RESOURCE MOBILIZATION ORIENTATION

Facilitator’s Manual
CONTENTS

TOOLKIT MATERIALS
PLANNING FOR THE WORKSHOPS
KEY CONSIDERATIONS FOR TEACHING AND LEARNING
SELF ASSESSMENT SHEET

Background - WHO Mandate for Resource Mobilization
Outline of Resource Mobilization Workshop Training objectives

FACILITATING MODULE 1: SETTING THE STAGE
Introduction
Learning objectives
Key concepts

FACILITATING MODULE 2: PRINCIPLES OF RESOURCE MOBILIZATION
Introduction
Learning objectives
Key concepts

FACILITATING MODULE 3: PLANNING FOR RESOURCE MOBILIZATION
Introduction
Learning objectives
Key concepts

FACILITATING MODULE 4: FUNDING LANDSCAPE
Introduction
Outline of the module/discussion
Key concepts
Further reading
ACKNOWLEDGEMENTS

This module (Resource Mobilization Orientation – Facilitator’s Manual) has been prepared by the World Health Organization’s Regional Office for the South-East Asia (SEARO) to identify innovative ways to build new strategic partnerships that leverage WHO’s leadership role in health and contribute towards viable solutions to regional health challenges. The Regional Office is committed to building upon regional health achievements while tackling new and emerging challenges that confront its 11 Member States. By commissioning this module, the Regional Office recognizes the untapped potential across the South-East Asia Region for new partnerships that can mobilize the necessary human and financial resources to build healthier societies.

Invaluable inputs for collection of country-level data for this module were made by WHO representatives and staff in Member States of the Region. The Module also benefited from the contributions of a number of people. The contribution of Professor May Soe Maung, Rector, University of Public Health, Yangon, Myanmar; Mr William Slater, Director, Office of Public Health, USAID, Myanmar; and Ms Angela Ryan Rappaport, President, Suitcase Consulting, Viet Nam, are noted in particular.

Several WHO staff were involved in compiling, improving, validating and analyzing the contents of the Module. The contributions of Ms Maria Manuela Enwerem Bromson, former Technical Officer, Partnership, Interagency Coordination and Resource Mobilization (PIR), SEARO, who initiated the concept; Mr Robert Chelminski, Compliance Officer, SEARO and Ms Paula Caruso, former Temporary International Professional, PIR, SEARO and their valuable inputs are particularly acknowledged. Dr Francisco Katayama, Technical Officer, PIR, SEARO, assisted by Mr Paramjeet Singh, PIR Associate and Mr Anand Mohan, Executive Assistant, PIR, SEARO in finalizing the module. Editorial assistance was provided by the Reports and Documents team of SEARO headed by Ms Martha Lorena Bonillal Espinosa, Documents Officer. We also acknowledge the contribution made by the Information Management and Dissemination (IMD) team headed by Mr Charles Raby, Technical Officer; and Health Situation and Trend Assessment team headed by Mr Mark Landry, Regional Adviser.
# ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADB</td>
<td>Asia Development Bank</td>
</tr>
<tr>
<td>ASEAN</td>
<td>Association of South – East Asian Nations</td>
</tr>
<tr>
<td>BMGF</td>
<td>Bill and Melinda Gates Foundation</td>
</tr>
<tr>
<td>CD</td>
<td>Communicable Diseases</td>
</tr>
<tr>
<td>CIDA</td>
<td>Canadian International Development Agency</td>
</tr>
<tr>
<td>CSR</td>
<td>corporate social responsibility</td>
</tr>
<tr>
<td>DAC</td>
<td>Development Assistance Committee</td>
</tr>
<tr>
<td>DFID</td>
<td>Department for International Development</td>
</tr>
<tr>
<td>EU</td>
<td>European Union</td>
</tr>
<tr>
<td>GFATM</td>
<td>Global Fund to fight AIDS, TB and Malaria</td>
</tr>
<tr>
<td>GHI</td>
<td>global health initiatives</td>
</tr>
<tr>
<td>INGO</td>
<td>international nongovernmental organization</td>
</tr>
<tr>
<td>M&amp;E</td>
<td>monitoring and evaluation</td>
</tr>
<tr>
<td>MDG</td>
<td>Millennium Development Goal</td>
</tr>
<tr>
<td>MOPAN</td>
<td>Multilateral Organisation Performance Assessment Network</td>
</tr>
<tr>
<td>MoU</td>
<td>memorandum of understanding</td>
</tr>
<tr>
<td>MTSP</td>
<td>Medium Term Strategic Plan</td>
</tr>
<tr>
<td>NCD</td>
<td>noncommunicable disease</td>
</tr>
<tr>
<td>NGO</td>
<td>nongovernmental organization</td>
</tr>
<tr>
<td>NTD</td>
<td>Neglected tropical disease</td>
</tr>
<tr>
<td>OECD</td>
<td>Organisation for Economic Co-operation and Development</td>
</tr>
<tr>
<td>PEPFAR</td>
<td>US President’s Emergency Fund for HIV/AIDS Relief</td>
</tr>
<tr>
<td>SWAp</td>
<td>Sector Wide Approach</td>
</tr>
<tr>
<td>TB</td>
<td>tuberculosis</td>
</tr>
<tr>
<td>UNDAF</td>
<td>UN Development Assistance Framework</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
### Assessment sheet

<table>
<thead>
<tr>
<th>Skill sets</th>
<th>1 Some awareness</th>
<th>2 Understanding</th>
<th>3 Knowledge</th>
<th>4 Skills</th>
<th>5 Competence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Global health landscape / WHO reform</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Principles of resource mobilization</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Planning for resource mobilization</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Funding landscape</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Donor communications and stewardship</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negotiation and reporting</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proposal writing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proposal writing–Focus on results</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WHO-specific requirements</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
TOOLKIT MATERIALS

A workshop is intended to be an interactive, dynamic time for sharing new ideas and “thinking together”. This toolkit has been designed with this kind of workshop in mind: The facilitator is ensures the content is presented, but especially that all participants are interacting effectively. These materials utilize a variety of engaging materials and learning strategies in order to help the facilitator make sure this happens.

**Participant workbooks**

The participant workbook aims to provide all the information a participant might need for the introduction and each of the nine modules. It should be noted to participants that the information on the slides is reproduced in the book, and they do not need to copy the content of the slides.

Each workbook also includes a list of resources, references, and reading materials, should a participant which to delve into a specific topic in more detail.

**Slide decks**

Each module has a corresponding set of slides. In order to promote group interaction and critical thinking, the slides are brief. This also avoids the pitfall of simply reading from the slides without seriously engaging the mind. Finally, short slides allow for greater adaptability to specific workshop settings and groups of participants.

**Facilitators’ manual**

This guide contains the workshop content, as well as essential information about planning and conducting the workshop. This guide should be updated prior to each workshop.

