabi Fund
 - Arab Fund for Economic and Social Development
 - Arab Gulf Program for United Nations Development Organizations
 - Iraqi Fund for External Development
 - Islamic Development Fund
 - Kuwait Fund for Arab Economic Development
 - Libyan Arab Foreign Investment Company
 - OPEC Fund for International Development
 - Saudi Fund for Development

- o Seven countries of the Eastern European bloc

- o Other Developing Countries:

- China
 - Israel
 - Mexico
 - Argentina
 - Brazil
 - India
 - Korea, Republic of
 - Taiwan

⁶ OECD, Development Cooperation, 1988 Report, pp. 211-220. Paris, 1989

o Nongovernmental Organizations:

In 1983, OECD estimated 3000 active NGOs in international work. The count is clearly an underestimate of total private and voluntary organizations overseas. Preliminary estimates based on a review of Canadian, British and Scandinavian NGOS suggest that at least half of all NGOs carry out a health-related function.

Major Canadian, European, and U.S. international foundations are operational in health, but the full number has not been clearly identified, in part due to deficiencies in current data collecting systems.

o Private commercial organizations

In this context, the pharmaceutical industries provide a major opportunity for concessional financing. Drugs continue to assume a major role in the costs of national health system. The provision of concessional sales for generic or "essential" drugs merits greater exploration as a cost-saving procedure. Under tropical conditions, the availability of transport and equipment also merit search for concessional sources.

A. Analysis

For Sub-Saharan Africa, the total number of potential official and nongovernmental external resources is far in excess of the utilization now being made by the HPN sector. Ministries of Planning or Development and UNDP representatives will be aware of the major donors, but there are several reasons why knowledge of this potential is not readily available to a given Ministry of Health and often beyond the reach of private sector national institutions outside the government:

1. Ministries of Health are not often fully aware of information which may be available in a Ministry of Planning.
2. Ministries of Planning are often unaware of donor potential to finance HPN activities when past patterns for a specific donor may have concentrated in another sector, e.g. agriculture.
3. The knowledge of Ministry of Planning and UNDP is based on currently cooperating donors rather than on the potential from sources not currently cooperating. For example, in the Americas it is demonstrable that major

sources such as Japan, Italy and West Germany have not been approached for HPN support in certain countries because the government was unaware of donor policies favoring HPN.

4. Ministries of Health are not functionally organized to track the potential supply of external financing in the absence of source information. As of 1989, there is no regionally-circulated information by any international organization, including WHO, which provides an updated list of potential HPN sources for each specific country. For example, what are the major current and potential official and NGO sources for the HPN sector in Zaire?

Certain countries in the region have a very good picture of existing HPN resources, e.g. Kenya and Tanzania. The UNDP seeks to identify health sources in all its Country Profile reports. This report, however, excludes sizeable segments of potential availability, including the long-range potential of private and voluntary agencies. And the report itself may never reach or be utilized by a Health Ministry.

B. Conclusion

With variation among African countries, the HPN sector has no current regular or periodic access to the full range of official and nongovernmental sources of external financing or the associated knowledge necessary for the mobilization of these funds.

This conclusion does not imply that a recipient country should negotiate cooperative programs with all of the potential sources noted above. National political preferences on the part of both the external source and a requesting government will influence choices. Without a better knowledge of the potential supply of external financing, choices are constrained and the rate of progress is slowed.

On the basis of the author's direct dialogue with official sources, there is clearly far greater supply of finance for HPN than there is expressed demand. To initiate change requires a system which regularly provides to each regional country at the Ministry of Health level a comprehensive list of potential official and NGO sources, including associated information on programs, policies and preferences; and an orientation or training in the utilization of potential sources.

VIII. CURRENT AND PROJECTED DEMAND FOR HPN ACTIVITIES AND THE CONSTRAINTS TO DEMAND

This section should be read in conjunction with the African site visit report of Patrick F. Morris included in this report.

A. General Status

Tables 5 through 7 express the effective demand for HPN financing in the form of officially-negotiated projects by external source and by donor category. Table 7 summarizes this demand which averages 3.4 percent of annual bilateral financing (1987) and 4.5 percent of annually multilateral financing for the same year. The combined all-sources average is 3.7 percent. This level of HPN assistance is below worldwide averages on the order of 5.2 percent for bilateral aid and 7.8 percent for multilateral A.I.D. (DAC/OECD). What influences official demand for HPN?

The demand for financing from specific donors may be much higher, e.g. 15.6 percent for A.I.D. and, in effect, 90-100 percent for UN agencies such as WHO, UNFPA and UNICEF. Effective demand directly reflects the efforts made by the external source to negotiate agreements, a factor which also reflects the level of resident representatives. The large number of regional A.I.D. HPN personnel are not matched by any other bilateral source in Africa with the exception of France, whose bilateral health commitments would represent a far higher proportion of its ODA if it were not that French assistance provides very substantial general budget support. UNFPA, WHO and UNICEF have large resident staff numbers to dialogue and negotiated agreements.

Most bilateral and multilateral donors assign staff to approved projects without assigning resident health representatives to negotiate future programs. Consequently, with the noted exceptions, donors have few field resident HPN representatives.

The rationale for this process is built into individual donor policies. Except for the A.I.D. program which is subject to prior Congressional approval and earmarking of functional accounts, the predominant pattern of donor assistance is to require prior expression of recipient country interest. Geographical allocations by country are often estimated in advance, but the sectoral allocations are flexible.

External sources, in principle, insist that cooperation fit within an approved national development plan. A.I.D. requires its Country Development Strategy Statement (CDSS). The World Bank requires a Policy Framework Paper as a basis for its assistance. In the absence of health representatives and in light of weak Ministries of Health, the HPN sector is not infrequently poorly represented.

Given this variety of external approaches and the early developmental stage of many African Ministries of Health, the evidence from Africa for this assessment is that Ministries of Health respond to offers of external assistance rather than actively undertake their own health sector analysis, identify their own priorities, and seek their own financial resources.

As outlined in the appended Morris report:

- o Malawi has a strong central planning office, but criticizes the MOH planning unit for poor financial planning of its proposals for donor aid.
- o In Niger, donors such as the French, IBRD and A.I.D. have detailed health sector programs, but the government itself does not have a proposed and costed health development plan.
- o In Zaire, health sector analysis by the World Bank in 1987 found that Health Zone Financing and capital investments were being made without an adequate system of planning, programming or resource allocation.
- o Kenya, like Malawi, has longer experience in managing the large external resources which are concentrated in that country.

Collectively, these examples suggest a varying pattern of response to externally initiated opportunities, at least in countries of major donor concentration. For large sources such as A.I.D., UNICEF and UNFPA, successful programming implies the requirement of government to concentrate heavily in important but nevertheless externally-preferred priorities such as Child Survival and family planning. Against this trend, European donors have noted that the initiation of other HPN priorities are often difficult since the available manpower and energy is consumed in the implementation of current projects. The suggestion is that where a national problem such as maternal mortality and morbidity is identified, the establishment of a new activity (parallel in magnitude to child survival) is excluded due to total absorption of Ministries of Health with prior programs. Like the nominal support for maternal programs in Africa, the all-pervasive nature of malaria continues to take a heavy toll on young children. The application of malaria control beyond the marginal efforts within the CCCD Program has been suggested by the highly-successful effects of vector control in specific areas of Africa, both East and West (for example, in Ethiopia and Liberia). Initiation of new efforts along these lines becomes difficult under the prevailing pattern of external financial cooperation.

European donors have been referring to this phenomena as a "distortion" of effort, not because of the recognized high value of existing priorities, but because the effort is so all-consuming of national personnel that governments have little flexibility in developing their own preferences.

The implication of HPN demand in Africa is that the magnitude of potential demand is much higher and broader in range than current "international priorities" suggest. In a 1988 WHO/Geneva report on Global Strategy for Health for All by the Year 2000, 29 out of 44 African countries (66 percent) reported on the percentage of GNP spent on the health sector. Of the 29 reporting countries, 26 (90 percent) were spending less than five percent of GNP.

Expressions of African demand have been formalized since the 1978 United Nations Conference on Primary Health Care (Alma Ata), the Declaration of Heads of State and Government in Addis Ababa, July, 1987, and more recently in the Bamako Initiative.

B. Constraints to Demand

As the world's least developed geographic region, it is not unexpected that many of the necessary and sufficient prerequisites for development are weak or missing. Limits do exist--technically, financially and administratively--and the art of development recognizes that the rate of development is constrained by these limits.

For the HPN sector in Africa, there is no evidence that political will or policy statements are matched by sufficient professional skills or the necessary financing. However, there is a large and growing resource of professional manpower with technical and administrative skills gained over the past 30 years. There is far less orientation to health financing, national or external.

In the context of attracting external financing at a rate consistent with current personnel and local currency availability, most regional countries face the following barriers:

1. Limited training or staff capacity to undertake national health planning or health sector analysis

Within current planning units, technical and administrative experience far outweighs available skills in national or external financing. It should be noted that functional accounting is still not practiced by most Ministries of Health. Consequently, ministries are not accurately informed on total annual sources of income, national and external, or of the accurate distribution of that income by functional programs. The models for this activity exist in

several manuals such as E.P. Mach and B. Abel-Smith, Planning the Finances of the Health Sector, WHO, 1983.

2. Unfamiliarity with potential source of external finance or the patterns of external cooperation

Illustratively, Morris (see attachment) reports that Malawi has one of the best central planning units in Africa. But the health planning unit submits proposals to the central planning unit (EPND) without having knowledge of the potential sources of finance. It is left to EPND to find the resources. In practice, however, how can a health plan or proposal be prepared without a realistic estimate of financing potential? In effect, health planning takes place without knowledge of financial sources, a practice which, by definition, cannot be called good health planning.

And why do Ministries of Health not have this information? Largely because organizations in a position to be familiar with external financing have not undertaken to collect and provide that information regularly to the potential user.

3. Weakness in the justification of health proposals in national economic development terms, including estimation of recurrent costs and alternative operational costs
4. Unfamiliarity with the methods for processing proposals and negotiating with four different categories of external resources: Multilateral banks, bilateral agencies, UN agencies, and nongovernmental organizations.
5. Reluctance of national planning authorities to approve social sector programs during periods of economic constraint or structural adjustment.
6. Absence of a regional or international technical advisory system through which to obtain country-specific information, training, and technical guidance on potential sources of external financing and the process of financial mobilization.

It should be noted that individual resident donors may be highly supportive for the purposes of their own program cooperation without, at the same time, supporting the capability of a government to attract financing from multiple alternative sources. The role of the UNDP and the World Bank are well recognized in convening Consultative Groups or Round Tables to meet national development priorities. Theoretically, HPN should be a component of this process. In practice, the HPN sector appears to be a weak competitor for a place on the agenda. The CGs and RTs are not intended to exclude any sector, although major financial investment issues understandably gain priority.

Special attention to HPN financing is not intended to displace prevailing mechanisms of external coordination through UNDP, World Bank or other specialized UN agencies. The issue, instead, is that global donor sources, now available to Africa, are willing to make concessional grants and provide other resources in both large and small amounts, often without counterpart requirements. Sustained institutional attention to the range of available resources is not adequately conveyed through the periodic or ad-hoc CG or RT mechanism. Information on HPN sectoral financing should be made available on a regular and ongoing schedule.

C. WHO Efforts to Mobilize Resources Through the Country Resource Utilization Review

Since the establishment of a Health Resources Mobilization Office in WHO/ Geneva in 1980, efforts have been made to undertake a limited series of Country Resource Utilization Reviews (see appended Morris report). For Africa, 16 CRUs have been carried out over the past nine years with five revisions. The list of countries includes:

- Gambia, 1980, revised 1982
- Sierra Leone, August 1984
- Guinea, 1984, revised 1988
- Lesotho, 1983
- Botswana, 1984
- Malawi, 1982
- Guinea-Bissau, 1983, revised 1985
- Benin, 1981
- Sudan, 1981, revised 1984
- Togo, 1984 (draft)
- Somalia, 1985
- Djibouti, 1986
- Zambia, 1985 (draft)
- Mali, 1986 (draft)
- Rwanda, 1988 (draft)
- Burundi, 1988 (draft)

Although WHO also sponsored CRU studies in other geographic regions, the rate of support for 44 African countries was approximately two per year. As an early somewhat experimental effort to raise external financing for primary health care rather than for the health sector as a whole, the studies served in effect as a shortened health sector analysis which touched briefly on national policy, PHC programs, obstacles and constraints to progress, financial analysis, and identification of project suitable for external financing. Given the intent of the CRU, limited attention was given to financial analysis of the national budget and to the justification of projects in terms of the national socio-economic development plan.

Nevertheless, the CRU served as an important experimental effort to help developing countries focus on the identification of priority projects and required financing as a national effort unrelated to specific donor-initiated proposals. The CRU served as a demonstration of the process which, ideally, a Ministry of Health would follow on an ongoing basis if it wished to sustain cooperation with external financial sources. The current experience, however, has a number of important drawbacks:

1. The effort has been essentially backstopped and funded from WHO/Geneva, albeit in cooperation with WHO Regional Offices. As a geographically extended activity of a central office, the rate of effort has been limited in a terms of the number of countries within the Africa Region (and other geographic regions).
2. The effort has not been sustained, institutionalized or financed within Africa, either at the WHO Regional Office or at the national WHO level.
3. More importantly, the CRU effort has been episodic. National governments have not yet gained the institutional capability to carry out the elements of external financial mobilization themselves.

The results of the African CRUs are mixed:

- o The Gambia reports \$1.3 million in donor responses in 1984.
- o Guinea-Bissau, as a result of a Roundtable in 1986, had virtually all external financing requests approved, a commitment of over \$40 million for the period 1986-1992.
- o In Benin, a health sector Roundtable results in pledges of \$13.8 million, about 70 percent of proposals.

For most of the 16 countries, the proposals are still in the process of government review and approval. There have been favorable responses in new internal national cooperation between the Ministries of Health and of Planning. The effort as a whole, however, has not yet gained the momentum or weight of professional support to permit the CRU activity and its principles--namely the principles and requirements of external financial mobilization--into the regular functions of the Ministry of Health.

The conclusion of the CRU experience is that it has served, and is now serving, as a valuable demonstration of the prerequisites which countries need in order to generate external financing in the context of national development plans. The weakness of the current CRU process is that it remains largely an externally initiated effort which has not yet been applied on a sufficient scale to allow the regional as a whole to increase its capability to attract external financing.

Adding further to this conclusion, the CRU experience serves as an important opportunity for regional extension with appropriate modifications in application to make the process a more indigenous regional effort.

IX. MAJOR REGIONAL OPPORTUNITIES FOR EXTERNAL FINANCIAL MOBILIZATION TAKING INTO ACCOUNT SPECIFIC PROGRAM INTERESTS OF THE A.I.D. AFRICA REGIONAL BUREAU

Opportunities for strengthening the capability of African countries to attract external financing and parallel opportunities for improving coordination among potential donors have varied with the stage of the program development cycle:

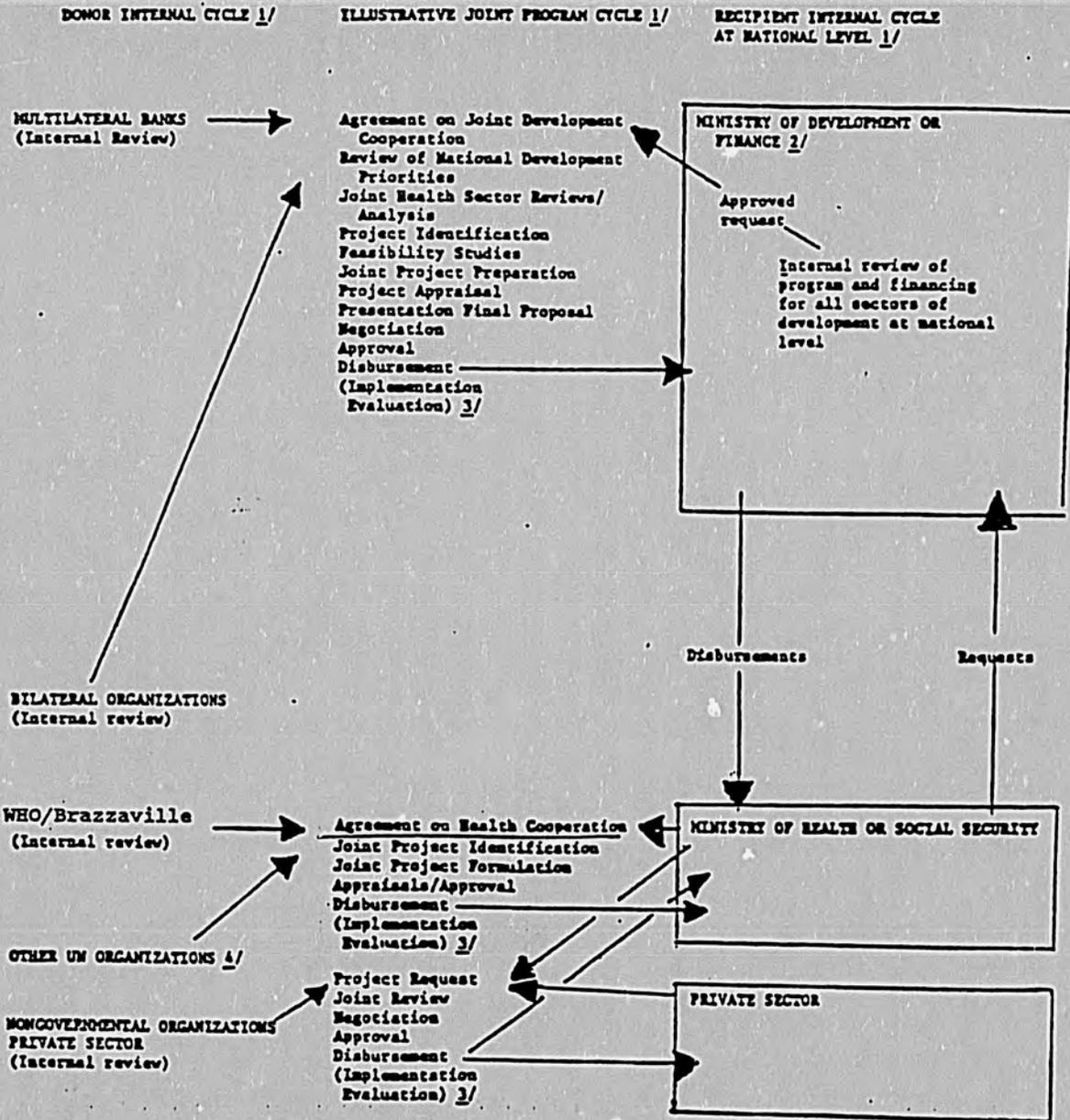
- o Collaborating with developing countries to strengthen financial planning through health sector analysis and identification of HPN priorities is not the same thing as actively attracting external financing.
- o Collaboration to attract alternative sources of external financing for HPN, which is not an organized activity among regional donors, is not the same thing as cooperation at country or regional levels after the financing has been identified.
- o Coordination among existing HPN donors at the country level, which is an important activity of USAID, WHO/Brazzaville, UNDP, and other resident donors, is not comparable to equivalent coordination activities at the regional or global level.
- o Coordination on technical issues of program planning, implementation and policy dialogue is not equivalent to joint efforts to attract global financial sources.

