

# Global Health Actors

Dr. Latefa Dardas



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## The Global Health System

- The global health system can be defined as the constellation of actors (individuals and/or organizations) “whose primary purpose is to promote, restore or maintain health”, and “the persistent and connected sets of rules (formal or informal), that prescribe behavioral roles, constrain activity, and shape expectations” among them. Such actors may operate at the community, national, or global levels, and may include governmental, intergovernmental, private for-profit, and/or not-for-profit entities.

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## Brief History of International Assistance

- The motives behind international involvement in health matters have been varied and complex over the centuries, starting around the 1300s:
  - Preventing plagues
  - Safeguarding global commerce & the slave trade
  - Protecting soldiers and colonists overseas
  - Protecting workers and improving colonial relations
  - Promoting 'civilization' in less developed regions
  - Religious, humanistic & social justice motivations



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## Pre-1800s

- Bubonic plague (mid-1300s, 1630s), cholera, smallpox & other mass afflictions
  - Disease spread due to increasing global commerce
  - Bubonic plague killed 20-50% of affected populations
  - *Quarantine* first created in Venice in 1348 requiring ships to wait 40 days before entering port
  - *Cordon sanitaire* soon thereafter, establishing a land barrier to people and goods around cities and regions
  - No knowledge then of causative agents for bubonic plague, smallpox, dysenteries, etc. (Bad airs, God, etc.)
  - No nations during this period; actions were local or regional



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## 1800s to mid-1900s

- Industrial revolution further increased commerce
- Imperial conquests led to colonization & exploitation
  - Invaders brought smallpox, measles, TB, etc., and in turn were felled by malaria, dysenteries, sleeping sickness
  - Slave trade became extensive with high mortality rates
  - Efforts to protect health of colonists, workers, missionaries
- Internal and international migrations
- Rise of modern public health
  - Sanitary reforms in many countries
  - Health Office of the League of Nations



A meeting of the League of Nations, Geneva, 1936

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## 1919-1944

- **League of Nations (1919-1920):**
  - Founded in 1919 out of the Treaty of Versailles, in the aftermath of WWI
    - A multi-national, collective security organization with mission to prevent the outbreak of another world war
  - Despite American President Woodrow Wilson's campaign for US' entrance into the League of Nations, the US never joined, crippling the organization
    - The LoN was rendered powerless despite its few successful conflict resolutions between member states
    - Ceased to officially exist in 1945, with the establishment of the United Nations
- **Bretton Woods Agreement (1944)**
  - Developed at the UN Monetary and Financial Conference of 1944
    - An agreement establishing guidelines international exchange rate management
      - Currencies pegged to gold
    - Established the *International Monetary Fund (IMF)* and the *International Bank for Reconstruction and Development (IBRD)*
      - IMF given the authority to intervene in discrepancies over exchange rates

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## Mid-1900s to late 1990s

- Rapid increase in the international, national and NGO organizations providing health assistance
- International collaborations through WHO, World Bank and others become the norm
- Much assistance is *supply driven*, i.e., what donors have available and/or want to offer
- Aid increasingly focused on specific diseases
- With some notable exceptions (e.g., smallpox eradication) most assistance has limited benefit

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## World Bank Group: 1945

- **Established after the international ratification of the 1944 Bretton Woods Agreement:**
  - Comprised of five organizations:
    - International Bank for Reconstruction and Development (IBRD)
    - International Development Association (IDA)
    - International Finance Corporation (IFC)
    - Multilateral Investment Guarantee Agency (MIGA)
    - International Centre for Settlement of Investment Disputes (ICSID)
- **Mission:**
  - *Assist poor countries in their human, economic, agricultural and "good governance" development projects through leveraged loans.*
  - *To "eradicate" poverty*

[www.worldbankgroup.org](http://www.worldbankgroup.org)

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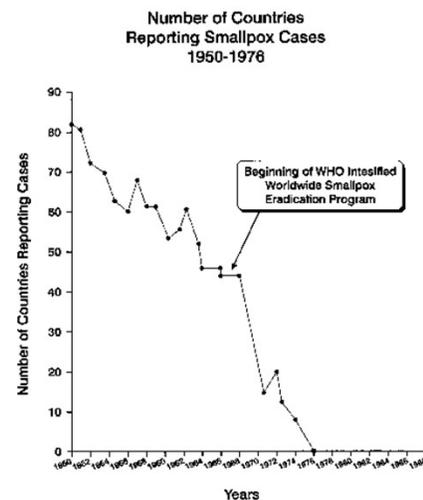
## 1948-present