PLANNING FOR THE WORKSHOPS

Good communication is essential to a successful workshop, and it should start before the participants even arrive. Make sure everyone knows the following in advance: Purpose of the workshop; time, date, and venue; participants’ responsibilities and schedule during the event; and any pre-workshop readings or assignments. Ask yourself what questions you would have if attending.

In order for participants to be well-rested and prepared to join the workshop whole-heartedly, encourage them to arrive one day early. If possible, have all participants lodge at the same place, so communication can continue at the end of the day, and group assignments can be more easily completed.
In your first session, make sure these points are noted:

1. **Introductions**: Participants and facilitators introduce themselves individually.

2. **Ground rules**: All agree to general code of conduct (respect, politeness, mode of address, speaking clearly, taking turns to speak etc.) at the beginning of the workshop.

3. **Keeping time**: Workshop organizer should act as a time keeper for the workshop sessions.

4. **Daily reviews**: The facilitators should hold daily reviews of the progress of workshop activities and adjust accordingly.

**KEY CONSIDERATIONS FOR TEACHING AND LEARNING**

You should read this section before you start conducting sessions.

**Preparing your sessions**

- Understand the content. In order to facilitate effective learning, you must understand the toolkit material and structure of the modules. Even if you are familiar with the topics or have conducted similar workshops, deep familiarity with the content and order of ideas is essential.

- Read all the content. Each module builds on previous modules, creating a cohesive whole. Review all modules in order to understand how they fit together. This will also help you avoid repeating previous content, or sharing something that was intended for later sessions.

- Review the objectives. Every session has a purpose (the session objectives). It is important that these are at the forefront of your mind throughout the session. Read and review these objectives, making note of how the content fits in with them.

- Consider your audience. As possible, seek to understand the participants’ background, experience, and perspective as you prepare. Which activities will be most well-received? How can you best elicit meaningful interaction and sharing of experiences? Keep in mind the number of participant and how that may affect the tone of the session, the division of groups for activities, and discussion elements.

**Facilitating sessions**

- Talk, don’t read. Rather than reading from the slides and presentation notes, share in a natural and lively way. Highlight and “unpack” the key ideas instead of reciting from a screen. Modulate your tone as appropriate to the content.

- Speak clearly. If participants have to strain to understand you, they will quickly become fatigued and lose interest. Consider the number of participants, size of
room, and project your voice so that everyone can easily hear you. Speak in a measured pace, especially if the audience includes non-native speakers.

• Don’t be boring. Make sure you face the audience, look across all faces, and make regular eye contact across the room. Moving around the room as you speak can encourage more engaged listening.

• Ensure understanding. Emphasize the main points from each slide, checking for comprehension before moving on. Ask questions, such as, “How does this apply in your context?” Or, “Why is this important?” It can be helpful to say, “Do you understand?” but don’t overuse this question.

Involving the participants

• Pay attention. You want participants to pay attention, so you should do the same. Is everyone engaged? Are they interested? Bored? Falling asleep? If enthusiasm is waning, do something about it.

• Shake things up. If participants are not engaged, there is little point in continuing. Invest five minutes in an ice-breaker, brief exercise, or short break and gain a return of renewed interest and enthusiasm for the material.

• Include everyone. When presenting, interact with all participants, by asking questions of all attending, regular eye contact, and walking around the room. Don’t hesitate to specifically ask a quiet individual a question, but don’t embarrass them either. Some will speak more than others, which is fine, but be careful not to let two or three dominate every interaction. If possible, assign an order in which participants can speak. If people know they will have a chance to talk, they will be less likely to interrupt.

• Encourage thoughtful sharing. Small groups can help people “think together”, and then bring something meaningful back to the larger group. Encourage all responses, and ask questions to clarify points being made. Comment positively on meaningful, concise responses to encourage more of the same. If you take comments and answers seriously, participants will feel more engaged and more thoughtful about the process.

• Encourage respectful discussion and sharing of ideas and experience. Learning is more effective and faster when it builds on what learners already know or have experienced.

• Connect material to life experiences. Assume that everyone has meaningful and relevant experiences with which to build on. Invite participants to share these experiences, and integrate the new concepts into their prior knowledge. When possible, refer back to what a participant shared to illustrate new material.

• Summarize regularly. Using the session objectives as a guide, revisit and extrapolate on the essential points throughout the session. Take care not to be repetitive, but do not hesitate to provide mental mileposts by recapping and reflecting regularly.

• Follow up. Note concepts that seemed unclear. Identify concerns to address later. Record meaningful ideas and anecdotes for later reflection or use in future sessions.
INTRODUCTION AND COURSE ORIENTATION
INTRODUCTION AND EXPECTATIONS:
WORKSHOP ON RESOURCE MOBILIZATION

Give a brief preamble of the module to participants

This module is designed to introduce you to the Resource Mobilization Workshop and the upcoming modules in the series. You will review the outcomes and recommendations from previous workshops and consider your expectations and objectives for this workshop. Upon completion of this module, you will be more knowledgeable about the content of the Resource Mobilization Training Workshops and be prepared for the upcoming modules.

Objectives [Slide 2]

1. To understand context for this workshop
2. To review outcomes from previous workshops
3. To consider and discuss our expectations and objectives for this workshop

Context for Country-level Resource Mobilization [Slide 3]

Covering objective 1. To understand context for this workshop

WHO Mandate for Resource Mobilization [Slide 4]

WHO remains an important and irrefutable leader in health at the global level. For example, more than 80% of external stakeholders and 94% of WHO staff see WHO as being either indispensable, or important for work to improve people’s health; two thirds of external stakeholders and WHO staff perceive WHO first and foremost as providing leadership on health matters; and 90% see WHO as the most effective organization when it comes to influencing policy for improving people’s health at the global level.

Current Funding Scenario [Slide 5]

External stakeholders clearly see the value in work that WHO does – and they are funding it – mainly through voluntary contributions. WHO is financed by a mix of assessed contributions provided by Member States (approximately 25%), and voluntary contributions provided by both State and non-State actors (approximately 75-80%).

Until WHO’s Programme Budget is financed in its entirety by assessed contributions, raising voluntary contributions through resource mobilization will continue to be of vital importance. Only 8.5% of voluntary contributions to the General Fund (total: USD 1.54 billion) was core support, as of 31 December 2012. The bulk was specified for particular projects or programmes (also called “ear marked”). More than 60% of WHO’s funding is supplied by ten contributors, with the top 20 donors providing more than 80% of WHO’s funding.