These differences between external financial mobilization and other components of "donor coordination" may be recognized in Figure 2, which illustrates the donor-recipient program process. Some of the more common features of this process as they apply to HPN financing are listed to indicate potential opportunities:

1. There are at least four major categories of external financing: Multilateral banks, bilateral organizations, WHO (and other specialized UN agencies such as UNICEF and UNFPA), and NGOs. The negotiating cycle differs with each group. Ministries of Health are often unaware that rapid financing is available through NGOs or the UN system when the bilateral route or multilateral route is more drawn out.
2. There are three different "internal" or self-contained cycles: the recipient government, external source, and the joint cooperative negotiation. As African health ministries are learning through the CRU process, major requests to banks and bilaterals must first be processed and cleared by the national development planning agency (or equivalent). In this context the

FIGURE 2

Basic Program Cycles for Mobilization of External Financing for Health



1/ The detail of this process varies with each financial source.
 2/ The name of the National Development Planning authority may vary with each country.
 3/ Implementation and evaluation are mentioned as sequential steps following mobilization of funds.
 4/ UNDP requires approval of Ministry of Development Planning or equivalent.

Source: Adapted from PAHO: Guidelines on External Financial Resource Mobilization for Health in the Region of the Americas, Washington, 1986.

first hurdle is the justification of health projects in terms of a national development plan, a justification requirement for which health ministries are poorly trained. It is at stage, for lack of training, that ministries are weak in articulating the financial feasibility of projects which may seem to be technically justified.

3. Ministries of Health reluctantly accept that they are not the primary point of negotiating with external financial sources. Consequently there is often an attempt to bypass the procedure of requesting that WHO or another UN agencies serve as a channel for financing. To a limited extent, this bypass may work. For significant financing, it fails because banks channel few funds via the UN (with limited exceptions) and bilateral agencies have legislative or parliamentary restrictions on the volume of aid which can be channeled through the UN system.
4. Ministries are not aware, however, that even banks and bilaterals often make planning or study grants with few restrictions to support the efforts of the HPN sector to prepare for larger proposals.
5. The complexity of the three cycles may be understood by personnel with the planning ministries but not clarified for Ministries of Health for lack of orientation.
6. The total number of official and NGO agencies potentially available to a specific country far exceed the actual number currently cooperating in country. Ministries do not have ready access to information on this potential. While this issue may not seem critically important for countries such as Kenya and Malawi which are already a focus of emphasis and concentration for many donors, for non-emphasis countries, the lack of information is a problem. This applies particularly to nongovernmental resources which are a continuing major HPN resource and source for new financing in Africa.
7. The policy consensus among both official and NGO sources are supportive of the same objectives in Child Survival, family planning and nutrition endorsed by A.I.D., albeit with variation in volume, country of preference, and preferred types of technical assistance. In effect, alternative financing for A.I.D. HPN program objectives remains to be fully explored.

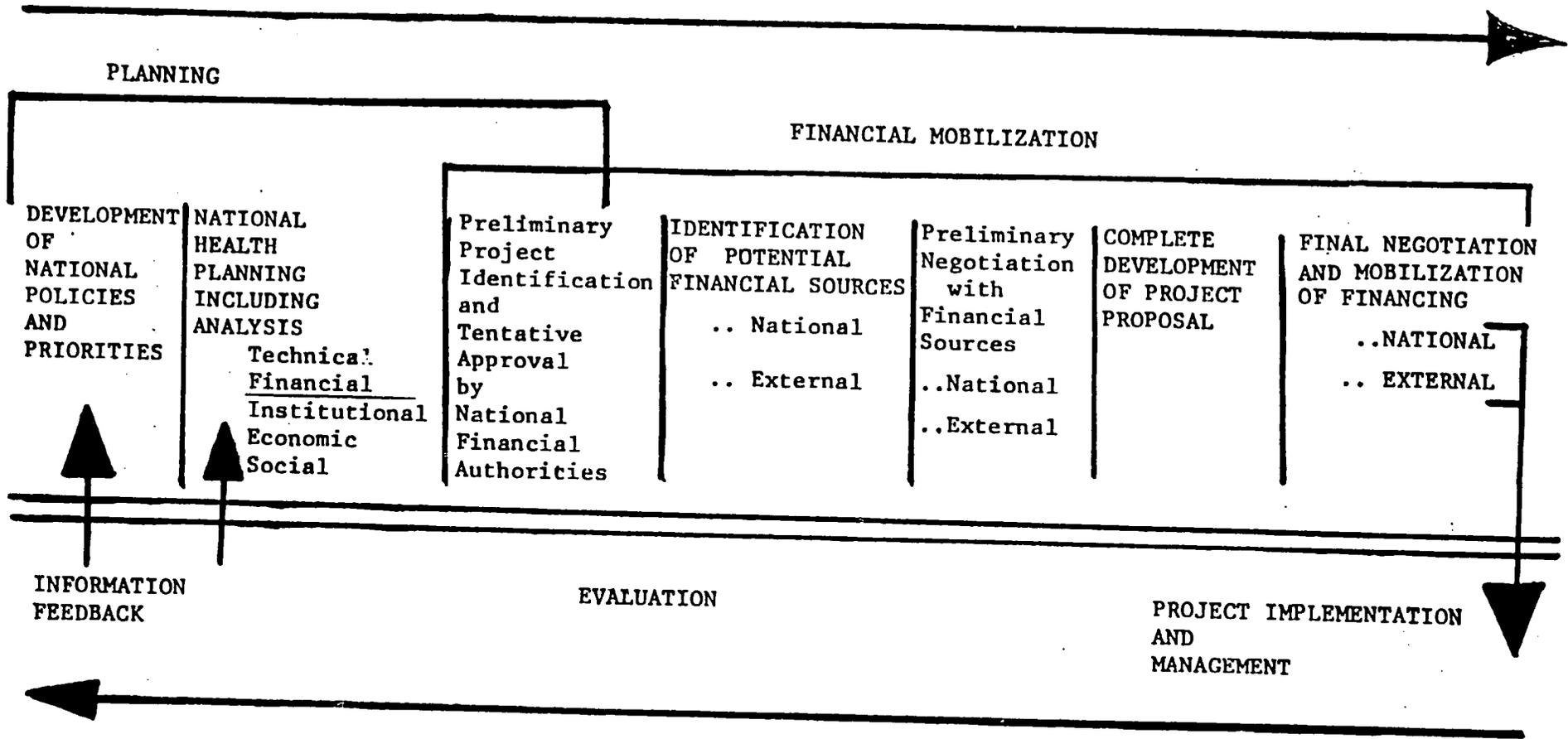
The general donor-recipient programming cycle as shown in Figure 2 is further expanded in Figure 3, which describes the cycle of financial mobilization as it applies specifically to the HPN sector. The opportunities for strengthening the capability for external financing are defined in terms of the process which at present is not applied fully in any Ministry of Health in Africa (For example, all the listed deficiencies have been partially addressed in the financial resource mobilization program operational through PAHO for the past six years).

1. At the entry point in the cycle, Ministries of Health may contribute to the formation of a national development plan. But the health plan itself, with perhaps the exception of Malawi, will be weak in one or more of at least five critical elements of health plan
 - o Technical feasibility
 - o Financial feasibility (Is national and external financing adequate for capital and recurrent costs?)
 - o Economic feasibility (Will the level of input achieve the stated objectives?)
 - o Institutional feasibility
 - o Social feasibility

In the region, it is the limited documentation of economic and financial feasibility which offers the best opportunity for strengthening the competitiveness of the HPN sector in terms of attracting external financing. Such strengthening is principally an issue of appropriate training and trainers.

2. Preliminary determination of the most appropriate and priority programs is a consequence of health planning and analysis in the context of an approved national development plan. Within these priority programs, the appropriate financial and technical requirements for external cooperation can be defined. For lack of this step, African ministries are weak in defining their own external financial agenda.
3. A commonly omitted but important step is for Ministries of Health to seek tentative approval for proposed projects at the planning ministry level prior to further development. Approval at the level of the Minister of Health does not necessarily represent "government" intent.

BASIC PROGRAMMING CYCLE FOR DEVELOPMENT FINANCING OF THE HEALTH
SECTOR AT THE COUNTRY LEVEL



4. Identification of potential financial sources, both national and external, are essential for practical planning. Even in the case of Malawi, the Ministry of Health assumption is that financing is the concern of the development planning or finance ministry--a partial truth. As a practice in HPN planning, program development in the absence of any basis for anticipating support cannot be considered to be useful health planning. (Planning has been defined as the art of the possible).

Step #4 above is beyond application for most Ministries of Health since there is no national or regional system for providing updated country-specific information on potential sources. This gap extends to knowledge of the potential of existing donors who may accept HPN components but are better known for working in other sectors.

5. In the absence of an approximate knowledge of external sources, ministries are not aware of available mechanisms for dialogue and contact through the good offices of existing official agencies or NGOs.
6. Most Ministries of Health are not aware that it is not necessary for the ministry to prepare a full detailed proposal before consideration by an external source. On the contrary, a brief preliminary proposal which contains essential information (as used by PAHO) is sufficient to identify need and to present a preliminary idea. If there is external interest, usually based on an indication of official national planning office approval, the external source is usually prepared to send its own technical personnel to cooperate in further exploration, studies and final project development.
7. Ministries of Planning may not necessarily be involved in the case of negotiation with the WHO, UNICEF or NGOs.
8. Final negotiation and financing depends on the category of negotiated sources. WHO and NGOs may negotiate directly with Ministries of Health while the official development agencies only negotiate with the authorized national planning or financial office.

By following these foregoing steps, a health ministry may arrive at the point where an external project is actually financed and the more familiar phase of country-level donor coordination begins.

Gaps in the mobilization cycle constitute regional opportunities. For example, it is important to note that during this assessment visit to Africa, the WHO Regional Office in Brazzaville expressed full cooperation and willingness to support the external financial mobilization process after the pattern of the Americas. It is relevant that the Regional Director, Dr. Monekosso, prior to his assumption of office in Brazzaville, has served as a WHO Representative in PAHO during the period of development of the first external financial resource mobilization system.

As Morris has described in his report, the WHO/Brazzaville Office has the beginnings of a financial mobilization office, a nucleus which admittedly requires professional strengthening. The opportunity is one of expansion through a permanent regional organization with professional personnel located in every country of the region.

The disadvantage of the WHO office, other than the early stage of its experience, is the health sectoral rather than development orientation of the organization. WHO fully accepts and endorses the principle that health must be an inherent part of development. Nevertheless, WHO is not itself a development financing organization in the same sense as the multilateral banks and bilateral agencies. For this reason, as noted earlier, WHO does not have the accountability or responsibility for well over 90 percent of all health financing in Africa.

To compensate for this historical role of WHO as primarily a technical rather than an economic or financial resource, the opportunities for health financing in Africa must take maximum advantage of the ongoing roles of the following:

- o The World Bank, which is able to provide detailed health sector analysis, offers major financing, and serves to encourage co-financing through its consultative groups. In the Americas, the Bank has cooperated in providing country-level training in project development and financing. It is of relevance to the Africa Bureau that financing can be made to the Bank as the "banker" or financial focus for regional projects as in the West African Onchocerciasis Program. Such cooperation could also extend to the Bank's current contacts with global financial sources for the purposes of identifying potential sources of health financing. The Bank applies this role generically to the financing of its loan projects, i.e. the search for co-financing. However, the Bank has not yet formally undertaken the identification of alternate sources of concessional HPN financing as a sectoral information service. Most importantly, the Bank is able to apply financial discipline through its Structural Adjustment Loan agreements in a way that cannot be matched by the

technical advisory efforts of other external financial sources or UN agencies.

- o The African Development Bank, which also provides sector financing at the country level.
- o The UNDP representative, who identifies sources of existing donor cooperation on an annual basis and arranges periodic Round Tables, but offers little direct financing or technical assistance in HPN.
- o UNFPA and UNICEF, which play a valuable role in coordination of programs and financing for family planning and children's services.
- o The Development Assistance Committee of OECD/Paris, which tracks regional health financing and total development flows to Africa, but does not offer technical or financial assistance and has no direct liaison with developing countries.

The opportunities for strengthening resource mobilization in Africa are multiple and should make the fullest use of ongoing efforts. The proposal, as developed in the final section of this report, suggests the principal components of an HPN financial mobilization methodology for Africa, with special attention to the needs of current A.I.D.-emphasis countries.

Conclusion

Regional opportunities are defined in terms of existing gaps in the donor-recipient program cycle applied to the HPN sector and in terms of the potential resources to address defined gaps.

The HPN sector is affected by major omissions or weakness at each point in the noted cycles (Figures 2 and 3). To strengthen the capability of governments to address defined gaps, it is important to build on prevailing regional mechanisms which are supported by WHO, the World Bank, other UN agencies, and DAC/OECD. For these purposes, two regional resources are particularly opportune:

1. The WHO Regional Office in Brazzaville, whose Director, Dr. Monekosso, has specifically indicated willingness to support the requisite components of external financial resource mobilization for health. For this purpose, WHO/Brazzaville has the successful model of WHO/ Washington (PAHO) with which to develop an African adaptation.

2. The World Bank, which is able to influence sectoral ministries to plan external financing rationally within the context of Structural Adjustment lending. The World Bank, in addition, could serve as a major regional information source on potential global sources of external HPN financing.

Given the numerous steps in the cycle of attracting external financing and the absence of any current region-specific mechanism to strengthen the HPN sector for this purpose, there is an important potential role for the A.I.D. Regional Bureau to play in supporting a system which is designed to strengthen the ability of African countries to identify and attract sufficient financing to accomplish regional HPN objectives.

X. TRAINING REQUIREMENTS FOR REGIONAL GOVERNMENTS TO IMPROVE THE UTILIZATION AND COORDINATION OF EXTERNAL FINANCING FOR THE HPN SECTOR

The preceding section outlines the basic program cycles in development financing as applied to the HPN sector. Given the limited number of professionals in Ministries of Health assigned to donor issues, the limited training in health financing, and the turnover of personnel, emphasis on both national and external health financing is of major importance. To date, training in national health care financing has been supported by a number of organizations. The same cannot be said for training in the process of external financial mobilization.

Consequently, with continuing emphasis on technical rather than financial planning, there is widespread unfamiliarity with the availability, mobilization and negotiation of external sources. Indeed, familiarity is primarily restricted to governmental experience with resident donors.

The issue of training in the PAHO Model, has been applied in the following way:

1. The target group has been assumed to include not only governmental representatives in Ministry of Health planning units, and Ministry of Planning representatives, but also WHO regional personnel at all levels (headquarters, sub-region, and country), and interested nongovernmental representatives.
2. The curriculum has covered key topics including:
 - o Identification of sources of external support
 - o Maintenance of country-specific profiles at the country level

- o Identification of financial demand for external financing and the criteria for justifying demand
 - o Analysis and rationalization of potential financial supply with defined financial demand
 - o Mobilization of external financing, including selection, preparation of specially designed preliminary proposals, justification and clearance, project negotiation and final project proposal development, and utilization of donor coordination procedures
 - o The importance of periodic training
 - o Monitoring of financial flows through functional accounting
 - o Evaluation of the process of attracting external financing at the country level.
3. The procedure for training was to hold workshops of three to 14 days in length at headquarters, sub-regional, and country levels. While WHO personnel were often oriented at headquarters and subregional levels, country-level training was found to be the most effective method of orienting government ministries. Experience in the Americas indicated that country level training was most effective because it permitted access to data on local financing and government priorities. Specific training exercises were more acceptable and meaningful if focused on national priorities than general examples as required at headquarters and sub-regional meetings.
 4. The basis of training in the Americas has been a guideline or manual which serves as a reference for participants.
 5. Training experience has included the utilization of training personnel from the Caribbean Development Bank. For Africa, comparable training resources would need to be identified.

Conclusion

For the HPN sector, the African Region has no current functioning system for providing ongoing training in external financial mobilization. For this reason, it has no active program to strengthen national capability to identify financial demand or potential supply.

For the region, the tested PAHO model is suitable for application in all respects, that is, the requirement for training and orientation at all levels, the need for a systematic curriculum, the application of small workshops at the country level, and the preparation of regional training manuals and materials. Experienced faculty exist in the Americas to provide a beginning.

Organized training for external financing need not replace ongoing efforts to carry out periodic Country Resource Utilization Reviews. The difference is that the CRUs are an exercise which do not attempt to leave an ongoing institutional base in the Ministry of Health, a result which is the objective of a comprehensive training system. What is required is an adaptation of the CRU which permits a continuing on-site ministry activity to assess the potential supply and expressed demand for external financing.

With appropriate support, the WHO Regional Office can serve as appropriate agent for training in the region. It is assumed that the World Bank and other UN agencies would be willing to cooperate in this effort. Catalytic financing to initiate such a system would require a multi-year commitment on the part of at least one regional donor.

XI. RECOMMENDATIONS: THE PRACTICAL COMPONENTS OF A DONOR COORDINATION AND EXTERNAL RESOURCE MOBILIZATION SYSTEM FOR SUB-SAHARAN AFRICA

Based on the Scope of Work (Section III) and the statement of problem (Section V), the recommendations are made with reference to the requirements for external financial mobilization and coordination among donors for this purpose. Recommendations do not specifically address technical coordination or policy dialogue which are ongoing activities at global, regional and country levels (Section X). It is assumed that coordination is a highly diverse cooperative activity which cannot fit into a single comprehensive pattern. Hence the limitation of recommendations to the objective of this assessment on the status and means to attract alternative sources of external financing for the HPN sector under the urgent and difficult conditions characteristic of Africa.