- **World Health Organization, 1948**
  - An arm of the United Nations dedicated solely to health
  - Established in 1948 on the first official 'World Health Day' to coordinate international health activities and assist governments in improving health services for their citizens
    - Activities range from providing best practice guidelines to addressing international pandemics and disease outbreaks
- **International Cooperation Agency (ICA), 1955**
  - First coordinating agency for US foreign aid
  - Provided economic and technical assistance operations to poor nations
- **United States Agency for International Development (USAID), 1961**
  - Established as a result of the 1961 Congressional Foreign Assistance Act to unify the US' foreign aid projects and goals
  - Intended to be free of influence from the military
    - Combined and unified under the common goal "*long range economic and social assistance development efforts*" the technical assistance provided by the ICA;
    - the loan activities of the Development Loan Fund;
    - the local currency functions of the Export-Import Bank
    - and the agricultural surplus distribution activities of the Food for Peace program of the Department of Agriculture

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## International Assistance Early Agenda

- Increased attention to specific diseases, successful eradication of smallpox, primary health care (PHC) and 'special PHC', with its emphasis on those diseases most easily prevented or treated.



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## Agenda of Late 1990s to Present

- New approaches to international assistance
  - More use of partnerships (international, public-private)
  - Increased funding (governments, banks, philanthropy)
  - More emphasis humanitarian motives
  - Greater recognition of the global nature of disease
  - Greater recognition of infrastructure & workforce needs
  - Greater attention to priorities of recipient countries
  - Greater emphasis on transparency and accountability

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## Some Milestones on Path to Global Health

- **1796**, Jenner discovers way to prevent smallpox
- **1851**, International Sanitary Conference, Paris
- **1854**, Discovery of cause of cholera
- **1863**, International Committee of the Red Cross
- **1902**, Pan American Sanitary Bureau, later PAHO
- **1913**, Rockefeller Foundation (hookworm, yellow fever, others)
- **1914**, Panama Canal completed (overcoming Yellow Fever )
- **1920**, League of Nations Health Organization
- **1945**, World Bank Group founded
- **1946**, U.N. Infant and Child Emergency Fund, UNICEF
- **1948**, World Health Organization founded
- **1977**, Eradication of smallpox
- **2002**, Global Fund to Fight AIDS, Tuberculosis and Malaria
- **2005**, Millennium Development Goals established

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## Global Health Actors By Decade Of Inception

Years	New actors
Before 1900	7
1900–09	2
1910–19	7
1920–29	2
1930–39	2
1940–49	14
1950–59	14
1960–69	9
1970–79	28
1980–89	23
1990–99	48
2000–09	45
2010–present	2

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## Three Major Types of Global Health Actors

### 1. Multinational Organizations

- A. Organizations within the UN system relevant to health
- B. Organizations outside of the UN system relevant to health

### 2. Bilateral Government-to-Government or to Sub-Government Levels

### 3. Non-Governmental Organizations (NGOs)

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## Multinational Organizations

- Overview
  - Most created since World War II
  - Number of countries participating and organizations involved has increased rapidly
  - All or most of the ~195 countries are members, most have votes and have input to policies and priorities
  - Countries contribute according to economic abilities
  - Multinational staff, in part selected to attain a good geographic representation
  - Multinationals may have regional & country level offices

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## Multinational Organizations

- **Organizations within UN system relevant to health:**
  - **WHO** (World Health Organization, 1948)
  - **UNICEF** (U.N. Infant & Children's Emergency Fund, 1946)
  - **UNFPA** (Population Fund, 1967)
  - **UNDP** (U.N. Development Programme, 1965)
  - **FAO** (Food & Agricultural Organization, 1943)
  - **UNESCO** (U.N. Educational, Scientific and Cultural Organization, 1945)
  - **UNHCR** (U.N. Refugee Agency, 1950)
  - **WFP** (World Food Programme, 1962)
  - **UNODC** (U.N. Office on Drugs & Crime, 1997)