Top 20 donors provide 80% of WHO's funding

Mandate for Country Level Resource Mobilization [Slide 6]

During the workshop, we will go into more detail about how you can articulate a mandate and raise funds more confidently for your organisation. The take home messages are that you must be able to articulate and defend the mandate for resource mobilization. For example:

Mandate:

• Health needs of the population are great so more resources are needed
• WHO is credible, has technical expertise, good investment to show results, strong financial management...
**SEARO Resource Mobilization Workshops in the past [Slide 7 + 8]**

Covering objective 2. To review outcomes from previous workshops

The objective of SEARO Resource Mobilization workshops is to build capacity of WCO staff and MoH/country counterparts to mobilize resources at country level. From 2005 to 2011, SEARO conducted 5 country Resource Mobilization Training Workshops in Bangladesh, Bhutan, Maldives, Myanmar, and Nepal and 2 regional workshops in India. The workshop content was centered on introduction to general principles and methods of Resource Mobilization. Over 230 participants attended the workshops. Of these participants, 40% were from WHO (WHO Country Office, SEARO or HQ) and 60% were from the countries’ Ministries of Health or similar agencies. The feedback received from the 2012 workshop was that there was a need or more hands-on practice at the workshops and post-training. In addition, it was requested that the format be changed so that participants come from across the region, and not just from a specific WCO. This workshop has been designed to respond to the recommendations received from previous workshops.

**Expectations [Slide 9]**

**Outline of NEW Resource Mobilization Workshop [Slide 10]**

During the workshop, we will go into more detail about how you can articulate a mandate and raise funds more confidently for your organisation. Below is the list of modules included in this Resource Mobilization Workshop Training:

- Module 1 – Setting the Stage
- Module 2 – Principles of Resource Mobilization
- Module 3 – Planning for Resource Mobilization
- Module 4 – Funding Landscape
- Module 5 – Donor Communications and Stewardship
- Module 6 – Negotiations and Reporting
- Module 7 – Proposal Writing Tips
- Module 8 – Proposals Focus on Results
- Module 9 – WHO Specific Requirements
Expectations from this workshop [Slide 11]

**ACTIVITY**

Ask participants ‘What are your expectations from this Workshop?’

Distribute cards in the size of half A4 for participants to write down their expectations and place them on the wall.

Goal and Objectives of the Resource Mobilization Training Workshop [Slide 12 + 13]

The goal of the Resource Mobilization Training Workshop is to develop knowledge and skills for effective mobilization of resources for country health programmes.

The overall objectives of the workshop are as follows:

- Understand mechanisms and tools for resource mobilization
- Identify the different types of resources and donors
- Strengthen how we communicate and negotiate with donors
- Review and improve existing proposals/RM plans
- Develop some resource mobilization action points to use when you return
- Clarify WHO-specific process and work flows related to resource mobilization

Questions?

Make sure to encourage any questions from participants to ensure they understood what was covered. This should include ensuring they understand the learning objectives and the two sessions of this module.

Further Reading

FACILITATING MODULE 1

Setting the stage
MODULE 1: SETTING THE STAGE

Give a brief preamble of the module to participants

e.g.

This module is designed to familiarize you with the trends in global health funding and governance. You will consider the impact of these trends on WHO resource mobilization and understand the WHO Reform. Upon completion of this module, you will be more knowledgeable about the current situation for the SouthEast Asia Region (SEAR) in terms of funding and shared challenges and the developed Resource Mobilization Strategy from SEARO.

Outline of the module/discussion [Slide 2]

Go through the module outline with the participants to ensure they understand what will be covered. This should include the learning objectives and the three sessions of this module.

Introduction [Slide 3 + 4]

Global Funding Trends:

In the last decade, there have been changes in the funding landscape due to a push towards greater aid effectiveness and financial efficiency. There has been a gradual shift from project-based to programme-based financing, with related earmarking and tracking of funds.

Country policies and systems have integrated programmes with these trends in mind, in order to help ensure ownership and sustainability. This also means many donors are choosing to align their monitoring and evaluation (M&E) with nationally agreed-upon indicators, targets, monitoring arrangements and reporting systems. The focus is now on impact and results, and you must be able to measure and demonstrate this.
**Larger, longer-term grants** are becoming more common and this often has a positive effect of pushing grant seekers to develop more strategic, long-term frameworks for their programme, with more robust objectives and more complex implementation approaches. The emphasis is also on local ownership and planning, or *local leadership*. There are strong requirements for **coordinated efforts**, for example Sector Wide Approach (SWAp pooled funds), with a focus on forming partnerships and establishing credibility through being networked into the other important stakeholders in a particular country/funding landscape.

**Sustainability** is paramount in this new funding era.

Paris Declaration on Aid Effectiveness:

In 2005 the World Health Organization endorsed the Paris Declaration on Aid Effectiveness and was the first UN agency to adopt a Resolution on the Paris Declaration, which articulated a clear approach to harmonization at the country level. Since its adoption in 2005, the Secretariat has reported to its WHO’s Governing bodies on the progress made/monitoring of WHO’s adherence to the Paris Declaration. The declaration outlined the five following principles:

1. **Ownership**: Developing countries set their own strategies for poverty reduction, improve their institutions and tackle corruption.

2. **Alignment**: Donor countries align behind these objectives and use local systems.

3. **Harmonisation**: Donor countries coordinate, simplify procedures and share information to avoid duplication.

4. **Results**: Developing countries and donors shift focus to development results and results get measured.

5. **Mutual accountability**: Donors and partners are accountable for development results.

**Learning Objectives [Slide 5]**

1. Learn about trends in global health funding
2. Consider their impact on WHO resource mobilization
3. Understand WHO Reform
4. Understand current situation for South – East Asia Region (SEAR) resource mobilization and future strategy
Sessions [Slide 6]

1. Global health landscape
2. WHO Reform
3. Overview of Resource Mobilization in SEAR

Session 1: Global Health Landscape [Slide 7]

Covering objectives

1. Learn about trends in global health funding
2. Consider their impact on WHO resource mobilization

Global Health Trends [Slide 8]

Despite progress in improving health outcomes globally, there remain a number of ongoing challenges that still require support as well as new issues emerging.

1. Child and maternal health
   - While there was progress towards achieving these two health-related Millennium Development Goals (MDGs), the 2015 set targets will not be met in most cases and a critical challenges remain

2. Climate change
   - The future will very likely include increased frequency and severity of weather related and other natural disasters. As fresh water resources decline, temperatures increase and food supplies are compromised, a host of health challenges will result.

3. Urbanization
   - Mega cities and other large urban areas are likely to absorb a growing number of residents. According to a WHO report, 50% of the world’s population lives in an urban setting and this number is likely to increase to 70% 2050.

4. Ageing population
   - According to a recent UNFPA report, within the next decade, there will be over one billion people worldwide over the age of 60. With rising life expectancies and decreasing fertility, senior citizen numbers will increase faster than any other statistical group.
5. **Noncommunicable diseases**

- NCDs include chronic diseases, injuries, disabilities, and diseases caused by environmental hazards. NCDs now kill more people globally than infectious disease. Worldwide, chronic illness is responsible for 36 million deaths each year representing nearly two-thirds of the world’s total deaths. The estimated cost of cumulative output loss is $47 trillion by 2030. Injury is a leading cause of death and disability for all age groups worldwide causing around 5 million deaths each year.

6. **Unfinished business of infectious disease**

- Despite increased attention and resources in recent years, a focus on infectious disease remains necessary in order to prevent global spread and recurrence. While HIV/AIDS, tuberculosis and malaria are decreasing in incidence, the absence of continued support could not only impede continued progress but cause a roll back. Furthermore, there is a growing need for global health attention to diseases that are epidemic prone or vaccine preventable.