The recommendations are particularly oriented to the limited outlook for increase in A.I.D. sectoral financing over the next several years, essentially reflecting Congressional budget prospects. Taken together with international consensus on Child Survival, family planning, tropical disease and AIDS priorities in the region, the important question is what role A.I.D. itself should play in stimulating the ability of African countries to attract financing.

The author proposes an adaptation of the successful model tested in the Americas through PAHO. The adaptation seeks to incorporate current ongoing HPN donor activities rather than replace them.

The recommendations are made to the A.I.D. Regional Bureau, proposing a catalytic role for A.I.D. to help establish a new cooperative regional strategy to attract HPN financing.

In cooperation with other donors or international organizations as designated below, the AID/AFR/TR/HPN Office would undertake to arrange and implement the following components:

1. Identification of global sources of official and NGO financing for HPN in Africa

This could be accomplished by:

- o Maintaining contact/liaison with major sources
- o Preparing a brief annual updated profile on each source indicating policy, program, financing, project approval procedures, key personnel and channels of communication.
- o Distributing edited texts in French and English to all regional users the level of the Ministries of Health and Planning, and to all appropriate multilateral and donor agencies.

For implementation, A.I.D. should seek the cooperation of those agencies which routinely gather donor information at the global level. While no source is currently performing this function on a regular basis, A.I.D. should seek the cooperation of the World Bank, DAC/OECD, and WHO Geneva for data collection, and the WHO/Brazzaville office for distribution to all regional Ministries of Health and Planning. A.I.D. should take the lead in making arrangements and should perform only those functions which cannot be arranged with referred sources.

2. Preparation of a Guideline on External Financing for Health after the pattern in the Americas

The guide should cover sources of information, trends in financing by recipient country and donor, strategy for financial mobilization, and guidance on the identification of constraints to external financing. It should include essential guidelines on preliminary proposal preparation. The document should be update annually and issued in French and English.

Implementation by A.I.D. assumes the willingness of the WHO/Brazzaville Office to develop and staff this function as an ongoing activity.

3. Identification of potential demand and constraints to demand at the country level

A.I.D., working through the WHO Regional Office/Brazzaville and in cooperation with UNDP at the country level, should support the preparation of a standard-format profile of the major internal program processes characteristic of each government and the major constraints to the approval of external HPN financing within each government. It is not essential that such information be collected for regional distribution. At minimum, each Ministry of Health should be encouraged to document the internal approval process and constraints for its own use. For this reason, the WHO office may be the most appropriate agency for encouraging this function.

This function is a basic application of national health sector planning and analysis which defines priorities within the context of a national development plan. Where national governments are weak in planning or not prepared for national health planning or financial analysis, A.I.D., in cooperation with WHO/Brazzaville, should undertake to strengthen national capability through training, with emphasis on preparing justification for external financing.

4. Analysis of identified financial demand with potential external financial supply

Each Ministry of Health should be encouraged to build this function into its own structure within a planning unit or a new office on resource mobilization. As the function requires knowledge of both external resources and internal demand, a period of institutional development will be essential, supported through the WHO/Brazzaville network.

Implementation of this function by A.I.D. assumes two directions of effort, one through support of the WHO Regional Office and the other through support by country USAID offices or other donors willing to support training and personnel in Ministries of Health to carry out this function.

5. Mobilization of external financing

This function, a primary responsibility of each country, requires determinations of financial source selection, matching demand with potential sources, preparation of

preliminary proposals, preliminary negotiation with potential sources, and final project preparation and negotiation.

Implementation of this function is the core of institutional development within Ministries of Health. The means is primarily through training and supervision over a sufficient length of time, but not less than five years. Such institutionalization is certainly a function for USAID sponsorship, but the technical resources to backstop it over a defined period of time through the A.I.D. Regional Office and in cooperation with WHO/Brazzaville would require separate support.

6. Provision of Training for Ministries of Health and International Personnel

Section IX has outlined the target group, curriculum outline and methods for orientation and training. In the absence of any parallel effort on the topic of external financing, it is entirely appropriate for A.I.D. to sponsor, in cooperation with WHO/Brazzaville and the World Bank, the activities listed in Section IX.

Since the subject matter is new to the Africa Region, including WHO and AID/AFR personnel, it is recommended that A.I.D. sponsor a five-year program of training, making maximum use of financing, resources and facilities available through WHO Brazzaville and World Bank. The target group will include key national HPN personnel, preferably those personnel with operational responsibilities for financing, planning and external relations. For orientation, A.I.D., WHO, and Bank personnel should be invited to attend.

Beyond regional orientation workshops at a regional level, both in French and English, the primary effort should be carried out on-site at the country level in workshops varying from one-two weeks duration. Periodic repeat workshops should be convened to adjust to personnel changes and turnover.

The curriculum and background materials, following the PAHO pattern, should be prepared at a central regional point, preferably at the Brazzaville office. The curriculum content should follow the PAHO pattern as outlined in Section IX.

7. Monitoring of financial flows and evaluation of resource mobilization for the region

As an A.I.D.-sponsored initiative, annual monitoring of financial flows to the region, and in particular to A.I.D.-

emphasis countries, should be required. In parallel, annual evaluation should document progress in the defined components of a regional system to mobilize and coordinate financing.

8. **The A.I.D.-specific role in sponsoring a regional financial mobilization system**

In this proposal A.I.D. would play a major role to support an African Regional Program. In support of this program, regional technical and financial institutions such as WHO, World Bank, UNDP, UNICEF and UNFPA offer the potential for sustained financial and technical support over the long term. The role of A.I.D. should be primarily confined to the sponsorship and establishment of a regional pattern which, in the long term, should be a joint donor activity with increasing national responsibility.

To introduce unfamiliar concepts and procedures to the HPN sector, however, it is recommended that AID/Africa Regional Bureau sponsor a five-year program, as outlined above. Several major factors indicate the relevance and acceptability of this approach:

- o It is in the direct interest of the A.I.D. Regional Bureau, for the purposes of its own HPN priority objectives (Child Survival, family planning, AIDS, tropical disease), to introduce the technical and administrative techniques for attracting multiple alternative sources of financing to supplement the current A.I.D. budget.
- o The Regional Director of the WHO Regional Office/ Brazzaville is committed to provide his best efforts to support the introduction and development of the proposed financial resource mobilization systems into the region.
- o The World Bank is committed in principle to the maximum encouragement of co-financing in all nationally-defined development priorities, including HPN. The proximity of World Bank Headquarters in Washington facilitates dialogue on specific regional arrangements.
- o The survey of all major bilateral and multilateral donors carried out for this assessment confirms that there does exist financing for the HPN sector which exceeds the current level of official government demand. Donors accept the need for increased HPN financing, subject to well-articulated and justified preliminary proposals.
- o The international donor climate includes a number of

rapidly-increasing sources, such as Italy, Japan, West Germany, OPEC Funds, UNICEF and UNFPA, whose resources exceed current official demand.

Based on these considerations, the A.I.D. Regional Bureau should initiate a project activity of not less than five years duration which is prepared to finance the following activities through an A.I.D.-selected contractor:

1. Continuing, updated identification of external financial supply:
 - o One full-time development economist stationed in Brazzaville.
 - o One full-time U.S.-based project officer for project management and identification of global in cooperation with the World Bank/Washington and WHO/Geneva.
2. Preparation and updating of Regional External Financing Guidelines:
 - o One full-time resource mobilization program officer based in Brazzaville.
 - o Financing for guideline translation, editing and distribution to all regional countries.
3. Identification of potential demand and constraints to demand at the country level:
 - o Two full-time technical advisors (one French-speaking, one English speaking) based in Brazzaville with the function of identifying demand and encouraging regional Ministries of Health to systematically gather this information for themselves.
4. Analysis of financial supply with official demand:
 - o This function to be carried out by officers assigned to three foregoing functions. It is assumed the normal coordination resources of the Regional Office will permit periodic consultation with regional donor groups such as the Banks and major bilaterals.
5. Training
 - o A.I.D. should prepare and finance a five year-program for training and orientation of a new resource mobilization curriculum through the medium of on-site workshops at the country level and periodic regional workshops for WHO and other international staff.

- o A.I.D. should be prepared to fully finance training workshops in A.I.D.-emphasis countries while identifying other donor sources for non-A.I.D. countries.
- o A.I.D. should include orientation on external financing for all A.I.D. Regional HPN personnel during annual sector meetings or other appropriate meetings.

6. Mobilization of Financing

The components of this activity, are the responsibility of requesting governments. With the background of training, countries should utilize proposed staff in Brazzaville, and as appropriate, the resources of the donor community in Africa. A.I.D., however, should make available up to 12 man-months (per year) of short-term consultant assistance to A.I.D.-emphasis countries through A.I.D. contract arrangements. If appropriate technical advisory skills are available through the WHO/Brazzaville Office, A.I.D. should encourage the use of such channels in the interest of establishing a permanent regional capability. Within the strategy of mobilization, every effort should be made to call on regional donors for specific expertise in proposal preparation.

7. Evaluation and Monitoring

It should be the responsibility of the A.I.D. contractor, in cooperation with WHO/Brazzaville, to provide an annual accounting of financial flows and progress in institutionalizing the proposed regional system.

Annexes

Annex I
ODA Commitments for all Development Sectors
To Sub-Saharan Countries, 1987 (\$ Millions)*

*Source: Geographical Distribution of Financial Flows to
Developing Countries, OECD, Paris, 1989.

	A N G O L A	B E N I N	O T S W A N A	N A F A S O	B U R U N D I	C A M E R O O N	A F R. R E P.	C H A D	C O M O R O S	C O N G O	D I V O I R E
DAC COUNTRIES											
Australia	-	-	0.3	0.1	-	-	-	0.0	0.0	-	-
Austria	0.5	0.0	0.0	0.4	0.4	0.1	0.1	0.0	-	-	-
Belgium	0.2	1.2	0.2	2.3	19.2	8.2	0.1	0.3	-	-	0.1
Canada	0.1	0.1	2.2	24.8	1.0	7.0	0.3	0.9	1.7	2.4	2.9
Denmark	-	17.4	8.2	9.5	-	-	-	-	0.1	0.6	4.5
Finland	-	-	0.0	-	-	0.0	-	-	-	-	-
France	3.7	25.8	2.8	66.8	25.4	73.3	85.9	74.3	22.6	117.6	190.6
Germany, Fed. Rep.	6.5	14.9	5.0	54.0	32.6	97.7	17.5	15.1	3.0	1.8	10.1
Ireland	-	-	0.1	-	0.2	0.0	-	-	-	-	-
Italy	20.8	4.3	0.1	50.0	7.8	4.5	0.5	34.8	0.1	2.6	2.8
Japan	0.0	6.4	0.0	3.3	13.1	41.9	7.1	0.1	1.9	0.1	6.9
Netherlands	18.5	4.5	5.7	34.8	0.8	15.7	0.4	7.3	0.2	0.2	1.0
New Zealand	-	-	0.2	-	-	-	-	-	-	-	-
Norway	3.1	0.2	6.3	4.5	-	0.3	-	-	-	0.0	0.3
Sweden	2.4	-	-	-	-	-	-	-	-	-	-
Switzerland	0.7	0.5	0.0	2.1	2.0	11.6	-	-	-	-	-
United Kingdom	0.4	0.2	11.8	0.3	0.2	6.1	-	8.9	0.0	0.1	0.3
United States	4.5	1.8	19.1	18.9	2.6	32.2	-	0.3	-	0.3	-3.7
TOTAL - DAC	61.4	77.1	62.1	271.8	105.1	298.7	114.6	154.8	30.5	126.4	216.6
MULTILATERAL											
AF.D.F.	-	44.8	36.4	-	-	0.6	6.5	42.7	-	-	-
AF.D.B.	-	-	-	-	-	-	-	-	-	-	-
AS.D.B.	-	-	-	-	-	-	-	-	-	-	-
CAR.D.B.	-	-	-	-	-	-	-	-	-	-	-
E.E.C.	67.7	42.6	14.6	9.6	45.2	32.8	43.8	79.9	8.7	0.9	47.4
IBRD	-	-	-	-	-	-	-	-	-	-	-
IDA	-	19.5	-	-	36.3	-	33.0	17.4	7.9	-	-
I.D.B.	-	-	-	-	-	-	-	-	-	-	-
IFAD	-	10.2	-	10.1	0.2	-	-	-	-	-	-
I.F.C.	-	-	-	-	-	-	-	-	-	-	-
IMP Trust Fund	-	-	-	-	-	-	-	-	-	-	-
U.N. Agencies	28.5	11.5	16.2	29.0	12.5	13.9	12.8	26.3	7.8	16.5	6.4
UNDP	-	-	-	-	-	-	-	-	-	-	-
UNTA	-	-	-	-	-	-	-	-	-	-	-
UNICEF	-	-	-	-	-	-	-	-	-	-	-
UNRWA	-	-	-	-	-	-	-	-	-	-	-
WFP	-	-	-	-	-	-	-	-	-	-	-
UNHCR	-	-	-	-	-	-	-	-	-	-	-
Other Multilateral	-	-	-	-	-	-	-	-	-	-	-
Arab Agencies	-	-	6.1	0.5	-	-	-	-	-	-	-
TOTAL - MULTILATERAL	96.2	128.6	73.2	49.1	94.1	47.3	96.1	178.0	25.5	17.9	53.8
Arab Countries	-	-	-	-	2.9	-	2.4	-	-	-	-
TOTAL - ALL SOURCES	157.6	205.8	135.3	320.9	202.1	346.0	213.1	332.7	55.9	144.4	270.4

	D J I B O U T I	M U L T I L A T E R A L G U I N E A	E T H I O P I A	G A B O N	G A M B I A	G H A N A	G U I N E A	G U I N E A B I S S A U	K E N Y A	L E S O T H O	L I B E R I A
DAC COUNTRIES											
Australia	-	-	18.2	-	0.0	0.3	0.0	-	0.4	0.1	-
Austria	-	-	0.7	-	0.0	0.2	0.0	0.1	7.7	0.1	0.0
Belgium	0.2	0.0	5.5	1.7	-	0.2	0.5	0.2	2.1	0.1	-
Canada	0.1	0.1	27.8	4.0	0.3	35.2	3.7	0.4	39.7	0.6	0.3
Denmark	-	-	-	-	-	14.9	-	5.4	34.4	3.8	-
Finland	-	-	12.9	1.3	-	-	-	-	10.7	-	-
France	46.5	14.1	7.2	67.0	4.6	8.1	50.8	5.1	29.8	2.7	0.8
Germany, Fed. Rep.	5.0	0.1	37.7	1.6	5.5	32.5	28.9	2.7	34.0	14.3	9.6
Ireland	-	-	0.1	-	0.1	0.1	-	-	0.3	4.4	0.1
Italy	26.7	7.1	256.1	0.0	9.9	14.8	10.0	23.4	67.0	1.6	0.0
Japan	3.5	0.6	15.5	0.1	5.2	100.5	9.5	2.2	67.3	3.2	9.9
Netherlands	-	0.1	7.4	0.1	1.0	22.9	0.4	11.5	77.0	1.1	0.2
New Zealand	-	-	-	-	-	-	-	-	0.0	-	-
Norway	-	-	5.5	-	1.2	7.9	0.3	-	21.2	0.2	0.0
Sweden	-	-	3.1	-	-	0.0	-	-	3.6	1.1	-
Switzerland	0.2	0.2	9.9	0.5	-	3.7	0.1	8.3	6.8	0.1	0.0
United Kingdom	0.3	0.3	14.0	0.0	9.7	45.4	0.7	0.1	50.0	3.6	1.5
United States	2.1	0.8	11.4	1.1	12.0	24.9	17.0	1.8	47.0	10.0	38.1
TOTAL - DAC	84.5	23.4	432.9	77.5	49.3	311.4	121.9	61.2	498.8	46.9	60.6
MULTILATERAL											
AF.D.F.	4.8	8.8	24.2	-	8.0	26.4	27.2	33.8	-	16.6	-
AF.D.B.	-	-	-	-	-	-	-	-	-	-	-
AS.D.B.	-	-	-	-	-	-	-	-	-	-	-
CAR.D.B.	-	-	-	-	-	-	-	-	-	-	-
E.E.C.	2.6	1.5	154.9	19.8	11.7	57.0	98.8	32.3	81.5	9.3	93.1
IBRD	-	-	-	-	-	-	-	-	-	-	-
IDA	-	5.1	46.0	-	5.6	289.6	88.2	22.9	62.6	-	-
I.D.B.	-	-	-	-	-	-	-	-	-	-	-
IFAD	-	-	5.8	-	-	0.2	0.2	5.5	-	-	-
I.F.C.	-	-	-	-	-	-	-	-	-	-	-
IMP Trust Fund	-	-	-	-	-	-	-	-	-	-	-
U.N. Agencies	6.5	2.9	110.5	3.5	12.3	27.1	13.7	10.1	16.3	17.9	5.7
UNDP	-	-	-	-	-	-	-	-	-	-	-
UNTA	-	-	-	-	-	-	-	-	-	-	-
UNICEF	-	-	-	-	-	-	-	-	-	-	-
UNRWA	-	-	-	-	-	-	-	-	-	-	-
WFP	-	-	-	-	-	-	-	-	-	-	-
UNHCR	-	-	-	-	-	-	-	-	-	-	-
Other Multilateral	-	-	-	-	-	-	-	-	-	-	-
Arab Agencies	0.2	0.1	10.1	-	0.2	4.4	9.2	-	-	-	-
TOTAL - MULTILATERAL	14.1	18.4	351.5	23.3	37.7	404.6	237.2	104.7	160.4	43.8	98.9
Arab Countries	5.0	-	-	-	3.2	8.7	5.6	3.2	0.2	3.9	-