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## Multinational Organizations

- **Organizations outside the UN relevant to health**
  - U.N. Affiliated Programs
    - Banks: Global Fund to Fight AIDS, TB and Malaria, 2002
    - UNAIDS (Joint U.N. Programme on HIV/AIDS, 1994)
    - And many others
  - World Bank Group, International Monetary Fund (IMF)
  - Others: World Trade Organization

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## Multinational Financial Institutions: Strengths

- Substantial funding
- Bank imposed 'conditionalities'
  - Extensive pre-project planning usually required, often with help of external consultants
  - Funds 'conditioned' on negotiated reforms and conditions, i.e., if you do "X" by "Y" year you will get "Z" funds
  - Funds released in 'tranches' according to attainment of pre-specified accomplishments
- Loans are increasingly coordinated with bilateral (national government assistance) agencies

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## Multinational Financial Institutions: Critiques

- They may undermine role of state and national sovereignty
  - Poor countries may be obliged to adopt potentially harmful policies, e.g., “structural adjustment programs”
- Economic considerations may dominate decisions
- Largest stakeholders (donors) dominate votes
- Challenge of corruption in recipient countries
- Correlates of program success may not be present
  - Country characteristics favoring good loan performance include good administration, stable currency, established legal system, sustained policies over time, lack of social strife, and low corruption. Countries that most need help lack many of these characteristics.

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## Bilateral Aid Agencies\*

- Many of the “rich” 34 OECD countries have official, government owned or controlled aid agencies: Examples include:
  - USAID (U.S. Agency for International Development)
  - DFID (U.K.)
  - SIDA (Sweden)
  - CIDA and IDRC (Canada)
  - DANIDA (Denmark)
  - JICA (Japan)
  - And many others

“Bilateral” nominally refers to aid assistance provided by one government to another government. In practice a donor government may provide funding to NGOs within its own borders, and these then provide assistance to organizations within the recipient countries. Governments can also provide assistance directly to NGOs and other entities in the recipient countries. For example, USAID provides large contracts to US NGOs to provide capacity-building services and tools to recipient countries.

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## Bilateral Aid Agencies: Strengths

- Substantial resources from governments
- Generally have qualified, long-term staff
  - Subcontractors also tend to develop substantial expertise
- Moderately flexible, responding to changing conditions
- In U.S., increasing use of long-term commitments and very large (\$20-100 millions), multi-project and country contracts
- Can coordinate activities with other bilateral and NGO programs

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## Bilateral Aid Agencies: Critiques

- Political factors may drive assistance ('Cold War' period)
- Programs may require purchases of drugs, equipment, etc., in donor country, thus increasing costs & decreasing recipient flexibility to find best/cheapest products
- Programs may be more oriented toward donor's priorities, industries, programs and capabilities than recipient's priorities
- Aid may be poorly coordinated or even competing with other, especially non-governmental, programs
- Programs may siphon off best host country health workers with higher salaries, better administration, etc.
- Foreign aid is politically vulnerable due to a small constituency (e.g., equipment makers, contractors)

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## Non-Governmental Organizations (NGOs)

- NGOs defined by their extraordinary diversity:
  - Non-profit and profit-based
  - Religious and secular
  - Narrow and broad scope programs
  - Wealthy and shoe-string operations
    - Big NGOs are called BINGOs
  - Well paid, marginally paid and volunteer staff
  - Long- and short-term commitments
  - Single-country, multi-country and regional focus
  - Single problem and multi-problem focus
  - Single sector and multi-sector focus
  - Emergency relief and development focus

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## Non-Governmental Organizations (NGOs)

### Charitable (secular) organizations

- Oxfam
- CARE
- Save the Children/UK (& US)
- International Red Cross
- Doctors without Borders
- Project Hope
- International Rescue Committee
- CARE
- Freedom from Hunger
- Child Family Health International
- Doctors for Global Health



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## Non-Governmental Organizations (NGOs)

### Faith-based organizations (FBOs)

- Catholic Relief Services
- Christian Aid
- Lutheran World Relief
- Unitarian Universalist Service Society