**Financing Global Health [Slide 9]**

The past decades have witnessed an increased commitment by donors towards global health. Since 1990 alone, financing has reached unprecedented levels to a historic high in 2010. Development assistance for health fell for the first time in 2011 owing to the global economic slowdown but now has levelled off. The top recipients of global health aid are listed here and aside from India at 1., 9 out of 10 are located in the Africa region which receives about 30% of health aid (over $8 billion).

Top recipients of global health aid (2012)

1. India ($2.27 Billion)
2. Nigeria ($2.25 Billion)
3. Tanzania ($1.89 Billion)
4. Ethiopia ($1.74 Billion)
5. South Africa ($1.7 Billion)

*Recipients 6-10 are also in sub-Saharan Africa.

**Financing Trends [Slide 10]**

Generally speaking, health aid increased from $5.7 billion in 1990 to $28.1 billion in 2012 and is expected to remain at about this level as we have entered an era of ‘no
growth’. South Asia as a recipient of health aid is about $1.7 billion and it is expected to decline slightly as select countries in the region shift from low to middle-income status.

*These numbers are based on the IHME 2012 Report on Global Health financing trends if people ask for more details. The report can be found online

**Governance and the Global Health Regime [Slide 11]**

**Activity**

Ask the participants: Besides WHO, what other actors are in the global health arena now?

Get participants to give a few examples. I.e. Civil society, UN agencies, NGOs, hybrid organizations, private philanthropies, private sector, academic institutions, research institutions.

In addition to the growing financial commitments to global health, the past decades witnessed an equally growing number of actors engaged in global health issues. In 1948, in the aftermath of WWII, WHO was created by 58 member states to coordinate international health. Today there are 194 member states as part of WHO and another 200 plus organizations and entities supporting global health.

WHO is no longer a singular authority but one of a growing range of actors seeking to affect change. However, WHO is the only actor with universal membership of all recognized states and therefore will continue to have a critical leadership role. Central to this system are the other relevant UN agencies in particular UNICEF, UNFPA, World Bank and other regional banks.

There are civil society organizations and NGOs which are increasingly playing an influential role. There are the hybrid organizations such as GAVI, Global Fund and UNITAID which are providing innovative solutions.

Finally, today’s landscape includes a growing range of private philanthropies, private sector and academic and research institutions. Combined, these actors are influencing the global health agenda.

**Governance Challenges [Slide 12]**

There are three main challenges to governance of the global health regime:

1. First, there is the issue of sovereignty. National responsibility remains a cornerstone for a functioning health system but in this globalized world there is an increasing
interdependence creating a need for transnational coordination and a global defining of roles and responsibilities.

2. Second, there is a growing need to shift ‘health’ out of a silo and more effectively integrate it across other sectors such as trade, investment, security, migration, etc.

3. Third, there are two levels of challenges related to accountability.
   - First, there is a growing problem of legitimacy for international organizations that are responsible to member states rather than the people whose rights they are supposed to uphold. (Are these organizations accountable to member states or upholding people’s rights?)
   - Second, there is a lack of accountability for the growing range of non-state actors increasingly engaged in global health. (Who monitors the accountability of non-state actors?)

Combined, these challenges impede the performance of the global health system.

**Responding to Global Health Challenges = WHO Reform [Slide 13]**

The current WHO reform process has been driven by the governance challenges listed in the previous section. WHO reform process has three main objectives:

1. The first is programmatic and focused on improving health outcomes
2. The second is governance and creating greater coherence in the global health regime
3. The third is management which is exploring how WHO can be an organization that pursues excellence by being more effective, efficient, responsive, transparent and accountable as an organization

**Session 2: WHO Reform [Slide 14]**

Covering objective 3. Understand WHO Reform

**WHO Reform—Resource Mobilization Context [Slide 15]**

The World Health Assembly in 2013 produced this quote about WHO Reform: "WHO needs a transparent, well-coordinated resource mobilization mechanism, with fair allocation of resources that are used and managed effectively and produce desired results."—WHA 2013.

WHO is moving towards coordinated, organization-wide resource mobilization, and is seeking to broaden the donor base and dialogues with donors to align resources with the programme budget. There is a need for resources to be based on bottom-up project planning and costing. There will still be gaps and this will take time, therefore Country-level RM will still be important to secure sufficient resources.
WHO Reform – Financing Dialogue [Slide 16]

In this new era, financing and resource allocation should be aligned with priorities in the programme budget.

WHO and Member States have committed (June and November 2013 Funding Dialogue) to greater:

- **Alignment**: Aligning voluntary, ear-marked contributions to WHA priorities
- **Predictability**: Member States and other funders increasing the predictability of their funding, for example, making public in advance their provisional commitments and moving towards multiyear commitments
- **Flexibility**: Funders moving the level of earmarking, for example, from project-level to programme-level, or from programme-level to category-level
- **Broadening of the contributors base**: In the first instance among Member States, and then among other non-State funders
- **Transparency**: Member State calls for increased transparency and accountability around WHO financing (results and programmatic, budgetary and financial monitoring information)

Session 3: Overview of Resource Mobilization in SEAR [Slide 17]

Covering objective 4. Understand current situation for SEAR resource mobilization and future strategy

Proportional Contributions from top 10 donors [Slide 18]

Share of VC by donors for 2014-2015 (As on 31 July 2015)
Total VC: USD 314 m (PB + Non PB distributed)

- GAVI, 18%
- USA, 14%
- DFID, 7%
- Bill and Melinda Gates Foundation, 5%
- GSK, 4%
- RoK, 3%
- India, 3%
- UNDPS, 3%
- UNFIP, 2%
- DFAT, Australia, 3%
- Others, 37%

* The key thing to note on this slide is that the majority of funding is received from very few donors
WHO South-East Asia Region – Trends and Challenges [Slide 19]

*The findings in this section are based upon feedback from a survey conducted with all 11 SEARO country offices.

While there are great variations between the countries across this region, there are nevertheless a number of shared priorities, challenges and gaps with regards to health programming and financing. The programmatic challenges are outlined according to the five main result areas of WHO work based on its reform:

1. Communicable Diseases: This programme area is considered a medium to high priority across the region with highest priority placed on TB. The main donors supporting WHO CD programmes in region are: GAVI, GF, AusAid, USAID, Gates, DFID and Sasakawa. More than half the countries report that they are adequately funded for this area of work.

2. Noncommunicable Diseases: this is considered a medium to high priority across the region and is a high priority for NCDs specifically (i.e. The separate subprogramme area). All 11 countries reported NCDs as a high priority. There are almost no donors supporting work on NCDs in region which is indicative of the funding situation globally. In the region, only Bangladesh, Thailand, Indonesia and India receive funding from Bloomberg Foundation and from Russia for Nepal and Sri Lanka.

3. Promoting health through life course: all but one country listed reproductive health, maternal and newborn health as the highest priority in this category.