	A G A S C A R	M A L A W I	M A L I	U R I T A N I A	Z A M B I Q U E	N I G E R	N I G E R I A	R W A N D A	S E N E G A L	R A L E O N E	S O M A L I A
DAC COUNTRIES											
Australia	-	0.5	-	-	8.6	-	0.2	-	-	0.0	0.1
Austria	0.0	-	0.0	0.2	4.3	0.0	0.8	-	-	0.0	0.3
Belgium	0.3	0.0	2.4	0.3	0.3	7.1	0.5	3.4	0.6	0.1	1.0
Canada	8.3	0.7	25.5	4.5	5.0	13.2	2.6	24.6	5.0	0.2	0.6
Denmark	-	23.7	-	-	29.2	-	-	22.0	33.8	0.4	-
Finland	-	-	-	-	23.6	-	-	-	3.6	-	-2.6
France	111.7	5.0	65.2	43.1	39.4	69.9	6.8	4.1	0.1	-	10.2
Germany, Fed. Rep.	9.8	21.7	56.7	3.3	33.0	42.5	5.4	33.2	174.8	2.3	33.3
Ireland	-	0.0	0.0	-	0.0	-	0.0	37.8	40.5	17.3	0.0
Italy	2.0	6.1	32.7	20.3	148.5	60.3	2.6	0.2	-	0.1	328.3
Japan	20.8	24.0	9.5	-	12.5	16.5	6.8	5.6	85.0	16.4	24.4
Netherlands	0.5	13.6	18.7	21.2	46.0	10.4	3.7	5.2	35.5	7.3	0.2
New Zealand	-	-	-	-	-	-	-	3.7	16.9	1.0	-
Norway	4.3	0.1	3.6	0.4	40.3	5.3	0.6	-	-	0.5	0.1
Sweden	-	-	-	-	-	-	-	0.2	0.7	0.0	0.8
Switzerland	8.9	0.6	1.4	0.0	23.9	4.1	-	0.6	-	-	1.3
United Kingdom	0.9	50.5	1.6	0.3	52.4	0.3	-	18.3	8.6	-	16.9
United States	23.4	12.9	14.6	8.8	60.5	28.5	8.8	0.3	1.7	4.3	46.5
TOTAL - DAC	191.1	159.2	232.7	102.2	527.4	258.1	59.6	176.2	453.9	61.9	461.4
MULTILATERAL											
AF.D.F.	13.9	12.4	41.0	14.6	-	3.9	-	24.6	63.4	-	33.9
AF.D.B.	-	-	-	-	-	-	-	-	-	-	-
AS.D.B.	-	-	-	-	-	-	-	-	-	-	-
CAR.D.B.	-	-	-	-	-	-	-	-	-	-	-
E.E.C.	73.1	62.2	52.3	39.6	133.8	63.4	11.0	68.0	194.0	29.5	32.6
IBRD	-	-	-	-	-	-	-	-	-	-	-
IDA	134.0	53.9	-	52.4	108.6	85.5	-	36.5	151.6	-	44.1
I.D.B.	-	-	-	-	-	-	-	-	-	-	-
IFAD	0.0	6.9	0.2	-	16.3	14.7	0.1	0.2	-	-	0.2
I.F.C.	-	-	-	-	-	-	-	-	-	-	-
IMF Trust Fund	-	-	-	-	-	-	-	-	-	-	-
U.N. Agencies	18.7	22.4	27.8	15.3	31.8	29.8	15.5	16.7	22.7	10.2	112.3
UNDP	-	-	-	-	-	-	-	-	-	-	-
UNTA	-	-	-	-	-	-	-	-	-	-	-
UNICEF	-	-	-	-	-	-	-	-	-	-	-
UNRWA	-	-	-	-	-	-	-	-	-	-	-
WFP	-	-	-	-	-	-	-	-	-	-	-
UNHCR	-	-	-	-	-	-	-	-	-	-	-
Other Multilateral	-	-	-	-	-	-	-	-	-	-	-
Arab Agencies	5.4	-	8.5	11.3	5.0	8.4	-	7.3	6.7	-	-
TOTAL - MULTILATERAL	245.1	157.7	129.8	133.2	295.5	205.8	26.6	153.3	438.4	39.8	223.1
Arab Countries	3.2	-	5.9	15.2	10.8	0.9	-	10.8	0.0	23.0	8.7
TOTAL - ALL SOURCES	439.4	316.9	368.4	250.6	833.7	464.7	86.1	340.2	892.3	124.6	693.2

	S W A Z I L A N D	T A N Z A N I A		T O G O	U G A N D A	Z A I R E	Z A M B I A	Z I M B A W E
DAC COUNTRIES								
Australia	0.3	0.1	2.1	-	0.2	-	1.4	10.8
Austria	0.4	0.0	3.2	0.0	0.1	0.2	2.2	0.6
Belgium	1.3	0.6	3.2	2.7	0.2	142.3	1.5	0.8
Canada	11.1	3.1	34.2	2.3	15.3	18.1	44.9	6.4
Denmark	0.2	-	50.1	-	30.1	-	26.3	5.2
Finland	20.9	-	22.0	-	0.0	-	5.9	7.1
France	4.9	0.3	5.2	32.3	1.1	42.0	1.6	14.7
Germany, Fed. Rep.	51.2	4.2	105.9	18.7	14.1	41.5	18.6	38.3
Ireland	2.3	0.1	3.1	-	0.1	-	3.3	1.1
Italy	109.4	1.3	265.2	3.5	29.5	58.8	75.3	28.6
Japan	47.7	0.2	54.8	2.6	2.0	50.4	42.5	5.4
Netherlands	64.2	0.8	80.0	0.9	2.1	1.3	36.3	35.7
New Zealand	-	-	0.1	-	0.0	-	-	0.1
Norway	1.1	0.5	68.5	-	1.4	1.0	29.8	40.9
Sweden	0.3	-	-	-	-	-	-	2.5
Switzerland	1.1	0.1	12.8	0.1	1.7	1.3	2.2	0.0
United Kingdom	22.7	4.1	58.1	0.2	22.1	4.0	37.0	19.8
United States	88.2	2.4	66.8	9.2	13.7	52.7	22.3	6.0
TOTAL - DAC	427.4	17.7	835.2	72.7	133.6	413.5	350.9	224.0
MULTILATERAL								
AF.D.F.	22.0	8.6	125.5	-	37.8	14.8	0.9	-
AF.D.B.	-	-	-	-	-	-	-	-
AS.D.B.	-	-	-	-	-	-	-	-
CAR.D.B.	-	-	-	-	-	-	-	-
E.E.C.	53.3	16.1	146.4	1.6	83.2	136.5	83.9	22.3
IBRD	-	-	-	-	-	-	-	-
IDA	151.7	-	23.0	61.2	120.0	229.3	10.0	-
I.D.B.	-	-	-	-	-	-	-	-
IFAD	-	-	-	6.1	12.1	7.8	21.0	-
I.P.C.	-	-	-	-	-	-	-	-
IMF Trust Fund	-	-	-	-	-	-	-	-
U.N. Agencies	94.8	8.7	34.8	7.5	40.5	21.9	16.3	14.5
UNDP	-	-	-	-	-	-	-	-
UNTA	-	-	-	-	-	-	-	-
UNICEF	-	-	-	-	-	-	-	-
UNRWA	-	-	-	-	-	-	-	-
WFP	-	-	-	-	-	-	-	-
UNHCR	-	-	-	-	-	-	-	-
Other Multilateral	-	-	-	-	-	-	-	-
Arab Agencies	1.0	-	4.6	-	5.6	-	-	-
TOTAL - MULTILATERAL	322.8	33.4	334.3	76.4	299.2	410.2	132.2	36.8
Arab Countries	267.8	-	4.0	-	2.2	-	-	5.0
TOTAL - ALL SOURCES	1018.0	51.1	1173.5	149.1	435.0	823.7	483.1	265.8

Annex II

Geographical Distribution of ODA MAJOR RECIPIENTS OF INDIVIDUAL DAC MEMBERS' AID

<i>Gross disbursements</i>		Australia		<i>Percentage of total ODA</i>	
1970-71		1980-81		1986-87	
Papua New Guinea	66.9	Papua New Guinea	42.9	Papua New Guinea	31.9
Indonesia	8.2	Indonesia	7.0	Indonesia	6.5
India	2.2	Bangladesh	3.0	Malaysia	5.8
Thailand	2.0	Philippines	1.9	Thailand	2.6
Malaysia	1.6	Pakistan	1.8	China	2.1
Viet Nam	1.5	Fiji	1.7	Philippines	2.0
Pakistan	0.8	Burma	1.6	Fiji	1.8
Laos	0.6	Thailand	1.3	Ethiopia	1.7
Kampuchea	0.6	Egypt	1.3	Bangladesh	1.3
Sri Lanka	0.6	Malaysia	1.2	Solomon Islands	1.3
Fiji	0.5	Sri Lanka	1.0	Burma	1.2
Burma	0.4	Tanzania	1.0	Egypt	1.1
Nepal	0.4	Solomon Islands	0.9	Vanuatu	1.0
Singapore	0.3	Tonga	0.7	Hong Kong	1.0
Bangladesh	0.3	Kenya	0.6	Tonga	0.7
Nigeria	0.1	Kampuchea	0.6	Western Samoa	0.7
Korea	0.1	Sudan	0.6	Singapore	0.6
Western Samoa	0.1	Vanuatu	0.5	Mozambique	0.6
Zambia	0.1	Western Samoa	0.5	Laos	0.6
Philippines	0.1	India	0.4	Tuvalu	0.5
Tonga	0.1	Kiribati	0.4	Tanzania	0.4
Ghana	0.1	Ethiopia	0.4	Kiribati	0.4
Mauritius	0.1	Mauritius	0.4	Nepal	0.3
Malawi	0.1	Uganda	0.4	Kenya	0.3
Uganda	0.1	Zimbabwe	0.4	Sri Lanka	0.3
Total above	87.8	Total above	72.6	Total above	66.5
Multilateral ODA	10.9	Multilateral ODA	21.3	Multilateral ODA	24.0
Unallocated	0.8	Unallocated	4.1	Unallocated	7.1
Total ODA \$ million	214	Total ODA \$ million	662	Total ODA \$ million	690

1970-71		Austria		<i>Percentage of total ODA</i>	
1970-71		1980-81		1986-87	
Thailand	13.8	Indonesia	17.7	Algeria	30.6
Pakistan	11.3	Algeria	15.3	Egypt	8.3
India	11.1	Turkey	10.1	Turkey	3.8
Algeria	7.3	Lebanon	6.8	India	3.3
Sudan	5.0	Malaysia	6.3	Iran	3.2
Israel	2.4	Jordan	4.7	Greece	1.3
Brazil	1.5	India	4.4	Philippines	1.1
Tunisia	0.8	Cyprus	3.6	Yugoslavia	0.9
Turkey	0.8	Tunisia	2.9	Rwanda	0.9
Kenya	0.6	Egypt	2.1	Cape Verde	0.8
Nigeria	0.6	Iran	2.1	Korea	0.7
Bolivia	0.4	Philippines	1.8	Guatemala	0.7
Mexico	0.3	Nigeria	1.7	Nicaragua	0.6
Burkina Faso	0.3	Tanzania	1.6	Angola	0.6
Guatemala	0.2	Greece	1.4	Taiwan	0.6
Iran	0.2	Yugoslavia	1.0	Mozambique	0.5
Costa Rica	0.2	Zambia	0.8	Ethiopia	0.5
Zaire	0.2	Guatemala	0.6	Tunisia	0.4
Ethiopia	0.1	Cuba	0.5	Tanzania	0.4
Afghanistan	0.1	Mozambique	0.5	Nigeria	0.3
Tanzania	0.1	Brazil	0.4	Mexico	0.3
Peru	0.1	Mexico	0.4	Peru	0.3
Congo	0.0	Cape Verde	0.4	Iraq	0.3
Madagascar	0.0	Viet Nam	0.4	Senegal	0.3
Colombia	0.0	Taiwan	0.4	Colombia	0.3
Total above	57.4	Total above	88.4	Total above	61.0
Multilateral ODA	29.0	Multilateral ODA	23.8	Multilateral ODA	27.1
Unallocated	13.4	Unallocated	-18.2	Unallocated	6.8
Total ODA \$ million	21	Total ODA \$ million	209	Total ODA \$ million	217

Geographical Distribution of ODA
MAJOR RECIPIENTS OF INDIVIDUAL DAC MEMBERS' AID

<i>Gross disbursements</i>		Belgium		<i>Percentage of total ODA</i>	
1970-71		1980-81		1986-87	
Zaire	39.9	Zaire	25.0	Zaire	20.7
Rwanda	9.0	Rwanda	5.5	Rwanda	4.5
Burundi	7.4	Burundi	4.3	Burundi	3.1
Indonesia	3.5	Indonesia	3.0	China	2.1
India	3.3	Morocco	2.5	Indonesia	1.5
Tunisia	2.5	Tunisia	2.1	Cameroon	1.2
Pakistan	1.6	Niger	1.9	Niger	1.0
Turkey	1.6	India	1.9	Senegal	0.8
Morocco	1.2	Philippines	1.6	Zambia	0.7
Chile	1.0	China	1.6	Tunisia	0.6
Peru	0.5	Turkey	1.6	Ethiopia	0.6
Philippines	0.4	Côte d'Ivoire	1.3	Morocco	0.6
Senegal	0.3	Senegal	1.0	Côte d'Ivoire	0.6
Argentina	0.3	Bangladesh	0.9	Bangladesh	0.5
Brazil	0.2	Tanzania	0.8	Turkey	0.5
Cameroon	0.2	Peru	0.8	Mali	0.5
Côte d'Ivoire	0.2	Algeria	0.8	Peru	0.5
Algeria	0.2	Cameroon	0.7	Nepal	0.5
Colombia	0.2	Sudan	0.5	Thailand	0.5
Bolivia	0.1	Pakistan	0.5	Ecuador	0.4
Iran	0.1	Egypt	0.5	Congo	0.4
Egypt	0.1	Bolivia	0.4	Tanzania	0.4
Niger	0.1	Viet Nam	0.4	Somalia	0.4
Benin	0.1	Malaysia	0.3	Burkina Faso	0.4
Mexico	0.1	Lebanon	0.3	Gabon	0.4
Total above	74.3	Total above	60.1	Total above	43.4
Multilateral ODA	23.7	Multilateral ODA	29.4	Multilateral ODA	36.1
Unallocated	0.9	Unallocated	4.7	Unallocated	13.4
Total ODA \$ million	134	Total ODA \$ million	590	Total ODA \$ million	625

		Canada		<i>Percentage of total ODA</i>	
1970-71		1980-81		1986-87	
India	29.0	Bangladesh	5.0	Bangladesh	4.7
Pakistan	11.0	India	4.2	India	2.8
Nigeria	2.7	Pakistan	3.7	Indonesia	2.7
Sri Lanka	1.9	Sri Lanka	2.7	Pakistan	2.6
Ghana	1.9	Tanzania	2.0	Tanzania	1.7
Algeria	1.5	Kenya	2.0	Jamaica	1.4
Tunisia	1.5	Egypt	1.8	China	1.4
Niger	1.3	Indonesia	1.6	Niger	1.3
Turkey	1.2	Cameroon	1.5	Kenya	1.3
Morocco	1.2	Mali	1.1	Sri Lanka	1.2
Tanzania	1.1	Zambia	1.0	Ethiopia	1.2
Cameroon	1.0	Ghana	1.0	Senegal	1.2
Senegal	0.9	Zaire	0.9	Thailand	1.2
Colombia	0.9	Senegal	0.9	Zambia	1.1
Jamaica	0.9	Jamaica	0.9	Ghana	1.0
Guyana	0.9	Turkey	0.9	Mali	1.0
Malaysia	0.8	Malawi	0.8	Peru	0.9
Indonesia	0.7	Tunisia	0.7	Zaire	0.8
Kenya	0.6	Burkina Faso	0.7	Mozambique	0.8
Viet Nam	0.6	Thailand	0.6	Sudan	0.3
Burma	0.6	Madagascar	0.6	Egypt	0.3
Côte d'Ivoire	0.5	Haiti	0.6	Cameroon	0.7
Chile	0.5	Rwanda	0.5	Burkina Faso	0.7
Trinidad & Tobago	0.5	Nepal	0.5	Costa Rica	0.6
Uganda	0.5	Ethiopia	0.5	Philippines	0.6
Total above	64.0	Total above	36.6	Total above	34.5
Multilateral ODA	22.6	Multilateral ODA	37.6	Multilateral ODA	34.8
Unallocated	8.4	Unallocated	17.7	Unallocated	21.2
Total ODA \$ million	363	Total ODA \$ million	1143	Total ODA \$ million	1822

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<i>Gross disbursements</i>		Denmark		<i>Percentage of total ODA</i>	
1970-71		1980-81		1986-87	
Tanzania	5.5	Tanzania	7.1	Tanzania	10.6
India	4.7	Bangladesh	5.5	Bangladesh	4.9
Egypt	4.2	India	4.7	India	4.7
Kenya	3.5	Kenya	3.8	Kenya	3.1
Zaire	3.0	Sudan	3.0	China	2.4
Uganda	2.2	Mozambique	2.3	Egypt	2.3
Zambia	2.4	Burma	1.9	Malawi	2.2
Pakistan	2.0	Egypt	1.8	Botswana	1.7
Tunisia	2.0	Viet Nam	1.5	Mozambique	1.6
Kampuchea	1.9	Philippines	1.4	Senegal	1.3
Malaysia	1.8	Sri Lanka	1.0	Burkina Faso	1.1
Peru	1.7	Pakistan	0.9	Cameroon	1.1
Malawi	1.5	Botswana	0.9	Benin	1.0
Côte d'Ivoire	1.3	Malawi	0.8	Zimbabwe	1.0
Indonesia	1.2	Angola	0.8	Thailand	0.9
Colombia	1.1	Jordan	0.8	Morocco	0.9
Bolivia	1.0	Togo	0.8	Nicaragua	0.8
Thailand	0.8	Zambia	0.8	Zambia	0.8
Chile	0.7	Indonesia	0.7	Nepal	0.8
Turkey	0.7	Zimbabwe	0.7	Sierra Leone	0.7
Jordan	0.6	Nepal	0.5	Somalia	0.7
Korea	0.6	Burkina Faso	0.4	Mauritania	0.7
Morocco	0.6	Bolivia	0.4	Sudan	0.7
Sri Lanka	0.6	Afghanistan	0.3	Niger	0.6
Ghana	0.5	Gambia	0.3	Angola	0.6
Total above	46.4	Total above	43.1	Total above	47.2
Multilateral ODA	44.3	Multilateral ODA	45.7	Multilateral ODA	41.7
Unallocated	7.0	Unallocated	7.2	Unallocated	5.5
Total ODA \$ million	67	Total ODA \$ million	455	Total ODA \$ million	878