## Non-Governmental Organizations (NGOs)

### Philanthropic foundations

- Bill & Melinda Gates
- Atlantic Philanthropies
- Carnegie
- Rockefeller
- Clinton Global Initiative
- Carlos Slim
- Josiah Macy, Jr.
- Kellogg
- Ford
- MacArthur
- Seva



See supplemental material information

## Non-Governmental Organizations (NGOs)

### Membership organizations

- Global Health Council
- American Public Health Association
- American Academy of Family Physicians
- American Academy of Pediatrics
- Rotary International
- Global Health Education Consortium



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## Non-Governmental Organizations (NGOs)

### Consulting / contracting organizations (PVOs)

- John Snow International
- Management Sciences for Health
- Abt Associates
- IntraHealth International
- Family Health International
- Academy for Educational Devt.



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## Non-Governmental Organizations (NGOs)

### • Some major university programs

- Duke University
- Emory University
- Oxford University
- Harvard University
- Vanderbilt University
- University of Toronto
- University of Washington
- Johns Hopkins University
- Univ. of Calif. at San Francisco
- London School Hygiene & Tropical Medicine



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## Examples of work done by Philanthropic Foundations

- **Bill and Melinda Gates Foundation, Carlos Slim, & others**
    - Collectively these foundations have increased global spending for HIV/AIDS (from \$250M to \$7B 1996-2004)
  - **Clinton Global Initiative (CGI):** involving the private sector and getting participant commitments for involvement
    - If no follow-up by a CGI participant, no further invitation to the CGI
    - Increased investment in research and development
    - 10/90 gap: Only 10% of the world's R&D is spent on problems affecting 90% of the population
  - **Rotary Clubs and polio eradication**
    - a success, maybe, since small pockets of prevalence are resistant to immunization for religious or other reasons
- Foundation can significantly influence government and inter-governmental organizations

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## Examples of work done by Philanthropic Foundations

### Gates - Grand Challenges in Global Health

- Create new vaccines
- Improve childhood vaccines
- Cure latent and chronic infections
- Improve nutrition to promote health
- Improve drug treatment of infectious diseases
- Control insects that transmit agents of disease
- Measure disease and health status accurately and economically in developing countries
- And perhaps, improve health systems and their human resources

BILL & MELINDA  
GATES foundation

See Gates Foundation website: <https://www.gatesfoundation.org/>

## Non-profit NGOs: Strengths

- Great variety of programs to meet many needs
- Potentially very flexible with fast response times
- Volunteers & non-profit status lower operational costs
- Staff with high personal commitment to providing help
- Can easily relate to host country organizations
- Less tainted by association with government
- Lower corruption potential
- Campaigns help educate the public to human needs