4. Health systems: the majority of countries listed health systems as a critical programme area and one that is underfunded. There are only a few donors supporting health systems development including GAVI, WB and EU. However, the support provided is limited compared to the needs.

5. Preparedness, surveillance and response: most countries in the region believe this remains a priority programme area. The two subprogramme areas given highest priority are alert and response capacities, and emergency risk reduction and management. Most country programmes claimed that this area is adequately funded and believe the current donor based will continue.

WHO South-East Asia Region – Trends and Challenges (cont.) [Slide 20]

Critically underfunded areas of work

- NCDs
- Health systems

Shared across the region as well are the areas that are not being well-funded. Noncommunicable diseases and health systems are two areas that are critically
underfunded, and there are also very few donors who are interested in funding them. The priority therefore is to convince donors that funding these areas is important.

When asked to identify the two fund priorities, 9 countries listed health systems, 8 listed NCDs and 3 listed health through the life course (none listed CDs). Generally, in regards to the next biennium, six countries anticipated funding to remain the same, three anticipated a reduction and two expected to remain the same.

**WHO South-East Asia Region – Trends and Challenges (cont.): Resource Mobilization Challenges** [Slide 21]

1. Countries shifting from low to middle income
   - For example, Thailand, India, Bhutan, Sri Lanka, Maldives and Timor Leste list the shift from low to middle income as ’a critical hurdle to funding.’

2. High donor presence and funding pooled
   - Bangladesh, Nepal, Indonesia and Myanmar state that the high donor presence and lack of access to pooled funds as ’a constraint for resources.’

3. Minimal or no donor presence
   - Sri Lanka, Timor Leste, DPRK, Maldives and Bhutan list ‘the absence of donors’ as a challenge.

4. Implementation (to be covered next)

**VC Funds: Implementation (2014–2015)** [Slide 22]

<table>
<thead>
<tr>
<th>Total budget: $ m</th>
<th>Operational budget: $ m</th>
<th>Resources: $ m</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Of the total resources,</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carry-over from 2012–13: $ m</td>
</tr>
<tr>
<td>Mobilized during 2014–15: $ m</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Implementation (expenditure only): $ m (% against available resources)</th>
</tr>
</thead>
</table>

| Total Utilization (expenditure + encumbrances): $ m (% against available resources) |
SEARO Resource Mobilization Strategy [Slide 24]

SEARO is currently working on developing a resource mobilization and partnerships strategy. The strategy will include the following points:

- Developing a flexible approach to respond to regional trends and financial challenges
- Exploring how WHO can diversity its regional pool of donors
- Identifying ways WHO can foster partnerships
- Understanding the private sector as a partner
- Integrating RM, communications, planning
- Exploiting a variety of funding modalities

Questions? [Slide 25]

Make sure to encourage any questions from participants to ensure they understood what was covered. This should include ensuring they understand the learning objectives and the two sessions of this module.
THINK ABOUT IT! [Slide 26]

Ask participants to reflect on the impact on their own country by asking the following question:
- What are resource mobilization challenges in your country? (Try to be as specific as possible)

Quiz

Go through the questions outlined on the slide/below for the quiz. Refer back to the slide numbers in the parentheses for the answers.

1. There have been significant trends seen in global health funding in the last decade, name 4 of these trends. (Slide 3)
2. What are the 5 principles of the Paris Declaration on Aid Effectiveness? (Slide 4)
3. Name 3 global health issues that remain a challenge. (Slide 8)
4. What one country in the top recipients of global health aid is not in Africa? (Slide 9)
5. What percentage of all global health aid does Sub-Saharan Africa receive? (Slide 9)
6. What are some examples of other actors in the global health arena currently? (Slide 11)
7. What are the 3 governance challenges we are facing today? (Slide 12)
8. What are the 3 WHO Reform objectives? (Slide 13)
9. In this new era, financing and resource allocation should be aligned with priorities in the programme budget and subsequently, WHO and Member States have committed to increase 5 things. What are those 5 things? (Slide 16)
10. What are the 5 shared challenges SEAR faces? (Slide 19)
11. What are the 2 critically underfunded areas in SEAR? (Slide 20)
12. What are the 4 resource mobilization challenges in SEAR? (Slide 21)
13. Name 4 (out of 6) of the SEARO Resource Mobilization Strategy (Slide 24)
Further Reading


FACILITATING MODULE 2
Principles of resource mobilization
MODULE 2: RESOURCE MOBILIZATION KEY PRINCIPLES

Give a brief preamble of the module to participants

e.g.

This module is designed to familiarize you with the key principles of resource mobilization and to be able to easily see the big picture of the recourse mobilization cycle. It will outline the four components to resource mobilization and walk you through the steps. You will become comfortable with these four steps and will walk away with some resource mobilization tips and ‘don’ts’, as well as cultivating donor relations.

Outline of the module/discussion [Slide 2]

Go through the module outline with the participants to ensure they understand what will be covered. This should include the learning objectives and the two sessions of this module.

Learning Objectives [Slide 3]

1. Understand key principles of resource mobilization
2. See the “big picture” of the resource mobilization cycle
3. Become familiar with the four components of the RM Cycle
4. Understand some RM “don’ts”

Introduction [Slides 4 + 5]

In 2005 the World Health Organization endorsed the Paris Declaration on Aid Effectiveness and was the first UN agency to adopt a Resolution on the Paris Declaration, which articulated a clear approach to harmonization at the country level. Since its adoption in 2005, the Secretariat has reported to its WHO’s Governing bodies on the
progress made/monitoring of WHO’s adherence to the Paris Declaration. The declaration outlined the five following principles:

1. **Ownership**: Developing countries set their own strategies for poverty reduction, improve their institutions and tackle corruption.

2. **Alignment**: Donor countries align behind these objectives and use local systems.

3. **Harmonisation**: Donor countries coordinate, simplify procedures and share information to avoid duplication.

4. **Results**: Developing countries and donors shift focus to development results and results get measured.

5. **Mutual accountability**: Donors and partners are accountable for development results.

**Sessions**

1. Importance of Resource Mobilization
2. Resource Mobilization Planning Process
3. WHO Reform and Resource Mobilization Planning Process

**Session 1: Resource Mobilization – Key principles** [Slide 6]

Covering objective 1: Understand key principles of resource mobilization

**It’s not just about money** [Slide 7]

**The impact of Resource Mobilization** [Slide 8]

When Resource Mobilization is done well, the following are the results can occur:

- You can mobilize **new** or additional resources
- You can **diversify** funding sources
- You can build or expand **partnerships** and **relationships**
- You can increase **communications**
- You can build organizational capacity
- You can properly monitor and **evaluate** your resource mobilization activities
**Key Principles of Resource Mobilization [Slide 9]**

There are many aspects in Resource Mobilization but the key principles are:

- You have to **ask**
- A personal approach to the donor is preferred
- Understand the donor’s viewpoint
- Demonstrate your impact on people
- Show need and use of funds
- Always say thank you
- Build long-term relationships with donors
- Be accountable and report back in a timely fashion

**Bilateral Agencies [Slide 10]**

- Show commitment to the cause
- Be persuasive
- Learn how to deal with rejection
- Show persistence
- Be truthful
- Show patience and tact
- Be organized
- Donor contacts
- Look for opportunism


**Many kinds of resources [Slide 11]**

Funding is the main resource that we talk about when we speak about resources but there are many other things to consider a resource.