<i>Gross disbursements</i>		Finland		<i>Percentage of total ODA</i>	
1970-71		1980-81		1986-87	
Tanzania	4.7	Tanzania	13.7	Tanzania	8.5
India	3.6	Viet Nam	8.7	Zambia	5.8
Kenya	1.1	Zambia	6.0	Somalia	3.6
Pakistan	1.0	Mozambique	2.7	Sri Lanka	3.3
Ethiopia	0.9	Kenya	2.7	Kenya	3.1
Tunisia	0.5	Egypt	2.1	Viet Nam	2.9
Jordan	0.2	Bangladesh	1.8	Ethiopia	2.8
Zambia	0.2	Peru	1.1	Nepal	2.0
Nigeria	0.2	Somalia	1.0	Mozambique	2.0
Uganda	0.2	Sri Lanka	1.0	Nicaragua	1.9
Turkey	0.2	Turkey	0.9	Egypt	1.9
Yemen	0.1	Burma	0.7	Sudan	1.9
Syria	0.1	Sudan	0.7	Zimbabwe	1.5
Peru	0.1	Uganda	0.6	Namibia	1.2
Lebanon	0.1	Liberia	0.5	Burma	0.7
Thailand	0.1	Philippines	0.5	Bangladesh	0.7
Chile	0.1	Ethiopia	0.4	Peru	0.7
Algeria	0.0	Indonesia	0.3	Angola	0.5
Egypt	0.0	Honduras	0.3	Indonesia	0.4
Ghana	0.0	Kampuchea	0.3	Uganda	0.3
		Thailand	0.3	China	0.3
		Nicaragua	0.2	Cape Verde	0.3
		China	0.2	India	0.2
		Zimbabwe	0.2	Chad	0.1
		Colombia	0.1	Rwanda	0.1
Total above	13.7	Total above	47.0	Total above	46.8
Multilateral ODA	78.0	Multilateral ODA	41.2	Multilateral ODA	39.6
Unallocated	8.3	Unallocated	10.1	Unallocated	11.6
Total ODA \$ million	10	Total ODA \$ million	123	Total ODA \$ million	373

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<i>Gross disbursements</i>		France		<i>Percentage of total ODA</i>	
1970-71		1980-81		1986-87	
Reunion	9.7	Reunion	13.0	Reunion	9.2
Algeria	8.8	Martinique	11.7	Martinique	6.8
Martinique	7.0	New Caledonia	4.2	Polynesia, French	5.2
Guadeloupe	5.7	Polynesia, French	3.6	New Caledonia	4.8
New Caledonia	2.9	Morocco	3.3	Morocco	3.4
Morocco	2.8	Senegal	2.7	Guadeloupe	3.1
Côte d'Ivoire	2.6	Côte d'Ivoire	2.3	Senegal	3.0
Madagascar	2.2	Guiana	2.2	Côte d'Ivoire	2.7
Tunisia	2.2	Cameroon	2.1	Guiana	2.3
Guiana	2.1	Algeria	1.8	Madagascar	1.9
Indonesia	2.1	Tunisia	1.6	Congo	1.9
Polynesia, French	1.9	Central African Rep.	1.6	Egypt	1.9
Senegal	1.8	Burkina Faso	1.5	India	1.5
India	1.8	Brazil	1.5	Central African Rep.	1.4
Gabon	1.6	Guadeloupe	1.5	Cameroon	1.3
Cameroon	1.5	Niger	1.3	Mexico	1.2
Chad	1.5	Mali	1.3	Mali	1.2
Niger	1.4	Madagascar	1.3	Tunisia	1.2
Burkina Faso	1.0	Egypt	1.2	Niger	1.2
Djibouti	1.0	Indonesia	1.1	Algeria	1.2
Iran	0.9	Congo	1.1	Chad	1.1
Congo	0.8	Gabon	0.9	Gabon	1.1
Egypt	0.8	Mexico	0.8	Burkina Faso	1.0
Central African Rep.	0.8	Zaire	0.8	Guinea	0.9
Benin	0.7	India	0.7	Indonesia	0.8
Total above	65.5	Total above	64.8	Total above	61.3
Multilateral ODA	10.2	Multilateral ODA	15.2	Multilateral ODA	8.7
Unallocated	16.9	Unallocated	6.8	Unallocated	14.1
Total ODA \$ million	1135	Total ODA \$ million	4407	Total ODA \$ million	5438

<i>Gross disbursements</i>		Germany		<i>Percentage of total ODA</i>	
1970-71		1980-81		1986-87	
India	10.7	Turkey	8.5	Turkey	4.9
Pakistan	7.3	Bangladesh	6.9	India	4.8
Israel	5.1	India	4.1	Indonesia	3.3
Indonesia	5.0	Sudan	3.3	Egypt	3.0
Turkey	4.2	Indonesia	3.2	Brazil	2.5
Brazil	3.8	Tanzania	3.1	Israel	2.1
Morocco	3.1	Egypt	2.2	Pakistan	2.1
Tunisia	1.9	Israel	1.9	China	1.7
Afghanistan	1.8	Brazil	1.8	Morocco	1.5
Nigeria	1.7	Yemen	1.4	United Arab Emirates	1.4
Chile	1.6	Peru	1.4	Peru	1.4
Argentina	1.6	Pakistan	1.4	Bangladesh	1.4
Egypt	1.2	Thailand	1.3	Sri Lanka	1.3
Peru	1.1	Tunisia	1.2	Sudan	1.1
Viet Nam	1.1	Somalia	1.0	Tanzania	1.1
Iran	0.9	Kenya	0.9	Kenya	1.1
Côte d'Ivoire	0.9	Zaire	0.9	Zaire	1.0
Ghana	0.9	Ghana	0.8	Somalia	1.0
Colombia	0.9	Portugal	0.8	Portugal	0.9
Yemen	0.8	Burkina Faso	0.8	Zimbabwe	0.9
Kenya	0.8	Syria	0.8	Cameroon	0.8
Thailand	0.7	Burma	0.8	Yugoslavia	0.8
Burma	0.7	Mali	0.7	Burma	0.8
Tanzania	0.7	Niger	0.7	Tunisia	0.8
Togo	0.7	Colombia	0.7	Zambia	0.7
Total above	59.2	Total above	50.3	Total above	42.6
Multilateral ODA	22.0	Multilateral ODA	25.9	Multilateral ODA	26.0
Unallocated	4.9	Unallocated	5.9	Unallocated	8.0
Total ODA \$ million	766	Total ODA \$ million	4226	Total ODA \$ million	4832

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<i>Gross disbursements</i>		Japan		<i>Percentage of total ODA</i>	
1970-71		1980-81		1986-87	
Indonesia	22.9	Indonesia	11.2	Indonesia	8.6
Korea	19.8	Korea	6.9	China	7.1
India	10.2	Thailand	5.9	Philippines	6.4
Pakistan	7.9	Bangladesh	5.0	India	4.7
Philippines	4.4	Philippines	4.7	Thailand	4.6
Burma	3.5	Burma	4.1	Bangladesh	4.2
Thailand	2.9	Pakistan	3.6	Burma	3.1
Taiwan	2.5	Egypt	2.7	Malaysia	2.9
Iran	1.4	Malaysia	2.3	Korea	2.3
Sri Lanka	1.3	India	2.2	Pakistan	2.2
Malaysia	1.3	Sri Lanka	1.4	Egypt	1.8
Singapore	1.1	Zaire	1.3	Sri Lanka	1.8
Nigeria	1.1	Tanzania	1.1	Turkey	1.7
Kampuchea	0.9	Turkey	0.9	Nepal	1.0
Viet Nam	0.9	Nepal	0.8	Brazil	0.9
Laos	0.9	Brazil	0.8	Kenya	0.8
Kenya	0.3	Kenya	0.8	Mexico	0.8
Tanzania	0.2	Bolivia	0.7	Sudan	0.7
Peru	0.1	Paraguay	0.6	Zambia	0.7
Afghanistan	0.1	Peru	0.6	Iraq	0.7
Uganda	0.1	China	0.6	Bolivia	0.6
Brazil	0.1	Zambia	0.4	Paraguay	0.6
Bolivia	0.1	Madagascar	0.4	Tanzania	0.5
Nepal	0.1	Tunisia	0.4	Peru	0.5
Ethiopia	0.1	Iran	0.4	Honduras	0.5
Total above	84.1	Total above	59.7	Total above	59.7
Multilateral ODA	14.9	Multilateral ODA	31.5	Multilateral ODA	26.9
Unallocated	0.3	Unallocated	2.2	Unallocated	3.9
Total ODA \$ million	555	Total ODA \$ million	3592	Total ODA \$ million	7425

<i>Gross disbursements</i>		Netherlands		<i>Percentage of total ODA</i>	
1970-71		1980-81		1986-87	
Indonesia	22.1	India	9.6	Indonesia	6.8
Suriname	11.9	Suriname	6.6	India	6.3
Netherlands Antilles	11.0	Indonesia	5.1	Netherlands Antilles	3.4
India	6.7	Netherlands Antilles	5.0	Tanzania	3.4
Pakistan	1.5	Tanzania	5.0	Sudan	2.8
Nigeria	1.3	Bangladesh	3.4	Kenya	2.7
Kenya	1.3	Kenya	2.6	Bangladesh	2.7
Chile	0.9	Sudan	2.6	Mozambique	2.2
Tanzania	0.7	Sri Lanka	2.2	Zambia	1.9
Colombia	0.7	Pakistan	1.7	Pakistan	1.6
Tunisia	0.6	Peru	1.6	Aruba	1.5
Cameroon	0.6	Zambia	1.4	Zimbabwe	1.5
Bangladesh	0.6	Jamaica	1.3	Egypt	1.4
Turkey	0.6	Yemen	1.2	Yemen	1.3
Peru	0.6	Burkina Faso	1.2	Peru	1.2
Viet Nam	0.5	Egypt	1.2	Sri Lanka	1.2
Uruguay	0.4	Mozambique	1.1	Burkina Faso	1.1
Thailand	0.4	Nicaragua	0.9	Mali	1.1
Côte d'Ivoire	0.3	Guinea-Bissau	0.8	Nicaragua	1.0
Rwanda	0.3	Uganda	0.8	Philippines	0.9
Uganda	0.3	Colombia	0.7	Angola	0.8
Brazil	0.3	Viet Nam	0.7	Senegal	0.8
Philippines	0.3	Mali	0.6	Colombia	0.7
Zambia	0.3	Cape Verde	0.6	Bolivia	0.6
Korea	0.3	Zimbabwe	0.5	Ghana	0.6
Total above	64.2	Total above	58.5	Total above	49.5
Multilateral ODA	25.3	Multilateral ODA	23.6	Multilateral ODA	30.8
Unallocated	8.3	Unallocated	8.0	Unallocated	9.9
Total ODA \$ million	209	Total ODA \$ million	1631	Total ODA \$ million	2006

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<i>Gross disbursements</i>		Ireland		<i>Percentage of total ODA</i>	
1970-71		1980-81		1986-87	
		Lesotho	11.6	Lesotho	7.1
		Sudan	3.0	Zambia	5.4
		Tanzania	2.6	Tanzania	5.1
		Zambia	2.2	Sudan	3.9
		Swaziland	0.6	Zimbabwe	1.5
		Kenya	0.4	Kenya	0.6
		Rwanda	0.4	Rwanda	0.4
		Burundi	0.3	Burundi	0.4
		Bangladesh	0.2	Ethiopia	0.4
		Nigeria	0.1	Bangladesh	0.3
		Liberia	0.1	Gambia	0.2
		Mauritius	0.1	Peru	0.2
		Thailand	0.1	Sierra Leone	0.2
		Gambia	0.1	Uganda	0.2
		India	0.1	China	0.2
		Sierra Leone	0.1	Ghana	0.2
		Cameroon	0.1	India	0.1
		Zimbabwe	0.1	Botswana	0.1
		Peru	0.1	Liberia	0.1
		Yemen	0.1	Nigeria	0.1
		Papua New Guinea	0.0	Swaziland	0.1
		Ecuador	0.0	Philippines	0.1
		Paraguay	0.0	Indonesia	0.1
		Burkina Faso	0.0	Nepal	0.1
		Argentina	0.0	Djibouti	0.1
Total above	33.3	Total above	22.5	Total above	26.9
Multilateral ODA	33.3	Multilateral ODA	65.5	Multilateral ODA	53.7
Unallocated	33.3	Unallocated	11.9	Unallocated	18.8
Total ODA \$ million	0	Total ODA \$ million	29	Total ODA \$ million	57

		Italy		<i>Percentage of total ODA</i>	
1970-71		1980-81		1986-87	
Indonesia	15.1	Somalia	3.9	Somalia	7.7
Egypt	9.6	Malta	2.8	Ethiopia	5.5
Yugoslavia	8.7	Ethiopia	1.7	Tanzania	4.5
Turkey	7.4	Tanzania	0.9	Mozambique	3.8
Somalia	4.0	Mozambique	0.8	Sudan	3.4
Pakistan	3.7	Indonesia	0.7	China	2.7
Ethiopia	2.8	Egypt	0.6	Tunisia	2.5
Mexico	2.7	Libya	0.5	Pakistan	1.6
Tanzania	2.3	Zimbabwe	0.5	Senegal	1.5
Algeria	2.2	Nicaragua	0.4	India	1.5
Guinea	2.0	Zaire	0.4	Kenya	1.3
Tunisia	1.3	Algeria	0.4	Angola	1.2
India	1.2	Yugoslavia	0.3	Zaire	1.2
Kenya	1.2	Viet Nam	0.3	Egypt	1.2
Sri Lanka	0.9	Zambia	0.3	Burkina Faso	1.1
Madagascar	0.7	Guinea	0.3	Uganda	1.1
Syria	0.6	Morocco	0.2	Zambia	1.0
Morocco	0.6	Lebanon	0.2	Mali	0.9
Benin	0.5	Tunisia	0.2	Cape Verde	0.9
Cameroon	0.4	Thailand	0.2	Niger	0.8
Chile	0.4	Brazil	0.2	Indonesia	0.6
Libya	0.3	Sudan	0.2	Zimbabwe	0.6
Kampuchea	0.2	Pakistan	0.2	Chad	0.6
Yemen	0.2	Peru	0.1	Mauritania	0.6
Sudan	0.1	Mexico	0.1	Peru	0.5
Total above	69.0	Total above	16.2	Total above	48.4
Multilateral ODA	28.3	Multilateral ODA	76.7	Multilateral ODA	32.6
Unallocated	1.7	Unallocated	4.7	Unallocated	7.4
Total ODA \$ million	230	Total ODA \$ million	713	Total ODA \$ million	2540

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<i>Gross disbursements</i>		New Zealand		<i>Percentage of total ODA</i>	
1970-71		1980-81		1986-87	
		Cook Islands	12.6	Cook Islands	19.0
		Western Samoa	5.6	Niue	6.2
		Indonesia	5.4	Tuvalu	4.7
		Fiji	5.4	Western Samoa	4.5
		Niue	4.8	Fiji	3.8
		Papua New Guinea	3.8	Tonga	3.2
		Tonga	3.7	Indonesia	2.8
		Thailand	2.5	Papua New Guinea	2.4
		Tokelau	2.3	Tokelau	2.1
		Philippines	1.8	Solomon Islands	1.8
		Tanzania	1.3	Kiribati	1.6
		Solomon Islands	0.9	Vanuatu	1.6
		Malaysia	0.8	Thailand	1.2
		Nepal	0.6	Philippines	1.1
		Peru	0.6	Malaysia	0.2
		Tuvalu	0.5	Bangladesh	0.2
		Kiribati	0.5	Botswana	0.2
		Vanuatu	0.5	Peru	0.2
		India	0.4	India	0.1
		Zimbabwe	0.3	China	0.1
		Bangladesh	0.2	Tanzania	0.1
		Singapore	0.2	Nepal	0.1
		Jamaica	0.1	Singapore	0.1
		Korea	0.1	Zimbabwe	0.1
		Sri Lanka	0.1	Colombia	0.1
Total above	—	Total above	54.7	Total above	57.6
Multilateral ODA	21.4	Multilateral ODA	26.5	Multilateral ODA	21.6
Unallocated	78.6	Unallocated	18.4	Unallocated	20.3
Total ODA \$ million	15	Total ODA \$ million	70	Total ODA \$ million	81

<i>Gross disbursements</i>		Norway		<i>Percentage of total ODA</i>	
1970-71		1980-81		1986-87	
		Tanzania	8.8	Tanzania	8.7
		India	4.4	Bangladesh	4.5
		Bangladesh	4.4	Mozambique	4.0
		Kenya	4.4	Kenya	3.7
		Pakistan	3.1	Zambia	3.6
		Mozambique	2.4	India	3.3
		Botswana	2.3	Zimbabwe	2.3
		Sri Lanka	2.0	Botswana	1.7
		Zambia	2.0	Sri Lanka	1.6
		Portugal	1.7	Pakistan	1.5
		Sudan	1.7	Nicaragua	1.5
		Zimbabwe	1.2	Ethiopia	1.2
		Turkey	1.1	China	0.8
		Viet Nam	1.0	Madagascar	0.6
		Madagascar	0.9	Sudan	0.6
		Jamaica	0.8	Bhutan	0.4
		Papua New Guinea	0.6	Nepal	0.4
		Burma	0.6	Mali	0.4
		Indonesia	0.5	Philippines	0.4
		Philippines	0.4	Maldives	0.4
		Ethiopia	0.3	Thailand	0.3
		Benin	0.3	Niger	0.3
		Cameroon	0.3	Indonesia	0.3
		Thailand	0.2	Uganda	0.3
		Rwanda	0.2	Jamaica	0.3
Total above	39.7	Total above	45.7	Total above	43.1
Multilateral ODA	58.5	Multilateral ODA	42.4	Multilateral ODA	40.3
Unallocated	1.5	Unallocated	8.9	Unallocated	12.4
Total ODA \$ million	40	Total ODA \$ million	477	Total ODA \$ million	846