## Non-profit NGOs: Critiques

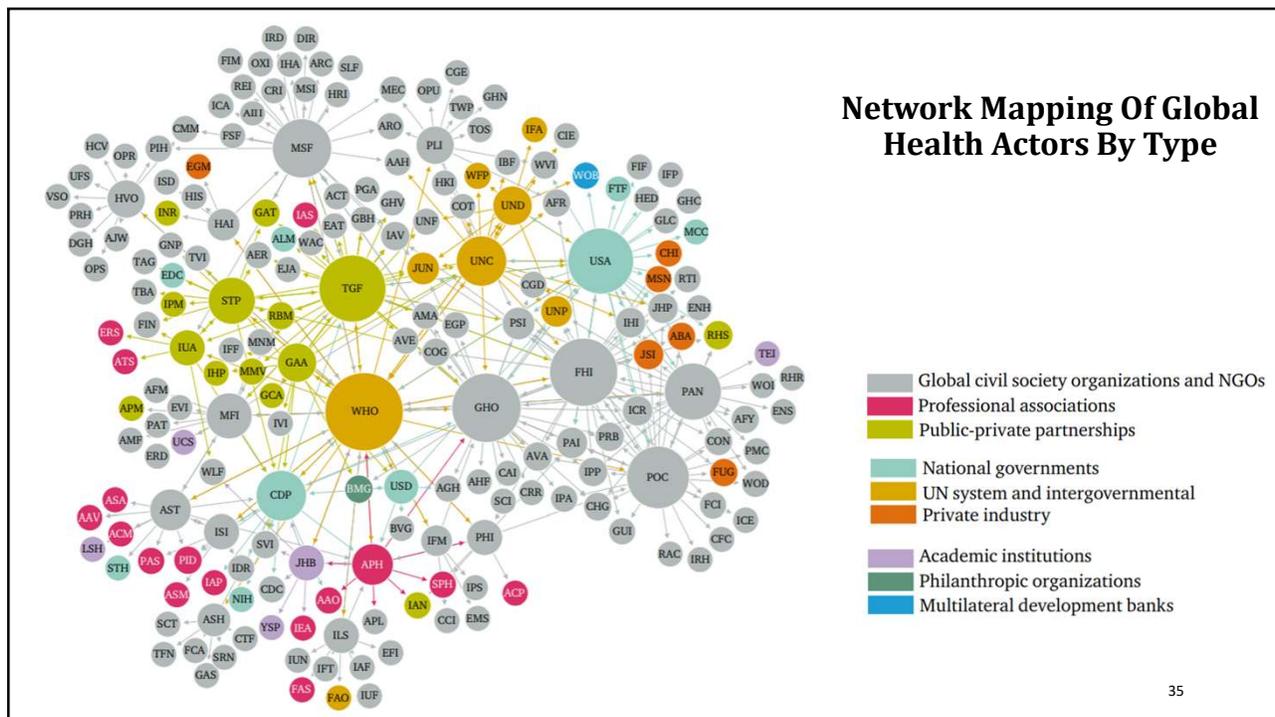
- Limited accountability and ability to evaluate effectiveness
- High motivation not necessarily matched by expertise
- May have high volunteer turnover and short stays
- May compete or not coordinate actions with similar NGO and country programs
- Programs often narrowly focused on specific diseases or problems, with limited attention to infrastructure development
  - Specific diseases and problems are more 'marketable' to donors
  - Program results are easier to document with limited, measurable, though not necessarily meaningful, objectives, e.g., meals delivered, educational talks given, persons trained, medicines handed out, books delivered

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## Non-profit NGOs: Critiques

- Program dependence on external support compromises sustainability in host country
- NGO salaries can distort host country salary structure and compete for competent government personnel
- Host country can be seriously burdened by many, often overlapping, NGOs working on targeted programs, each with its own staffing, audit and accountability requirements

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## Weaknesses in the Functions of Global Health Actors

- Budget is not sufficiently large and flexible to fulfil their mandates.
- Few global health actors are involved in cross-sectoral advocacy.
- Few global health actors are involved in the sharing of intellectual property.
- System complexity and an increase in the bureaucratic hurdles that recipient countries are required to navigate in order to access funds.

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▪ **There are currently 203 Global Health Actors\*. Examples include:**

- World Health Organization.
- Bill & Melinda Gates Foundation
- Gavi, the Vaccine Alliance
- The Global Fund to Fight AIDS, Tuberculosis and Malaria
- Doctors Without Borders/Medecins Sans Frontieres.
- United Nations Children's Fund.
- World Bank.
- Centers for Disease Control and Prevention (CDC)
- Joint UN Programme on HIV/AIDS
- United States Agency for International Development.
- National Institutes of Health

\* See Supplementary File\_3 for full list of actors.

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## Location Of Global Health Actors

- The 203 global health actors are located in 73 cities in 16 countries, with 98.5% of headquarters based in high-income countries.
- The most common countries for global health actors to headquarter themselves in were the United States (n = 135), Switzerland (n = 23), and the United Kingdom (n = 13), followed by Belgium (n = 7), the Netherlands (n = 6), and Canada (n = 4).
- Two actors' headquarters were located in low- and lower-middle-income countries (i.e. Syria and Senegal) and one in an upper-middle-income country (i.e. South Africa). Significantly, no actors were headquartered in the 'BRIC' countries (i.e. Brazil, Russia, India and China). The top three most common cities for headquarters were Washington, DC (n = 42), New York (n = 28) and Geneva (n = 21).

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## Global Health Actors' Primary Intent

- The large majority of identified actors in the global health system are NGOs (n = 138); by contrast, the next largest actor-type is public-private partnerships (n = 18).
- In total, 61.6% of global health actors (n = 125) listed improving health as the primary intent of their organization, compared with 38.4% of actors (n = 78) who listed improving health as one of multiple primary intents. This ratio illustrates the complex interaction between health and other global policy domains – such as international development, trade and environmental protection.