**ACTIVITY**

At this slide, ask participants to give examples of some other things that can be provided as a resource. Encourage them to think back to a time when they have received these kinds of resources and the experience of working with a non-financial resource.

Non-financial types of resources:

- Time and expertise
- Goods or in kind donations
• Voice (especially in advocacy initiatives)
• Influence
• Information

**Session 2 – Resource Mobilization Cycle [Slide 12]**

Covering objectives

2: Introduce the resource mobilization cycle (RM Cycle);
3: Become familiar with the different components of the RM Cycle and;
4: Understand some RM “don’ts”

**Resource Mobilization Cycle [Slide 13]**

• The most important thing to note about the Resource Mobilization Cycle is that it is indeed a cycle;
• There is a starting point and each stage leads to the next until you begin at the first step again, following through the steps continuously
• Resource Mobilization is not just about the end product (submitting a proposal), but about the work leading up to the proposal and the continued work afterwards
• To be successful, this pre- and post-work is critically important
• There are four basic components to the cycle:
  1. Needs analysis and planning
  2. Donor research/cultivation
  3. Proposal writing (there are other ways that donors are solicited for funding, but since WHO raises funds primarily from institutional donors we will concentrate on proposals)
  4. Reporting and Stewardship
Step 1: Needs Analysis [Slide 14]

Much of the needs should be captured in each WHO Country Cooperation Strategy and Operational Plan.

Questions to that will guide you in this step are:

- What is the problem or the need?
- Who does it affect and where?
- How many are affected – how big is the problem?
- Why has it happened?
- What can be done about it?
- What will happen if nothing is done?
- How much funding is needed for the work?

Planning according to your country [Slide 15]

Refer to the following documents to ensure proper planning according to your country’s goals and strategies:

- WHO General Programme of Work 2006-2015, Medium Term Strategic Plan (MTSP), Programme Budget
- WHO Country Cooperation Strategy (4-6 years) and Country Plan, in support of country’s national health policy, strategy, or plan
- Programme Budget
- Country’s Operational Plan
**WHO Planning Framework at Country Level [Slide 16]**

![Diagram of WHO Planning Framework]


**Resource Mobilization Gaps/Needs [Slide 17]**

The below table outlines the resource mobilization gaps and needs of your programme:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2a. Requirement</td>
<td>2b. Available</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL RM NEEDS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**ACTIVITY**

Get participants to reflect on the following questions when drawing up the Resource Mobilization Table of Needs:

- What is your organization going to raise money for in the next few years?
- What will the funds accomplish?
- What does the timeline say about your organization’s financial situation?
- Why is it important to distinguish between restricted and unrestricted funds?
- Why is it important to identify resource gaps?
- What will happen if the funds are not received?

Source: IDRC Resource Mobilization Guide for CBOs 2010
Step 2: Donor Cultivation [Slide 18]

- Process of getting to know the donor
- Ensure to target and research specific donors you are interested in pursuing and will benefit your team the greatest (can be different donor for each programme’s funding needs!)
- Consider UN/multilateral, bilateral, government, INGOs, and corporate sector donors.

When deciding on donors to approach, consider the donor’s:

- Link—connection to WHO
- Interest—in the programmes
- Capacity—how much?

Researching donors: Funding Priorities [Slide 19]

When considering donors, what information it useful to research about them? You should be:

- Looking at their current interests (policies and priorities)
- Checking their official policy, reports, statements made by government officials on various issues
- Looking at their grant making strategies and streams
- Determining whether they have a local, national, or regional reach
- Considering whether they prefer consortiums
- Looking at where they fund and what they have funded in the past
- Asking if there is a donor country office in your country? Or a regional office?
- Refining your project idea to present it in a way that matches the donor’s focus
- Asking how can your project advance their agenda?

Researching donors: Practicalities [Slide 20]

Before approaching a donor, ensure you know:

- Deadlines (annual cycle?)
- Legal requirements (e.g. foreign funding)
- Application formats and procedures
- What information you will need to supply
- How the work has to be evaluated
- Contact points
- Any other specific requirements
**Step 3: Proposals [Slide 21]**

The funding proposal forms the basis of your relationship with a donor. If the donor can see that it is hastily written, without careful thought and planning, the relationship may be a very short one! Rather, give the impression based on fact, that you are thorough, careful and committed to doing a good job, right from the start.

**Proposal Writing: The basics [Slide 22]**

- Plan the project before you start writing
- Understand all the questions/sections first
- Focus on technical details but also on overall persuasiveness, logic and flow of the writing
- Ensure you have enough time to write the proposal
- Ensure the right people involved (technical, finance, Resource Mobilization focal point)
- Develop a matching budget

**Step 4: Reporting [Slide 23]**

- Demonstrate the impact of the funding (the results of the programme)
- Demonstrate fiscal accountability and transparency (by spending in line with the donor’s expectations and reflecting an efficient use of funds)
- Quantitative reporting (this includes financial reports and ‘impact numbers’)
- Qualitative reporting (the narrative of the programme, ‘storytelling’)
- Essential to adhere to all timelines and donor requirements

**Now what? [Slide 24]**

**ACTIVITY**

- Ask participants to think about the next steps after submitting a report to a donor. Give time for multiple answers and make sure participants truly reflect.

**Donor Stewardship [Slide 25]**

- Concept of ongoing donor relations
- Bringing donors closer to the programme results and to the WCO/Ministry
- Nurturing relationships with individual managers/decision-makers and/or with donor organizations broadly
- You are seeking information and opportunities to renew their support
Resource Mobilization Tips [Slide 26]

- Make personal contact with your donor! (visit/call)
- Assume nothing – be prepared and have a pitch prepared in case the opportunity presents itself
- Prepare handouts or other documentation
- Be flexible in the early stages (but not too flexible)
- If presented with a 'no', what kind of 'no' was it? What reason was given? Is it surmountable?
- Keep in contact on to your donors, including non-participating donors

Source: Adapted from "21 Tips for Fundraising", by David Glover, Team Leader, Environmental Economics, IDRC (handout)

Fundraising Don’ts [Slide 27]

A few things to keep in mind when fundraising:

- Don’t send ‘unsolicited’ proposals
- Don’t send a shopping list
- Don’t run down your competitors
- Don’t make claims you can’t substantiate
- Don’t request more than donor’s maximum grant
- Don’t stalk the funder!
- Don’t submit your reports late
- Don’t submit without proof reading
- Don’t work alone – teamwork is vital

Source: Bisi Adeleye-Fayemi, African Women’s Development Foundation, presentation made in 2009

QUESTIONS?