Geographical Distribution of ODA
MAJOR RECIPIENTS OF INDIVIDUAL DAC MEMBERS' AID

<i>Gross disbursements</i>		Sweden		<i>Percentage of total ODA</i>	
1970-71		1980-81		1986-87	
Pakistan	6.9	Viet Nam	8.7	Tanzania	7.4
India	6.5	Tanzania	8.2	India	5.0
Tanzania	6.4	India	6.2	Mozambique	5.0
Ethiopia	4.9	Mozambique	3.6	Viet Nam	4.1
Kenya	2.3	Zambia	3.2	Ethiopia	2.8
Tunisia	2.2	Bangladesh	2.8	Zambia	2.8
Viet Nam	1.7	Ethiopia	2.7	Bangladesh	2.6
Turkey	1.2	Sri Lanka	2.4	Zimbabwe	2.2
Brazil	0.9	Kenya	2.3	Sri Lanka	1.8
Sri Lanka	0.6	Angola	2.0	Nicaragua	1.7
Zambia	0.5	Botswana	1.5	Kenya	1.7
Afghanistan	0.4	Guinea-Bissau	1.2	Angola	1.6
Sudan	0.4	Pakistan	1.2	Botswana	1.2
Nigeria	0.4	Zimbabwe	1.2	Algeria	1.1
Korea	0.3	Laos	1.2	Guinea-Bissau	1.0
Botswana	0.3	Cape Verde	0.8	Laos	0.9
Cuba	0.2	Turkey	0.6	Lesotho	0.6
Swaziland	0.1	Nicaragua	0.6	Cape Verde	0.5
Lesotho	0.1	Kampuchea	0.6	China	0.5
Jordan	0.1	Somalia	0.6	Afghanistan	0.3
Sierra Leone	0.1	Tunisia	0.5	Cuba	0.3
Burundi	0.1	Lesotho	0.4	Uganda	0.2
Malaysia	0.1	Uganda	0.3	Pakistan	0.2
Liberia	0.1	Portugal	0.3	Tunisia	0.2
Zaire	0.1	Swaziland	0.3	Kampuchea	0.2
Total above	36.8	Total above	53.4	Total above	45.9
Multilateral ODA	52.6	Multilateral ODA	29.9	Multilateral ODA	32.1
Unallocated	10.4	Unallocated	14.6	Unallocated	20.5
Total ODA \$ million	138	Total ODA \$ million	941	Total ODA \$ million	1236

		Switzerland		<i>Percentage of total ODA</i>	
1970-71		1980-81		1986-87	
India	14.6	India	4.5	Tanzania	3.7
Bangladesh	5.0	Bangladesh	4.3	India	3.4
Nigeria	4.4	Tanzania	4.0	Bolivia	2.7
Rwanda	2.7	Nepal	3.6	Mozambique	2.7
Pakistan	2.1	Turkey	2.9	Madagascar	2.5
Cameroon	1.9	Rwanda	2.6	Senegal	2.5
Peru	1.7	Mali	1.6	Rwanda	2.0
Turkey	1.7	Honduras	1.3	Nepal	1.9
Ecuador	1.6	Indonesia	1.3	Mali	1.9
Brazil	1.5	Senegal	1.1	Indonesia	1.7
Jordan	1.3	Peru	1.1	Pakistan	1.7
Paraguay	1.2	Madagascar	1.1	Cameroon	1.5
Nepal	1.2	Thailand	1.0	Honduras	1.4
Tunisia	1.1	Bolivia	1.0	Burundi	1.4
Tanzania	1.0	Egypt	0.9	Peru	1.3
Madagascar	0.9	Burkina Faso	0.8	Ethiopia	1.2
Benin	0.7	Sudan	0.8	Niger	1.1
Kenya	0.6	Kampuchea	0.8	Egypt	1.1
Israel	0.6	Kenya	0.8	Kenya	1.0
Indonesia	0.6	Somalia	0.7	Bangladesh	0.9
Colombia	0.5	Niger	0.7	Sri Lanka	0.8
Burundi	0.5	Mozambique	0.7	Benin	0.8
Chad	0.5	Pakistan	0.7	Thailand	0.8
Bolivia	0.5	Cameroon	0.7	Chad	0.7
Laos	0.5	Paraguay	0.6	Ghana	0.7
Total above	48.8	Total above	39.6	Total above	41.6
Multilateral ODA	34.3	Multilateral ODA	30.4	Multilateral ODA	26.3
Unallocated	9.4	Unallocated	20.6	Unallocated	19.7
Total ODA \$ million	30	Total ODA \$ million	247	Total ODA \$ million	488

Geographical Distribution of ODA
MAJOR RECIPIENTS OF INDIVIDUAL DAC MEMBERS' AID

<i>Gross disbursements</i>	United Kingdom		<i>Percentage of total ODA</i>		
	1970-71	1980-81		1986-87	
India	20.5	India	12.1	India	8.7
Kenya	4.0	Bangladesh	5.0	Bangladesh	2.9
Pakistan	3.6	Tanzania	2.9	Malaysia	2.4
Nigeria	3.5	Sri Lanka	2.9	Kenya	2.3
Malawi	3.4	Kenya	2.7	Zambia	2.3
Malta	3.2	Sudan	2.6	Sudan	1.8
Singapore	3.0	Zimbabwe	2.6	Pakistan	1.7
Malaysia	2.4	Pakistan	2.3	Ghana	1.6
Ghana	2.4	Zambia	1.9	Tanzania	1.5
Turkey	2.2	Turkey	1.7	Malawi	1.4
Sri Lanka	2.0	Malawi	1.3	Mozambique	1.2
Uganda	1.7	Ghana	1.2	Sri Lanka	1.0
Indonesia	1.6	Egypt	1.0	Egypt	0.9
Zambia	1.5	Indonesia	0.9	Gibraltar	0.9
Botswana	1.4	Solomon Islands	0.9	St. Helena	0.9
Solomon Islands	1.2	Uganda	0.8	Zimbabwe	0.8
Guyana	1.1	Botswana	0.8	Nepal	0.8
Fiji	1.1	Nepal	0.7	Falkland Islands	0.7
Seychelles	0.9	Malaysia	0.7	Ethiopia	0.7
Jamaica	0.9	Vanuatu	0.7	Gambia	0.7
Tanzania	0.8	Burma	0.6	Indonesia	0.7
Belize	0.8	Jamaica	0.6	Uganda	0.6
Jordan	0.8	Morocco	0.6	Botswana	0.6
Lesotho	0.7	Jordan	0.6	Somalia	0.5
Swaziland	0.7	Swaziland	0.5	Nigeria	0.4
Total above	65.6	Total above	48.5	Total above	38.1
Multilateral ODA	18.0	Multilateral ODA	31.2	Multilateral ODA	41.0
Unallocated	8.4	Unallocated	9.9	Unallocated	11.8
Total ODA \$ million	629	Total ODA \$ million	2232	Total ODA \$ million	1939

	United States		<i>Percentage of total ODA</i>		
	1970-71	1980-81		1986-87	
India	13.9	Egypt	12.6	Israel	15.8
Viet Nam	10.5	Israel	11.5	Egypt	11.3
Indonesia	7.8	India	3.3	El Salvador	3.2
Pakistan	5.0	Turkey	2.8	Philippines	3.1
Korea	4.5	Bangladesh	2.2	Pakistan	2.1
Brazil	3.6	Indonesia	2.1	Pacif. Isl.(trust Tr.)	2.0
Turkey	3.6	Pacif. Isl.(trust Tr.)	1.7	Honduras	1.7
Colombia	3.0	Pakistan	1.4	India	1.6
Israel	1.7	El Salvador	1.0	Bangladesh	1.6
Laos	1.6	Peru	0.9	Costa Rica	1.5
Pacif. Isl.(trust Tr.)	1.5	Portugal	0.9	Sudan	1.3
Morocco	1.4	Sudan	0.9	Guatemala	1.2
Nigeria	1.3	Somalia	0.9	Indonesia	1.0
Tunisia	1.3	Kenya	0.8	Jamaica	1.0
Thailand	1.1	Philippines	0.8	Bolivia	1.0
Philippines	1.0	Liberia	0.7	Peru	0.9
Dominican Republic	0.9	Jordan	0.7	Haiti	0.9
Chile	0.9	Nicaragua	0.7	Morocco	0.8
Jordan	0.7	Sri Lanka	0.7	Jordan	0.8
Bolivia	0.7	Korea	0.6	Somalia	0.7
Ghana	0.7	Jamaica	0.6	Turkey	0.6
Peru	0.5	Dominican Republic	0.6	Mexico	0.6
Panama	0.5	Haiti	0.5	Sri Lanka	0.6
Ethiopia	0.5	Senegal	0.5	Dominican Republic	0.6
Nicaragua	0.5	Morocco	0.5	Portugal	0.5
Total above	68.6	Total above	50.0	Total above	56.2
Multilateral ODA	11.4	Multilateral ODA	30.4	Multilateral ODA	19.7
Unallocated	11.3	Unallocated	10.5	Unallocated	13.6
Total ODA \$ million	3328	Total ODA \$ million	6973	Total ODA \$ million	9913

Geographical distribution of ODA
MAJOR RECIPIENTS OF DAC MEMBERS' AID

<i>Gross disbursements</i>		Total DAC		<i>Percentage of total ODA</i>	
1970-71		1980-81		1986-87	
India	11.5	Egypt	4.2	Israel	4.1
Indonesia	7.2	India	3.9	Egypt	4.0
Viet Nam	4.8	Bangladesh	3.4	India	3.3
Pakistan	4.6	Indonesia	3.4	Indonesia	3.0
Korea	3.4	Israel	3.1	Bangladesh	2.1
Turkey	2.5	Turkey	2.5	Philippines	2.1
Brazil	2.0	Tanzania	2.0	China	1.9
Papua New Guinea	1.8	Reunion	2.0	Pakistan	1.7
Colombia	1.4	Martinique	1.8	Tanzania	1.6
Algeria	1.4	Pakistan	1.6	Reunion	1.2
Reunion	1.4	Sudar	1.3	Thailand	1.2
Morocco	1.4	Kenya	1.2	Turkey	1.1
Tunisia	1.3	Thailand	1.1	Sudan	1.1
Nigeria	1.3	Korea	1.1	Kenya	1.1
Israel	1.2	Zaire	1.1	Mozambique	1.0
Martinique	1.0	Sri Lanka	1.1	Sri Lanka	0.9
Zaire	1.0	Papua New Guinea	1.1	Somalia	0.9
Laos	0.9	Philippines	1.0	Morocco	0.9
Thailand	0.9	Morocco	0.9	Martinique	0.9
Guadeloupe	0.8	Burma	0.8	El Salvador	0.9
Philippines	0.8	Zambia	0.7	Ethiopia	0.9
Egypt	0.8	Senegal	0.7	Senegal	0.9
Kenya	0.7	Peru	0.7	Zambia	0.9
Ghana	0.7	Tunisia	0.7	Zaire	0.8
Chile	0.7	Brazil	0.6	Malaysia	0.8
Total above	55.3	Total above	42.0	Total above	39.2
Multilateral ODA	16.1	Multilateral ODA	28.9	Multilateral ODA	25.2
Unallocated	9.6	Unallocated	7.9	Unallocated	10.9
Total ODA \$ million	7884	Total ODA \$ million	28720	Total ODA \$ million	41406

		EEC		<i>Percentage of total ODA</i>	
1970-71		1980-81		1986-87	
Cameroon	8.8	India	9.4	Ethiopia	5.2
Zaire	8.2	Sudan	4.0	India	4.7
Senegal	8.0	Egypt	3.5	Sudan	4.1
Madagascar	5.9	Bangladesh	3.4	Senegal	4.0
Côte d'Ivoire	4.8	Senegal	3.4	Turkey	3.3
Burkina Faso	4.1	Somalia	3.1	Reunion	2.7
India	3.6	Ethiopia	2.9	Egypt	2.7
Niger	3.4	Zaire	2.7	Côte d'Ivoire	2.1
Mali	3.3	Mali	2.6	Tanzania	2.1
Gabon	2.9	Tanzania	2.6	Papua New Guinea	2.0
Chad	2.9	Kenya	2.4	Bangladesh	1.7
Turkey	2.7	Zambia	1.9	Guadeloupe	1.7
Togo	2.6	Madagascar	1.9	Mozambique	1.7
Algeria	2.1	Guinea	1.7	Chad	1.6
Benin	2.1	Rwanda	1.6	Mali	1.6
Mexico	2.0	Morocco	1.6	Ghana	1.5
Pakistan	2.0	Côte d'Ivoire	1.6	Portugal	1.4
Congo	1.9	Turkey	1.5	Thailand	1.4
Egypt	1.8	Burundi	1.5	Uganda	1.4
Burundi	1.8	Pakistan	1.4	Martinique	1.3
Somalia	1.7	Uganda	1.4	Zaire	1.3
Netherlands Antilles	1.7	Malawi	1.4	Niger	1.3
Rwanda	1.5	Indonesia	1.3	Malawi	1.3
Bangladesh	1.4	Burkina Faso	1.2	Madagascar	1.3
Central African Rep.	1.4	Mauritania	1.1	Tunisia	1.2
Total above	82.6	Total above	61.1	Total above	54.8
Multilateral ODA	0.0	Multilateral ODA	0.0	Multilateral ODA	0.0
Unallocated	3.5	Unallocated	10.4	Unallocated	15.6
Total ODA \$ million	208	Total ODA \$ million	1265	Total ODA \$ million	1735

ATTACHMENT

REPORT OF A SITE VISIT IN MARCH, 1989 TO FIVE AFRICAN COUNTRIES TO ASSESS THE STATUS OF DONOR COORDINATION AND EXTERNAL FINANCIAL MOBILIZATION FOR HEALTH IN AFRICA

-Patrick F. Morris-

As the number of foreign donors for African development programs have increased, so have the number of coordination mechanisms to try to rationalize and channel assistance. In the international arena, UNDP has had the traditional and longstanding responsibility to coordinate and report on donor activity across the board in collaboration with host governments.

Since the beginning of the 1980s, IMF and IBRD have been putting more emphasis on the need for greater discipline by African countries in the investment of their limited resources and have been encouraging countries to establish coordination mechanisms which not only monitor national funding of all programs, but donor funding as well.

In health, WHO has been the designated agency for coordinating international health and it has instructed the WHO representative in each country to maintain contact with other donors in the field.

As a result of these activities as well as internal initiatives from African governments themselves, almost all African countries have formal and informal mechanisms for coordinating, monitoring and reporting on donor activity in development programs. The effectiveness and thoroughness of these coordinating mechanisms vary greatly from country to country, but because of them, it is possible to make a estimate of current donor activity in all of the developing countries in Africa in the health field. For the purpose of this report, a complete regional inventory would require a more extensive survey than authorized under the terms of this study.

WHO Coordinating Activities

WHO regional headquarters in Brazzaville (WHO/AFRO) considers itself the primary agency for collecting, compiling and keeping information on the existing mechanisms for coordinating donor health programs in individual African countries. As a result of the joint AFRO-OAU Declaration of Health in 1985, 65 percent of the countries in the region have a National Health Council, which is a multisectoral coordinating committee reporting directly to the President and chaired by the Minister of Health. Through this Council, WHO/AFRO can play an important coordinating role and finds it a useful mechanism at the policy level for

establishing health priorities and giving prominence to current WHO/AFRO guidelines and initiatives in each of the member countries as well as providing a framework within which all donors can design and operate their programs. WHO/AFRO views the councils as important channels for getting national attention for health problems, giving added authority to the Ministry of Health, serving as another avenue for WHO/AFRO to influence the direction of health programs in the country, and providing a potential mechanism for increased donor coordination at the local level. WHO country representatives are designated as advisors to the councils and instructed to encourage an active role for them.

At the operational level, WHO/AFRO established a Health Resource Mobilization unit in 1987 which was charged with working with individual African countries to identify national health priorities, identifying specific projects that require financing, and supporting regional and national efforts to acquire extrabudgetary resources for health development in member states. To carry out this effort the unit has built on and expanded an earlier program started in 1980 by WHO/Geneva called the Country Health Resource Utilization Review (CRU).

The CRU reports cover the following topics:

A. The Main Report

- 1) National Health Policy for reaching the goals of HFA/2000.
- 2) Primary Health Care system design.
- 3) Problems, obstacles and constraints associated with reaching the goals.
- 4) Financial implications and projected expenditures.

B. Summary Proposals for External Funding

C. Supporting Annexes

It is not a highly detailed or lengthy report, since it is intended to set the stage for more in-depth analysis and follow-up in each country. The Summary Proposals for External Funding are neither final, official nor detailed. They are summaries of project and program requirements which could provide tentative opportunities for external participation in health activities in the country. They are usually in the area of Primary Health Care

and are part of the broader national strategy for HFA/2000¹.
The summaries include:

- a) Estimated resource requirements, both capital investment and recurring costs
- b) Resources committed or expected to become available either from national or external sources
- c) The net short-fall, i.e. resources still required to carry out the program for the planned period.

There is usually a main Primary Health Care Proposal and related proposals. Related proposals serve as complementary strategies for strengthening planning, operational management or health systems research and evaluation.

The supporting annexes usually contain additional detailed information which supports the Main CRU Report, including:

- o Socioeconomic information related to health
- o Health status data, targets and indicators
- o National Health Development Plans
- o National Health financing and expenditure patterns and trends
- o Detailed information on the Primary Health Care program
- o Detailed information on related health programs

The CRU document is a study carried out by the developing country itself, involving the Ministries of Health, Planning, Finance and other sectoral authorities. The country is assisted by WHO/AFRO and WHO/Geneva. WHO helps countries prepare to undertake the studies by conducting workshops for national officials, indicating the kinds of information that must be collected and prepared on existing health resources prior to the arrival of a team of WHO consultants. Teams usually have three consultants, a health economist, a physician with public health experience in Africa and a member of the WHO/AFRO Health Mobilization Office. They remain in the country for approximately three weeks interviewing local officials and gathering the information necessary to compile their report. They also visit all the major donors in the country. The reports

1. A defined World Health Assembly program goal entitles "Health for all by the year 2000" (HFA/2000)

are written and reproduced for distribution in Geneva, then submitted to the country for approval.

To date, WHO has carried out CRU studies in the following 13 African countries since 1980:

1. Gambia, November 1980, revised 1982.
2. Sierra Leone, July/August 1984.
3. Guinea, October 1984, revised 1988
4. Lesotho, November, 1983.
5. Botswana, August, 1984.
6. Malawi, August, 1982.
7. Guinea Bissau, October, 1983, revised March, 1985.
8. Benin, August, 1981.
9. Sudan, 1981, revised 1984.
10. Togo, draft, September, 1984.
11. Djibouti, April, 1986.
12. Zambia, draft, August, 1985.
13. Mali, draft, June, 1986.
14. Rwanda, draft, February, 1988.
15. Burundi, draft, March, 1988.
16. Somalia, April, 1985.

As of August, 1988, only the first eight studies on the list have been approved by the host countries and printed in final form.