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## The Global Health System : A Time of Transition

- The global health system that evolved through the latter half of the 20<sup>th</sup> century achieved extraordinary success in controlling infectious diseases and reducing child mortality. Life expectancy in low- and middle-income countries increased at a rate of about 5 years every decade for the past 40 years. Today, however, that system is in a state of profound transition. The need has rarely been greater to rethink how we endeavor to meet global health needs.
- The global health system has vastly expanded over the past few decades. This expansion is characterized by greater funding, increasingly complex health challenges, and more – and more diverse – actors operating within the system.

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## The Global Health System: A Time of Transition

- The traditional actors on the global health stage—most notably national health ministries and the World Health Organization (WHO)—are now being joined (and sometimes challenged) by an ever-greater variety of civil society and nongovernmental organizations, private firms, and private philanthropists. In addition, there is an ever-growing presence in the global health policy arena of low- and middle-income countries, such as Kenya, Mexico, Brazil, China, India, Thailand, and South Africa.

## The Global Health System: A Time of Transition

- The global health landscape in general has become an intransparent patchwork of organizations and interests, where objectives of public health, development, economy, security, and foreign policy dominate to various degrees, and sometimes clash.
- The traditional United Nations' body for health, the World Health Organization (WHO), is subject to severe criticism regarding its focus, effectiveness, and independence from country specific, and private sector interests. In particular, the WHO is under siege on account of its spending having decreased, and its credibility is disputed by suggestions about the pharmaceutical industry having infiltrated the organization.
- Other major actors, such as the Global Alliance for Vaccines and Immunization (GAVI), Global Fund and the Bill and Melinda Gates Foundation (hereafter The Gates), make significant contributions to international health projects,<sup>1</sup> but they can be criticized for not being representative and accountable.

## The Global Health System: A Time of Transition

- ....Also changing are the relationships among those old and new actors—the norms, expectations, and formal and informal rules that order their interactions. New “partnerships” have come to exist alongside and somewhat independently of traditional intergovernmental arrangements between sovereign states and UN bodies (see Figure on slide 47 for an illustration of the underlying governance principles).
- The rise of multiple new actors in the system creates challenges for coordination but, more fundamentally, raises tightly linked questions about the roles various organizations should play, the rules by which they play, and who sets those rules.

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## The Global Health System: A Time of Transition

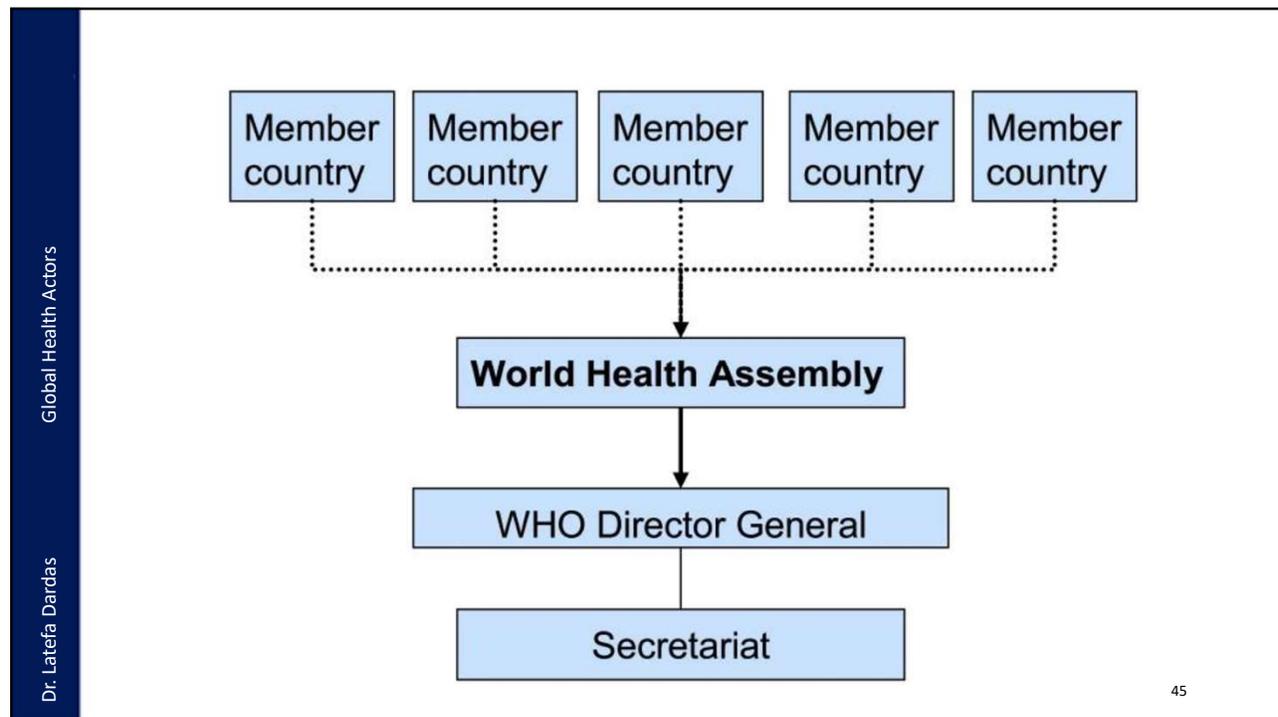
- The lack of a clear set of rules that constrain distortion of priorities by powerful actors can threaten less powerful ones. For example, despite widespread support for the overarching goals of the Bill & Melinda Gates Foundation, whose spending on global health was almost equal to the annual budget of WHO in 2007, there is considerable discussion, in some cases even unease and some tension, around the prominent role played by it.