Make sure to encourage any questions from participants to ensure they understood what was covered. This should include ensuring they understand the learning objectives and the two sessions of this module.
Quiz

Go through the questions outlined on the slide/below for the quiz. Refer back to the slide numbers in the parentheses for the answers.

1. What are some impacts of Resource Mobilization? Name 4. (Slide 6)
2. Name the four steps on the Resource Mobilization Cycle. (Slide)
3. What things should you be researching about your donor? Name 2 things about the donor’s funding priorities and 2 things about the donor’s practicalities you should research. (Slide 17 and 18)
4. What are some of the basics of proposal writing? Name 4. (Slide 20)
5. What are some resource mobilization tips? (Slide 24)
6. What are some fundraising ‘don’ts’? (Slide 25)

Further Reading

- Bisi Adeleye-Fayemi, African Women’s Development Foundation, presentation made in 2009
Give a brief preamble of the module to participants

This module is designed to familiarize you with the concepts of resource mobilization and how to plan for effective resource mobilization. It will outline the resource mobilization planning process and walk you through steps. You will become comfortable in planning for effective resource mobilization and understand the implications of WHO Reform on resource mobilization.

Outline of the module/discussion [Slide 2]

Learning Objectives [Slide 3]

1. Understand the importance of planning in resource mobilization
2. Learn how to plan for effective resource mobilization
3. Understand how WHO Reform process will affect resource mobilization planning

Introduction [Slides 4 + 5]

In 2005 the World Health Organization endorsed the Paris Declaration on Aid Effectiveness and was the first UN agency to adopt a Resolution on the Paris Declaration, which articulated a clear approach to harmonization at the country level. Since its adoption in 2005, the Secretariat has reported to its WHO’s Governing bodies on the progress made/monitoring of WHO’s adherence to the Paris Declaration. The declaration outlined the five following principles:
1. **Ownership**: Developing countries set their own strategies for poverty reduction, improve their institutions and tackle corruption.

2. **Alignment**: Donor countries align behind these objectives and use local systems.

3. **Harmonisation**: Donor countries coordinate, simplify procedures and share information to avoid duplication.

4. **Results**: Developing countries and donors shift focus to development results and results get measured.

5. **Mutual accountability**: Donors and partners are accountable for development results.

**Sessions**

1. Importance of Resource Mobilization
2. Resource Mobilization Planning Process
3. WHO Reform and Resource Mobilization Planning Process

**Session 1: Importance of Resource Mobilization [Slide 6]**

**Why create a Resource Mobilization Plan? [Slide 7]**

If the resource mobilization plan matches the programme needs, it can lead to great success, by demonstrating the following things:

- It identifies the action items for each part of the resource mobilization cycle
- It shows how the budgeted financial goals will be met
- It captures the needs analysis, donor research, anticipated proposals, and reporting/stewardship
- It is proactive, not just reactive, to Requests for Proposals (RFPs) or to donor demands
- It allows for identification of strategic or operational issues that may impact resource mobilization and their proposed resolution
- It can identify needed resources that will enable effective resource mobilization
- It allows you to monitor and evaluate your resource mobilization activities
Session 2: The Resource Mobilization Planning Process [Slides 8 – 10]

The resource mobilization planning process is a continuous process and each stage provides foundation for the next step.

Steps in the resource mobilization planning process:

1. **Identification** – generation of the initial project idea and preliminary design
2. **Preparation** – detailed design of the project addressing technical and operational aspects
3. **Appraisal** – analysis of the project from technical, financial, economic, gender, social, institutional and environmental perspectives
4. **Proposal preparation, approval and financing** – writing the project proposal, securing approval for implementation and arranging sources of finance
5. **Implementation and monitoring** – implementation of project activities, with on-going checks on progress and feedback
6. **Valuation** – periodic review of project with feedback for next project cycle.
1. **Identify Objectives [Slide 11 + 12]**

Look at the context in which your WCO operates (needs assessment) and based on this analysis, formulate your resource mobilization objectives.

External environment/context considerations:

- What kinds of grants are happening?
- What are the opportunities you may take advantage of?
- What are the threats/challenges?
- How well positioned is WCO in relation to donors engaged with the country? (What is the reputation and image of WHO and/or WCO in the country?)

Internal context considerations:

- Identify major project/programme expenditure for next three years (this will be based on the needs analysis for the country, as captured in the Country Office Plans)
- Identify income by source (resources received/expected) for next three years
- Compare the two and calculate the funding gaps or surplus – this is also called a table of needs
- Evaluate the gap and decide what is achievable (these are the resource mobilization goals)
- Ensure they are quantified in terms of programme targets and financial amounts
- Decide how to measure success

*A Table of Needs helps WCO and also gives guidance to donors about where additional resources are needed.*

### Table of Needs [Slides 13 + 14]

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2a. Requirement</td>
<td>2b. Available</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL RM NEEDS**
A few considerations when resource mobilization planning:

• What is your organization going to raise money for in the next few years?
• What will the funds accomplish?
• What does the timeline say about your organization’s financial situation?
• Why is it important to distinguish between restricted and unrestricted funds?
• Why is it important to identify resource gaps?
• What will happen if the funds are not received?

**Linking of a country’s finances and resource mobilization [Slide 15]**

(Linking of a country’s planned costs, financial resource management and resource mobilization)

It is important to have a clear understanding that the allocations of ALL known financial resource and forecast. This leads to a better alignment of resource to results deliverables in the approved programme budget. Too often, AC and other flexible funds are not being taken into account when planning resource mobilization, hence significant overshots.

<table>
<thead>
<tr>
<th>Item</th>
<th>Amount (m)</th>
<th>Amount (m)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cat 1-5 Planned costs, Country X</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Cat 1-5 Allocated AC</td>
<td></td>
<td>2.5</td>
</tr>
<tr>
<td>Carry-forward VC</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>New VC known</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Shortfall Cat 1-5 at start</td>
<td></td>
<td>5.5</td>
</tr>
</tbody>
</table>

2. **Prepare a Resource Mobilization Plan [Slide 16]**

Preparation of a resource mobilization plan requires identifying resource mobilization activities and other/supportive activities that are required.

---

Resource Mobilization Activities:
1. Resource Mobilization Objectives
2. Donor research/communication
3. Proposal and reports (both known and anticipated)
4. Stewardship activities

Support/other:
1. Roles and responsibilities
2. Required resources
3. General timeline (i.e. When the major items related to your resource mobilization plan will happen in the year)
4. Process for M&E

* This is a sample format for an RM Plan – adapt it to suit your needs.

3. Agreement/Approval [Slide 17]

Once identified, make sure to present the resource mobilization plan to all involved and secure commitment. Identify resources or tools that you will need to implement the plan such as:

Management support

- Necessary authority
- Necessary skills
- Adequate training
- Time
- Materials

4. Implement [Slide 18]

Once you have identified your objectives, prepared your plan, received agreement/approval, it is time to implement your resource mobilization plan.