After a CRU study is approved and printed, a Donors Roundtable is usually called to encourage additional donor participation and to identify possible new sources of external financing for the specific proposals made in the CRU. These Roundtables are coordinated with UNDP and sometimes take place under its auspices. To date, Roundtables have been held for four countries: Guinea-Bissau, Botswana, Gambia and Benin. There is no indication in WHO documents as to the results of these Roundtables in terms of additional donor contributions to specific projects (see Section IX of the Main Report).

Funds to finance the consultants for CRU preparation have been provided by WHO/Geneva. AID/W made a grant to WHO in 1985 to assist in carrying out a number of studies. Funds from the grant were exhausted in 1988.

The Health Resource Mobilization office of WHO/AFRO, on request, helps countries prepare, correct or improve proposals for submission to both bilateral and multilateral donors and encourages countries to prepare proposals for submission to the ADB and IBRD. The unit routinely gathers information on the activities of other donors in health in Africa. This includes the contributions and policies of bilateral, multilateral and

nongovernmental donors. Following the model in the Americas² the unit is preparing guidelines on financial resource mobilization for health in Africa which will include information on donors and their policies in African countries.

In addition to the CRU effort, WHO/AFRO actively promotes increased coordination of health activities among other members of the UN family. Joint technical working groups have been set up with UNICEF for MCH, CDD and EPI. The UNDP Director for the African Region and the WHO/AFRO Director have sent out a joint letter encouraging field offices to maximize their similarities, integrating programs wherever possible. WHO/AFRO urges UNDP Resident Representatives to visit its offices in Brazzaville for briefings and has instructed WHO representatives in each country to help host countries formulate health projects within the framework of the UNDP country programs. WHO/AFRO also contributed to and commented on the recent World Bank Health Policy on Africa statement while it was in preparation.

There is active collaboration between the African Development Bank (ADB) and WHO/AFRO. A Memorandum of Understanding describes arrangements for carrying out joint studies and sharing information. Periodic meetings are also held at both the policy and working levels to further this agreement. WHO/AFRO representatives attend meetings of the health sector committee of bilateral donors under the Coordination for Development in Africa (CDA) Committee, composed of UK, US, FRG, Canada and France. The U.S. chairs the health sector committee.

Finally, WHO has been particularly active in Africa in the fight against AIDS and has taken a leadership role in organizing pledging conferences for prospective donors as well as in initiating projects to combat the disease.

IBRD AND IMF ACTIVITIES

Financing of health care in Africa must necessarily take into account the much larger context of public sector financing generally and donor participation across the board in order to assess the attitudes of individual governments toward the requirements of the health sector and the likelihood that they are in a position to or will actively seek additional donor participation.

In this regard, it is important to note the low and even negative rates of economic growth which have taken place in

² Pan American Health Organization Guidelines on Financial Resource Mobilization for the Health Sector in the Region of the Americas, PAHO, Washington, 1986.

African countries in the late 1970s and early 1980s. In response to restricted national budgets, many donors have increased their overall flows of assistance to Africa in recent years. This is particularly true of the World Bank and the IMF, which have initiated economic stabilization and structural adjustment programs in most of the African countries since 1981.

These programs consist of both short- and long-term financial assistance to address immediate balance of payments and debt servicing problems, as well as to assist in structural changes aimed at improved economic performance. Even in countries where IMF does not have a stabilization program, IBRD prefers to provide its assistance only within the context of a Policy Framework Paper (PFP), drawn up by the host government, which addresses the country's economic problems and lays out general policies for structural adjustments to overcome them.

USAID, the other major donor in Africa, while differing procedurally from IBRD and IMF, also provides assistance within the context of a Country Development Strategy Statement (CDSS) which establishes an overall framework and strategy for the individual pieces of its program.

The combined impact of these requirements on African governments has been to put greater emphasis on economic planning, priority setting and increased monitoring and management of government resources, including those provided by international and bilateral donors. Specifically, host government Ministries of Finance and Ministries of Planning have been encouraged to exert close supervision and control over the planning, budgeting and allocation of funds of the operating Ministries. In some countries, this includes funds from not only domestic government revenues but from international donors as well.

As a consequence, there are few countries in Africa where the Ministry of Health can operate as a free agent to independently solicit funds from international and bilateral donors to finance new projects in health. In one sense, the policies of major donors such as IBRD, IMF and USAID have influenced the African countries in which they operate to coordinate foreign donor assistance through their Ministry of Finance or the Ministry of Planning, or both. This is the case for practically every country in Africa. This practice has forced most operating ministries, including the Ministry of Health, to undertake its own planning and priority setting exercises and to establish offices which interface with Planning and Finance. Out of this interaction, new programs and projects are discussed, revised and finally approved or rejected.

The larger in scope a new project is and the larger its financial requirements, the more scrutiny and attention it is likely to receive in the Planning and Finance Ministries. Thus,

as is to be expected, projects with large capital requirements are of much more concern than technical assistance projects. Nevertheless, technical assistance projects which anticipate increasing local budgetary contributions or increased recurring costs to be financed by the government are subject to careful review.

While the process varies widely from country to country in both inclusiveness and effectiveness, it is the established mechanism for dealing with new projects and potential foreign donor assistance. It must, therefore, be taken into account in designing a resource mobilization mechanism for health in individual countries.

As IBRD has implemented more Structural Assistance Loans (SALs) and USAID moves toward sectoral assistance loans, both aimed at influencing policy choices of the host country, the need has arisen to encourage greater coordination among the donors themselves with the object of introducing discipline and greater complementarity into donor activity.

In many countries the IBRD has taken the lead in stimulating this donor coordination on the macro-economic level as well as in sectors which have impact on the budget and on the achievement of development goals. One of the mechanisms it uses for this purpose is the Consultative Group, which it chairs and for which it provides secretariat services. Consultative Group meetings offer the host government an opportunity to present an overall program to invited donors and to indicate which parts of it will require donor financing. It offers the individual donor an opportunity to provide support within a comprehensive framework to a part or parts of a program in which it has special interest, and it offers donors collectively an opportunity to discuss policy questions and program direction with host government officials in a macro-economic context.

In recent years, the IBRD has taken another step in this process in some African countries, establishing, with host government agreement, donor coordinating groups, which are then divided into sector sub-groups, chaired by the lead donor or donor sector policy specialist. For example, in Malawi the Health Sector sub-group is chaired by the WHO representative assigned to the Ministry of Health, and the Population sub-group is chaired by UNFPA and the nutrition sub-group by UNICEF. In Kenya, the new Health Sector sub-group will be chaired by USAID, which is readying a new health sector loan.

UNDP, UNICEF and UNFPA Activities

Traditionally, UNDP has had responsibility for donor coordination and it still plays an important role in that regard.

It keeps track of donor contributions in countries where it operates and collects and periodically publishes a detailed listing of all technical assistance and capital assistance projects, including the name and description of the project, its budgeted cost, the amount disbursed during the year and the estimated project completion date. This information is for the use and benefit of the host government, as well as for the other donors. In countries with extensive technical assistance from foreign donors, UNDP undertakes to coordinate their activities through periodic meetings at which project information is exchanged. When a government expresses an interest in attracting additional donors to provide technical assistance for expanded government programs, UNDP can organize a UNDP Roundtable, so that the government can present its proposals to prospective donors and donors can announce their interests and intentions. As noted above, WHO/AFRO sometimes uses the UNDP Roundtable as the final phase of its CRU process. In some African countries, UNDP provides specialized personnel in staff positions to the Ministries of Planning or Finance to monitor and coordinate donor programs for the government (Malawi and Zaire).

UNICEF has developed a system for attracting additional donor participation and contributions for implementation through its own program. In this regard, the UNICEF system can be said to be self-contained. However, it does cooperate with other donors working in similar or complementary activities in Africa. It participates in IBRD- or UNDP-initiated coordinating mechanisms and has a formal working agreement with WHO/AFRO for coordination and closer collaboration. Nevertheless, because it is a self-contained system, both as regards receiving additional donor resources and carrying out its programs at the country level, UNICEF appears to give a lower priority to donor coordination than WHO, UNDP and UNFPA.

UNFPA undertakes to coordinate the population activities of donors in the countries in which it operates, promoting donor pledging conferences for new and expanded projects and encouraging frequent donor consultation and exchange of information at the working level for programs already underway. Other donors in this field look to UNFPA to perform this coordinating role.

While differences and occasional conflicts over turf and program exist among members of the UN family in Africa, the importance of coordination is recognized and there is a genuine effort on the part of the leadership to promote it. As a result, there is a much more active exchange of information, coordination and perhaps ease of communication among WHO, UNDP, UNICEF, UNFPA, IBRD and ADB than there is among the bilateral donors.

AFRICAN DEVELOPMENT BANK ACTIVITIES

Due to lack of prior clearance, it was not possible to visit the headquarters of the African Development Bank in Abidjan. Information in this report on ADB activities in health is limited and derived from interviews with other organizations dealing with ADB. This section is limited to a few general observations. ADB has only recently begun to expand its activities to include projects in health and related fields. The few projects that it has financed in health have been capital assistance projects such as water systems. It is only now beginning to fund some technical assistance in the health area. Due to its limited health staff, ADB relies largely on WHO/AFRO for technical assistance and guidance. There appears to be a good working relationship between the ADB health staff and WHO/AFRO.

USAID ACTIVITIES

Because A.I.D. is organized to provide country missions with substantial autonomy. Donor coordination within the region takes place primarily at country level. Each mission is responsible to keep track of other donor activities in the fields in which USAID is also providing assistance. Each functional office in the mission has responsibility for being aware of other donor activities. Wherever USAID has health, population or nutrition programs, the HPN office is charged with responsibility for maintaining contact with other donors and the extent and nature of their involvement. USAID missions generally welcome the coordinating efforts of the UN agencies, and the IBRD and favor open and continuing exchange of information. Missions provide detailed information annually to UNDP on all their activities for the UNDP Development Cooperation Report. USAID missions also participate actively in donor coordination groups organized under the auspices of IBRD, UN or host governments. AID/W and the REDSO offices in Abidjan and Nairobi rely on the country USAID missions for donor information. Neither AID/W nor the REDSOs regularly collect information on other donors in Africa.

While USAID missions are the source of most information on other donors, they view donor coordination as a host government responsibility or, in the breach, more appropriately a multilateral responsibility (IBRD, UNDP, WHO). This view is shared by most other bilateral donors. Therefore, donor coordination is not given any particular emphasis by USAID missions but considered a routine activity in response to an outside initiative.

This attitude is in keeping with the AID/W practice where reporting requirements on other donor activity are limited in scope and frequency. The Country Development Strategy Statements (CDSS) have a section for donor information, but in many

instances, it is ignored in USAID submissions. Sector Assessments and Project papers also require information on donor programs. Since this information has direct relevance to project or program approval, it is usually provided.

None of these documents however, are periodic in submission. Donor information in them is dated and unlikely to be updated until a new document is called for. In the case of the CDSS, they are out of date in most African countries and only a limited number of up-to-date revisions are being requested. Donor information in Sector and Project papers will not be updated unless new programs or projects in the same fields are initiated.

SPECIFIC COUNTRY SITUATIONS

Malawi

Malawi has programs with both IMF and the IBRD and has organized its government to be responsive to the requirements of Structural Adjustment. It has a strong Planning Office (EPND) reporting directly to the President. EPND and the Ministry of the Treasury work together closely in planning and controlling public expenditures. The Ministry of Health also has a planning office which deals with EPND. There is a published ten-year National Health Plan 1986-1995. It has a chapter on resource implications of the plan over the next ten years which includes manpower requirements, capital projects and financial requirements. All approved development projects contain estimates on recurrent costs over five years. It also has a summary by program of estimated expenditures on technical assistance by the Ministry of Health. A major assumption of the plan is that most of the funding to carry it out will come from outside donors.

The implementation of the National Health Plan must be carried out within the Public Sector Investment Plan (PSIP). The current PSIP is a five-year plan, 1988-89 to 1993-94. The projections in the plan for the Ministry of Health have investments increasing through 1990-91 then decreasing through 1993-94 back to 1988-89 levels. The PSIP has tables listing all of the activities of the Ministry of Health and the financing requirements over the five-year period with expected outside donor contributions for each project. It is estimated that the current PSIP will be 80 to 90 percent financed by outside donors. The major donors listed are ADF (African Development Fund), IDA and USAID. Other donors are UNICEF, CIDA, EC and The Netherlands. Since such a large portion of the investment budget is provided by outside donors, EPND closely monitors all donor programs, especially where capital assistance is involved.

According to the UNDP Development Cooperation Report dated February, 1988 (but containing data only through 1986), ODA to Malawi was on a decreasing trend from 1979 through 1985 from \$141 million to \$113 million, but with a large increase in 1986 to \$205 million. Infrastructure and agriculture received the major share of central government and donor disbursements. Health increased from five percent of the budget in 1976 to 15 percent in 1986. However, disbursements in health were very slow, suggesting an absorptive capacity problem. Disbursements on health technical assistance projects for 1986 were better, running second after agriculture. Of the total technical assistance for 1986, health and population together received 27 percent, which was larger than that of any other sector, Agriculture was next with 23 percent. The UNDP Report listed the following donors in health and population for 1986: DANIDA, GTZ, France, MASHAV, Netherlands, RSA, ODA, USAID, EDF, UNDP/WHO, WHO, UNFPA/DTCD, UNFPA, UNICEF, WFP, JICA/JOCV, VSO, USPC, IDA, KfW, EIB, ADF, Exim Bank of India, UNCDF and WFP. In addition to these donors, UNICEF reported in an interview that the EC, FRG, CIDA and Italy were contributing to UNICEF projects in Malawi. UNICEF indicated it was also working with the Save the Children Foundation on a cost recovery study and with Cornell University on a nutrition surveillance program. They were also receiving contributions from Rotary International.

The USAID Project Paper for Promoting Health Interventions for Child Survival (PHICS) 612-0231 of October, 1988, has a brief section on other donor support which states that 16 different donors are financing over 60 health projects. Donor contributions of approximately \$7.6 million account for 85 percent of Malawi's \$9 million health sector development budget. UNICEF, with funding from Italy and Rotary International, has a four-year (1986-89) \$4.5 million EPI/MCH program. In addition, UNICEF has a \$9 million, four-year "Child Survival and Development Program" (1988-1992). The IBRD has a \$11 million, six-year PHC program (1988-1993). UNFPA has a four-year \$3 million family planning program. The WHO role is that of an executing agency rather than a donor.

Another major player in public health in Malawi is a church-sponsored private sector organization, the Private Hospital Association of Malawi (PHAM). It receives some budgetary support from the Ministry of Health, but the large bulk of its funds come from foreign NGOs such as MEMISA of the Netherlands and MISERIOR of West Germany. It has also received some assistance from Project Hope, Danish Church Aid, the Christian Service Committee and Oxfam.

The GOM has organized itself to coordinate and rationalize this great diversity of activity in the health field by foreign donors. The planning office in the Ministry of Health has primary responsibility for this coordination, but EPND plays a

major role in controlling the volume and program content of bilateral and multilateral donor assistance, especially for capital projects. EPND has veto power over technical assistance projects which it considers may generate excessive recurrent costs or require too large a budgetary contribution from the GOM. EPND is critical of the planning office in the Ministry of Health for what it considers as over committing the government in health programs. It cites projects with high recurrent costs. The USAID \$17 million, five-year PHICS Project already signed by the Ministry of Health is being reviewed by EPND out of concern over possible excessive recurrent costs. EPND also faults the health planning office for not having a portfolio of projects ready for financing by potential donors. The health planning office responds that it has a clear idea of what assistance it needs and once a year in June it provides project proposals to EPND. Each is a three or four page proposal describing the project in general terms. EPND is then supposed to locate donors. EPND considers itself a clearing house for matching donors with project proposals.

In Malawi, coordination and control is related to the macro-economic commitments undertaken by the GOM in collaboration with IMF and the Structural Readjustment Program of the IBRD. UNDP has provided staff assistance to EPND to strengthen its donor coordination function. As part of this effort, IBRD has assumed a leadership role in organizing a donors coordinating committee and sectoral subcommittees. The health subcommittee is chaired by the WHO representative, the population subcommittee is chaired by the UNFPA representative and the nutrition subcommittee by UNICEF. Each subcommittee is composed of every donor providing assistance in the field and meets periodically to exchange information, to avoid duplication and to clarify goals and objectives. The Nutrition Subcommittee has produced a report defining the nutritional problem and suggesting a future focus for donor activity. The WHO representative has provided the MOH and the Health Subcommittee with a Country Profile which lists all donors existing in health.

Kenya

Kenya, like Malawi, has an agreement with IMF and is participating in a Structural Adjustment Program with IBRD. The Bank has organized the coordination of donor programs through Consultative Group meetings and, as in Malawi, through sectoral level coordination groups. It has concentrated on encouraging other donors to co-finance the structural adjustment operations. USAID, in close cooperation with IBRD, is supporting GOK's overall economic stabilization effort and is about to provide a sector grant to the MOH for a Health Care Financing Program aimed at introducing fundamental reform into the financing of health sector activities and at reordering priorities to increase resources for primary and preventive health service delivery. In

conjunction with this grant, IBRD is planning a large sector project for FY 1990. Cofinancing from other donors is expected to augment the Bank's preliminary planning level of \$50 million. The program to be financed will be based on a prior consensus among existing donors on a policy reform agenda for health care financing. The IBRD project is expected to have three main components: Policy Reform, Traditional Project Activities and Technical Assistance. The Policy Reform element will provide balance of payment support in tranches tied to the formulation and implementation of an agreed upon list of policy reform and program measures. The Traditional Project Activities will provide support to health service provider institutions. The Technical Assistance element will provide support for policy preparation and implementation policy reforms in the form of studies and institutional development assistance. USAID will take the lead initially through balance of payment support and technical assistance to be followed by much larger resource flows from the Bank and other donors. At a recent donor coordination meeting chaired by IBRD, it was agreed that USAID would serve as the lead donor with respect to coordinating the health care financing program. In this capacity USAID will convene regular meetings of concerned donors and ensure that interested donors are kept informed of important developments.

Collaborative studies are planned to prepare project documents and to define other donor participation. This includes a study of the willingness and ability to pay for health services financed jointly by SIDA and UNICEF and a Provincial and District study to be jointly financed by USAID and DANIDA to examine the operational efficiency and effectiveness of MOH hospital-based services as well as cost sharing issues. DANIDA and SIDA are also jointly involved in an assessment of rural health facilities to determine need for upgrading and expanding. As part of this they are analyzing methods for improved planning and budgeting at the district level in conjunction with an A.I.D.-financed Information and Planning System project.