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## Key Issues for Global Health Funding Recipients

- ❖ **Priorities:** Are they locally derived or in response to donor priorities?
- ❖ **Local buy-in:** Is there good local support for the proposed activity?
- ❖ **Flexibility:** Can funding allocations and activities be modified as experience dictates or is the budget tightly fixed?
- ❖ **Constraints:** What limitations will be imposed, e.g., equipment purchases only from donor country, 'gag order' for abortion services?
- ❖ **Monitoring and accounting:** Frequency and complexity of reporting requirements? Compatibility or not with existing data systems?
- ❖ **Intrusiveness:** Are foreign consultants and/or evaluators required and if so, who recruits, pays, directs, monitors and terminates them?
- ❖ **Compatibility:** Does program complement, complicate or compete with work in other areas?
- ❖ **Political implications:** Will donor support have potentially positive or negative repercussions?

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## Summary

- Health has long been an important part of development assistance, foreign policy and education -- but motivations, priorities and mechanisms have changed over time
- Development assistance accomplishments over most of the past 60 years have generally been disappointing
- Since the latter 1990s there has been a rapid rise in the number, variety and capabilities of organizations involved in, and funding available for, improving global health
  - Available funding is, however, still far short of needs
  - The increasingly complex 'aid industry' has complicated the work of both donors and recipients
- Each type of global health 'actor' has strengths, constraints and vulnerabilities.

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## Summary

- New assistance approaches can guide program development in the future. These collaborative partnerships are seeking better, more transparent ways to set priorities, allocate funds, and to monitor and evaluate performance. Programs to watch as they evolve include:
  - Global Fund to Fight AIDS, TB and Malaria
  - Millennium Challenge Corporation and PEPFAR
  - Collaborative partnerships such as Global Alliance for Vaccines & Immunizations, Roll Back Malaria, International AIDS Vaccine Initiative, and the Global Health Workforce Alliance
  - Major philanthropies such as the Gates and the new Carlos Slim Foundations

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## Summary

- **Key characteristics of effective program assistance models**
  - **Demand driven** (recipient initiated, planned and implemented)
  - **Accountable** (performance-based investments in which future support is contingent on good and effective use of past support)
  - **Transparent** (all major steps in the application, approval and project management phases are visible to anyone)
  - **Scalable** (if relevant, the project can go to “scale,” i.e., expand to a much larger scale. Too many “pilot programs” go nowhere!)
  - **Supplemental** (aid should supplement, not replace local funds)
  - **Collaborative** (programs partner, coordinate and/or collaborate with other relevant public and private sector programs)
  - **Capacity-building** (institutional and organizational capacities are strengthened by the assistance received).

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