There is also a donor coordinating mechanism in the Ministry of Health, which calls regular meetings with the participation of WHO, UNICEF, DANIDA and SIDA regarding the implementation of the Child Survival Program. UNFPA heads a donor coordinating committee on family planning, which includes all major donors. Other donors which provide assistance in health are Italy, Norad, Netherlands, FRG, Finland, UNDP, FPPI, IDA, OPEC and ADF.

Because of the way A.I.D. is organized, the REDSO office in Nairobi does not concern itself with donor coordination activities, relying instead on the individual missions to coordinate with other donors at the operational level. The regional Health and Population Officers have no detailed knowledge of other donor activities in HPN in the East African countries covered by REDSO, nor do they have information on

other donors in their library or files. When such information is needed, the missions are queried directly.

Congo

In 1986, Congo signed a standby agreement with IMF and entered into a monetary stabilization program. The Government of France provided a \$43 million structural adjustment loan the same year. In 1987, both IBRD and ADB made structural adjustment loans. However, during the year, IMF suspended the standby because of noncompliance. As in other countries, IBRD is emphasizing fiscal discipline and structural adjustment using sectoral strategy papers or sector reports. It has not yet provided any assistance in health, but has done a preliminary paper on the health sector. The government has a very limited planning capacity and has produced no in-depth sectoral studies. There is no planning office in the Ministry of Health. But there is a National Health Council which establishes priorities for government health programs. The Ministry also looks to WHO/AFRO, with its headquarters in Brazzaville, to be helpful in this regard. The government has no donor coordination mechanism, so the donors resort to ad hoc coordination, calling sporadic meetings to exchange information. France, as the largest bilateral donor, has taken steps in some fields to encourage donor coordination. UNDP fulfills its traditional role here, promoting donor coordination activities and producing the annual Development Cooperation Report which lists all donors, projects and funds committed and disbursed on each of them. The latest report is for 1987, which contains 1986 data. UNFPA has taken a leadership role in the family planning area, encouraging coordination and exchange of information among other donors. WHO, UNDP and the Italian government are cooperating with the MOH in a national primary health care program, as are the French and German governments on developing an integrated health system. Coordination in both of these areas is ad hoc and initiated by the donors, rather than the MOH. Recent meetings have been called to discuss water and sanitation, primary health care and AIDS.

In the 1986-87 time frame, WHO has the largest number of individual projects in health, while France and Germany are the largest bilateral donors. Other donors are the World Food Program (WFP) with its maternal/child health supplementary feeding program, UNICEF and the United Nations Women's Organization (UNWO). The EC, with its European Development Fund, has several small projects in health. In population and family planning, Canada is working with UNFPA. For the 1988-1992 period, the UNDP Development Cooperation Report predicts assistance from WFP, USAID, Canada and UNICEF. While France, Germany and Italy are not listed, they are expected to continue their programs beyond 1988.

Zaire

Of the five countries visited, Zaire has the most complex situation as it relates to donor assistance because of the decentralized nature of health care activities and the proliferation of multilateral, bilateral and NGO donors.

At the central government level, Zaire, like the other countries, has a Structural Adjustment Program with the IBRD and a stabilization program and standby agreement with IMF. The stabilization program with IMF began in 1983. In 1984, with the assistance of UNDP, an office for the Coordination of External Affairs was established in the Department of Planning. It has responsibility for keeping track of the activities of all existing donors. It serves as the technical secretariat for the government's participation in the IBRD organized Consultative Group. It issues quarterly reports on donor disbursements, annual reports on donor disbursements project by project, and an annual report on NGO activity. The present head of the office is provided by UNDP. There is also a Social Sector office in the Department of Planning which has responsibility for monitoring expenditures for government sponsored health programs. It has direct control over counterpart funds used for health activities and it issues an annual Health Investment Priority Program (PIP), which determines the projects it will fund. For example, the 1989 PIP identifies 300 priority projects to be supported by IBRD, ten of which are in health. The IBRD Sectoral Adjustment program emphasizes the importance of these offices in carrying out sectoral reform and maintaining fiscal discipline within the 1986-1990 Development Plan. The USAID mission has also carefully designed its assistance to be supportive of the Sectoral Adjustment program and the governmental infrastructure to administer it. All USAID assistance in health is within Structural Adjustment guidelines.

On the operational level, Zaire is divided into 300 rural health zones. There are a number of bilateral, multilateral and NGO donor organizations which have assumed responsibility as the principal health care providers in these zones. UNICEF is operating alone in 115 zones and with other organizations in 64 more. USAID assists the Church of Christ of Zaire (SANRU), which operates alone in 80 zones and with others in 19. The Belgians, Canadians and Italians operate in five zones. In addition, the Belgian assistance organization CTB assists the Catholic Medical Services Organization of Zaire which is operating 100 hospitals and 355 health centers, providing about 30 percent of the total health coverage in the country. The Kibanquist Church also provides health care in 180 health centers with assistance from Hadassah, and the Red Cross is involved in health care. A REACH study of Health Zone Financing found that 21 percent of the zone operating resources and 80 percent of the capital investments were provided by outside donors. A Health Sector Analysis done

by the IBRD in 1987 found that these activities were being carried out without an adequate system of planning, programming and resource allocation. There is no centralized information on service providers or source of payments for health care.

In 1986, the GOZ created a new entity, FUNAMES, to channel and coordinate all donor and NGO activity. While FUNAMES receives official support from the multilateral and bilateral donors which would welcome an effective donor coordinating mechanism, FUNAMES has not yet sorted out its role. It has never been fully funded, and its functions as it relates to the Ministry of Health (DSP) and the health zones has never been defined.

Thus, in spite of the intention of the GOZ to coordinate donor activities, coordination is in effect carried out on multiple levels, some of the most effective being done by the donors themselves on an ad hoc basis or by the executing agencies faced with specific coordination problems. For example, recent meetings have been held by the Directors of CCCD projects in which WHO, UNICEF, USAID, CTB, OXFAM and Rotary were represented, another meeting of the National Committee on Water which was attended by USAID, UNDP, WHO and UNICEF; another was the National AIDS Program donor meeting in February, 1989. In addition, the UN agencies perform their traditional coordinating roles. UNDP is helping the Department of Planning to set up a monthly meeting for UN donors. UNDP sponsored a Donor Roundtable in 1988, although it is unclear as to whether health was included in the pledging session. UNFPA tries to coordinate donor participation in population and family planning activities. WHO has taken the lead on donor coordination for AIDS. UNICEF chaired two meetings, one in September and one in December, 1988, to discuss the effect on the social sector of the World Bank Structural Adjustment Program. Unlike Kenya and Malawi, IBRD has not undertaken to organize a donor coordinating sectoral subcommittee on health in Zaire. Perhaps this is because it has not yet made a loan in the health area. Whatever the reason, it results in a confusion of donors and donor coordinating mechanisms.

During 1987, the major bilateral donors in health, in order of size of disbursements, were: Belgium, U.S., Italy, France, FRG, Japan and Canada. The multilateral donors were: UN Agencies and the EC.

Niger

Niger has had a monetary stabilization program since 1982 and structural adjustment credit from the World Bank since 1986. It is presently operating within a three-year budget program, 1987-1990, agreed upon with the Bank. The Bank is trying mobilize increased levels of external assistance within the framework of

the Special Program for Debt Distressed Sub-Saharan African Countries. For 1988-1990, it has identified a financing gap of \$240 million. Using the Consultative Group mechanism it hopes to strengthen aid coordination. It has prepared a sector program in primary health care and an expansion of population activities with IDA credits in health and water supply.

The Government of Niger is highly centralized and its Ministry of Planning is very powerful. This might presuppose a centralized and effective donor coordination mechanism, but the opposite is the case. According to USAID, the government has discouraged formalized donor coordination activities. For example, in 1986, following its general practice on encouraging donor coordination in relation to a Structural Adjustment Program, the Bank was unable to get the government to officially sponsor donor coordination efforts. Evidently, the Bank was also discouraged from setting up informal donor coordination committees and sub-committees as it has done in other countries. However IBRD sponsors informal meetings on structural adjustment which includes, IMF France, US, FRG, and Canada.

On the other hand, the UN agencies try to perform their traditional coordinating roles. UNDP sponsored a Roundtable in June, 1987 to identify increased donor participation in Niger development projects within the context of the government five-year plan. UNDP also publishes its annual Development Cooperation Report which lists all donors with projects financed during the previous year. The latest available report is for 1987. UNFPA promotes quarterly donor meetings on population and family planning activities.

In 1986, the French produced a detailed plan for its health program with the Government of Niger for the years 1987-1991. This is complete down to detailed job descriptions. IBRD prepared complete plans for its health program in two volumes, one each for 1987 and 1988. The USAID CDSS and the Health Sector Assessment are both dated 1986 and need updating.

USAID is the largest single donor in health followed by Belgium. Switzerland has made a large, long-term commitment through the WHO-OCP/Sahel Program. Other bilateral donors are China, South Korea, Egypt, France, Japan, Netherlands and the Soviet Union. Among the multilateral organizations, WHO and UNICEF are engaged in the largest number of projects. The World Food Program (WFP) and UNFPA are also active.

CONCLUSIONS

Because of the great diversity in the quality and effectiveness of donor coordination and resource mobilization mechanisms in Africa, it is difficult to make generalizations. It is quite clear that there is no regionally consistent pattern for coordinating donor activity in health. Nor is there a commonly accepted regional mechanism for mobilizing external resources for health projects. In spite of the existence of the HRM office at WHO/AFRO, and perhaps because it is a recent effort, it is striking how seldom WHO is mentioned at the country level as having a prominent role in donor coordination or in external financial mobilization resources for health. By contrast, UNFPA is the recognized leader for donor coordination and resource mobilization in population and family planning for the five countries visited during this assignment. Most important, however, none of the Ministries of Health visited have established mechanisms to seek out new sources of financing for health programs, even though the need for additional resources has been clearly identified.

CURRENT PERCEPTIONS ON THE CONSTRAINTS TO EXTERNAL HEALTH FINANCING

Perhaps the most frequently encountered perception among interviewed donors regarding the constraints to financial mobilization health in Africa is the limited absorptive capacity of individual governments. Cited evidence is the slow disbursement of funds in already approved projects and the millions of dollars in the pipeline for health activities already funded. USAID missions in Malawi and Kenya, for example, expressed the view that money wasn't a problem, but rather the lack of human resources and infrastructure to make efficient use of increased funds.

Contrary views were expressed in Zaire, where a highly decentralized primary health care system allows donors to bypass central government bureaucracies and make contributions at the local level, where they are immediately effective. A recent World Bank report indicated that health was expected to bear a relatively large share of the retrenchment burden in 1982 and that counterpart funds have helped restore the health budget to former levels. Another report recommended more than doubling the GOZ budget in health. There is similar concern in the Congo that the social programs have fared poorly under the Structural Readjustment Program. In Niger, there is a general consensus that there is substantial room for additional donors and increased donor activity.

WHO/AFRO has given the highest priority to decentralization of health administration and is pressing governments to take

action. Thus, the absorptive capacity question is related at least partially to how health activities are organized, and whether donor participation may be able to help alleviate organizational constraints. It is pointed out that the requirements for improved health care in Africa are so large and extensive that means must be found to break the bottlenecks that slow down or stop additional resources from being utilized.

The other side of the absorptive capacity coin is the limited resources argument, i.e. that the government cannot afford to provide all the resources that the health sector requires. This can be and is a real constraint on donor participation since almost all assistance requires local government budgetary outlays. Projections for future government funding requirements occasioned by ongoing or planned outside assistance may be deemed excessive and thus rule out going ahead with the project. Local currency availability may not be an absolute constraint since the donors can then reprogram assistance in ways which do not put additional burdens on limited government budgets. In the absence of more specific analyses of demand constraints, these perceptions are concerns for a number of countries, including Kenya and Malawi.

A major constraint in attracting additional external financing, which may generate little local currency demand, is the absence of organization to attract new resources. None of the visited Ministries of Health have a defined unit or function to focus on the mobilization of new external financing. None have current knowledge of potential sources or trained staff to prepare proposals.

As described above, the framework for a greatly expanded resource mobilization effort has already been initiated through WHO/AFRO at the regional level. Constraints to new financing will persist until these functions are established within each government.

OPPORTUNITIES

Among the five countries visited, Congo, Niger and Zaire are ready to accept additional donor assistance in health. Zaire, which is receiving assistance most from a greater number of donors, is the best organized to absorb assistance because of the decentralized nature of its program and the existence of World Bank and USAID budgetary assistance to help satisfy some of the local currency requirements. The Congo is probably the least able to absorb large quantities of new assistance because of the tight fiscal situation, the lack of sectoral studies, and governmental infrastructure to implement the programs. Its greatest need is for assistance in health planning and management to prepare for expanded programs. All the elements seem to be in

place for expanded contributions for health in Niger. There is a strong central planning office, a consensus among donors that additional assistance is necessary, and recognition of the need by the Structural Adjustment Program. Of the other two countries, Kenya and Malawi, the latter has the most comprehensive donor coordination mechanism and probably the best control over expenditures of any of the five. It is probably one of the best in Africa. Because of this, it is in the best position to seek out additional donors and increased donor contributions whenever it decides it can handle them.

ORGANIZATION AND TRAINING

As noted above, none of the governments in the five countries visited are organized to systematically seek out alternative sources of funding or to present carefully prepared project preliminary proposals to attract financing. Since practically all present outside funding comes from donors who actively seek out funding opportunities and help prepare the documentation necessary to receive it, most governments take a passive attitude to donor financing. They take limited advantage of IBRD Consultative Group meetings and UNDP Roundtables to solicit new or additional funding, but make almost no organized effort through HPN their own government chamber.

In order for African governments to accelerate the achievement of agreed regional health objectives, as they have collectively declared, special priority for both national and external financial mobilization is mandatory. Such an effort will require establishment of units either in the Ministry of Health or Planning that not only coordinate existing donor assistance in health, but possess the information and skill to attract potential HPN financing. The establishment of such offices will require a medium-term program for limited external technical and financial cooperation.

SYSTEM FOR INCREASING DONOR RESOURCES FOR HEALTH

IBRD Structural Adjustment and IMF Stabilization programs occupy a central role in most African countries in determining the size, nature and extent of large donor programs in all development-related activities. These programs will eventually influence even the smaller donor contributions as well as those of NGOs. Therefore, any effort to improve donor coordination and resource mobilization in health must take structured adjustment and stabilization programs into account. This is particularly true as regards the IBRD's own activities in donor coordination and resource mobilization, i.e. the Consultative Group mechanism and its donor coordination initiatives at the country level.

On close examination, there is no inherent conflict or duplication in promoting an improved system of donor coordination and resource mobilization in health and the broader, overarching coordination activities already being carried out by the World Bank. In fact, they are complementary and, if organized responsibly, will contribute to the Bank's overall objectives. Similarly, there is no conflict with the present donor coordination activities of UN agencies and efforts for the stimulation of increased donor participation in health. On the basis of this survey, it seems evident that the leadership void in donor coordination and resource mobilization in health must be filled and if skillfully presented would be welcomed by the Bank.

From a technical and health functional view point, the organization which most closely fits the requirements for promoting HPN sectoral donor coordination and resource mobilization for Africa is WHO/AFRO. Bilateral donors are often considered suspect if they undertake coordination activities and most feel uncomfortable in the role. Among the United Nations agencies, WHO is the only one that is concerned with HPN in the broadest sense, although UNFPA, UNICEF, and FAO specialized sub-sectoral health goals.

By agreement of all nations, the function of health coordination is a WHO constitutional responsibility, a natural extension of being the principal voice of health advocacy on the world scene. However, WHO/AFRO is a long way from fulfilling its responsibilities in this area and probably will need substantial assistance in order to do so.

The CRU process is sound and should be expanded, but the HRM office is limited to two professionals and the funds for conducting additional CRUs are limited. Only 16 CRUs have been prepared in nine years. The process is not well known outside of WHO itself. The CRUs get little or no distribution.

In part due to the short history of the Brazzaville HRM office, Ministries of Health have not established their own resource mobilization units, nor has the HRM office been able to provide up-to-date information on potential new financing. The effort has limited itself up to now to training sessions for Ministry personnel, primarily in preparation for the CRU exercise. There is no evidence of any training content in the general process of financial mobilization.

WHO representatives in many African countries are viewed as weak and ineffectual. They make little effort to coordinate donor activities and, where they do, they elicit little confidence among other donors. In only one of the five countries visited was the WHO representative referred to in laudatory terms. In general, the WHO Regional Office is not recognized for leadership in either donor coordination or resource mobilization.

There are indications that the new Regional Director, Dr.G.L. Monekosso, has made significant improvements in WHO/AFRO since he took office in 1987. He has been methodically upgrading the caliber of the regional staff as well as the WHO representatives at the country level. Some USAID staff have seen improvements in this regard. Dr. Monekosso has a very ambitious program to get individual African countries to implement commitments for improved health care in their countries. These steps indicate that WHO/AFRO would be enthusiastic about developing its donor coordination and resource mobilization potential if it could secure the referred technical and financial support.

In view of these facts, and in spite of WHO/AFRO's recognized weaknesses, I believe WHO/AFRO is the only logical entity for promoting increased mobilization of external financing for health in African countries and the coordination of donor activities. There is no doubt in WHO/AFRO that these are important functions within its charter responsibilities, functions which it has been endeavoring to carry out through its office of Health Resource Mobilization (HRM) and CRU process.

For WHO/AFRO to be effective and credible in this area, it must give a higher priority to this activity than it has in the past. This means upgrading the HRM office, increasing its staff and giving a much higher profile to its activities. The first requirement for improving the HRM would be to hire a Health Economist to head the office and to expand total professional staff to four.

With IBRD and Structural Adjustment playing such a central role in African development programs, it is important that Ministries of Health and WHO/AFRO have people on their staffs who understand the rationale which determines development priorities and the allotment of resources, people who can make the case for health in economic development terms. The HRM staff should expand its role and participate actively in IBRD organized Consultative Group meetings, improve contacts with donors and assist Ministries of Health to make their cases for increased donor participation in health programs. At the country level, WHO/AFRO should initiate a technical assistance effort to assist governments in establishing their own resource mobilization offices, to provide access to information on donors and potential donors, and to provide technical assistance in the preparation of well-justified preliminary proposals.