5. Monitor and Evaluation [Slide 19]

Ensure to monitor the plan at regular intervals during the year and evaluate the plan, both in terms of results (funds raised, cultivation activities, potential partnerships, etc.) and process (what worked, where were the setbacks, what needs to be improved in the future, etc.). During this process, consider resource mobilization objectives for next year.
Session 3: WHO Reform [Slide 20]

Implications for Resource Mobilization [Slides 21 + 22]

The below image refers to Session 2 of Module 1 – Setting the Stage.

Below are the ways in which WHO Reform affects Resource Mobilization:

• WHO-wide, there is a shift to programme-driven, rather than donor-driven, resource mobilization
• There is a need for resources to be based on bottom-up project planning and costing
• You may have to say “no” to donors
• There will still be gaps and this will take time, country-level resource mobilization will still be critical
• What is the purpose of the financing dialogue? [Slide 23]
• Full funding of the programme budget, with at least 70% predictable financing at the start of the 2016-2017 biennium
• Better alignment of resources to results and deliverables in the approved programme budget
• Flexible financing to support better alignment to results
• Expansion of the traditional donor base
• Increase transparency for a common understanding of financing sources and shortfalls

Questions?

Make sure to encourage any questions from participants to ensure they understood what was covered. This should include ensuring they understand the learning objectives and the two sessions of this module.
Quiz

1. What are some reasons to create a Resource Mobilization Plan? Name 4. (Slide 7)
2. Name the 5 steps in the Resource Mobilization Planning Process. (Slide 9)
3. Name 3 external environmental/context considerations when identifying objectives. (Slide 11)
4. What does the Table of Needs identify? (Slide 12)
5. What are some implications of WHO Reform on Resource Mobilization? Name 3. (Slide 22)

Further reading

Give a brief general preamble of the module to participants:

This module is designed to emphasize the importance of national context and donor motivation. It also highlights recent trends in donor behaviour, including the critical growth areas of philanthropy and corporate social responsibility. Finally, it emphasizes that successful resource mobilization relies more on how much you know about prospective donors, than what they know about your organization or initiative.

Introduction [slides 2–4]

Before your session, read this section carefully and speak to slides 2–4. Prior to showing slides 3 and 4, they can be introduced/prompted using the following questions to participants:

Slide 3: Which countries do you think are the five main global recipients of development assistance for health?

Slide 4: What proportion of all funding for global health assistance do the Bill & Melinda Gates Foundation contribute?

Over the past two decades, the global public health sector has been transformed. In 1990, global health funding was around US$ 5.6 billion and the principal actor was WHO. Today, over 40 bilateral agencies, 25 UN organizations, 20 global and regional funds, and more than 90 global initiatives, focus specifically on health activities and assistance. Funding for global health has reached around US$ 30 billion per year. With many commentators suggesting that the ‘golden age’ of global health financing is coming to an end, understanding the health-related funding landscape is arguably more important now than ever for anyone seeking to mobilize resources.
As recently as five years ago, the top five recipients of development assistance for health (2008–2010) were Ethiopia, India, Nigeria, South Africa and Tanzania. Three of those countries are now among the largest and fastest-growing middle-income economies.

The rate of increase in DAH has slowed as the global economic downturn has constrained aid budgets. Latest available data show that DAH is still increasing, but only by about 4.0% from 2012 to 2013. This includes increasing disbursements by public–private partnerships, such as GAVI and the Global Fund, as well as through direct bilateral and multilateral assistance. The aid architecture is undoubtedly changing, including an increasing emphasis on low-income settings. This is forcing even greater emphasis on domestic financing for health, particularly in middle-income countries and their decreasing eligibility for DAH.

As an increasing number of low- and middle-income nations experience strong economic growth, demands and expectations of health services are likely to increase significantly. During this time, public sector health spending will need to draw increasingly from domestic government health budgets, as contributions from external donors are inevitably reallocated to least developed countries.

In 2013, while donors provided low- and middle-income countries with more than five times the DAH they did in 1990 (US$31.3 billion), this was less than 1% of what developed countries spent on improving and maintaining the health.1

Private philanthropy has also grown significantly, with the Bill and Melinda Gates Foundation (BMGF) being the notable example, and which now contributes around 5% of all funding for global health assistance. Nongovernmental organizations have also had a growing and financially sustained position in the global health landscape. For example, Partners for Health, which had an annual budget of US$ 40 million in 2008, now operates in nearly 20 countries with an annual budget of US$ 120 million.

Outline of the module/discussion [slide 5]

Go through the module outline with the participants to ensure they understand what will be covered. This should include the learning objectives and the two key concepts of this module.

---

Learning objectives [slide 6]

At the end of this module, participants will:

• Be aware of the types of donors that fund global health programmes/initiatives.
• Understand current and potential emerging sources of funding for WHO/SEARO.
• Know where to find information on specific donors.
• Brainstorm around potential donors for your country and identify specific action points.

Key concepts

• Who funds global health?
• Identifying interested donors in your country.

1. Who is funding global health?

Major health-focused donors can be divided into the following main groups:

Bilateral agencies [slide 9]

This donor group is one of the most familiar for WHO in the SEARO region, and one of the most predictable funding sources. While many donors active in the region might be in a position to increase their financial commitments to health, bilateral agency funding is currently plateauing and hence largely static. Once exception may be newly-classified middle-income countries considered to have emerging market economies (EME). EME aid programmes are growing, and their civil societies are also expanding in some countries.

As a group, bilateral donor countries have diverse and specific respective priorities for allocating support, as well as preferred strategies/approaches, and understanding these tendencies is crucial before discussing support for specific programmes. Bilateral donors generally transfer funds directly to another country, making the use of funds – and resulting outcomes and impact – more transparent and accountable. Bilateral funding can be core and/or earmarked for specific programmes and priority areas.
Industrialized and middle-income country governments are urged by their constituencies to support developing countries and related areas of work, frequently as part of their official foreign policy, and as a continuation of historical colonial, political and trade relationships. Most national donor governments provide aid through independent agencies, such as the United States Agency for International Development (USAID), the United Kingdom Department for International Development (DFID) and the Japan International Cooperation Agency (JICA). In 2013, two important donor countries – Australia and Canada – surprised the development community by abolishing their specialized international development agencies, opting to fully integrate their functions and responsibilities into the department of foreign affairs in each country.

**Patterns of government development aid [slides 10–12]**

Many potential motivations exist for countries to provide development aid [slide 10]:

- To build a relationship: Aid can be part of bilateral agreements that include trade agreements and other aspects of the relationship.
- To alleviate global poverty and hardship, and promote peace.
- To build a partnership: To be part of a group of participating countries, such as the Commonwealth.
- Foreign policy: A country may have various geopolitical objectives, and aid can help them meet those goals.
- Economy improvement: Investing in global development and growth will ultimately impact the future of each nation.

While on average donors dedicate around 18% of development aid specifically to health, some countries treat health as a major priority and assign a far higher proportion to health-related areas [slide 11]:

- Ireland and United Kingdom (~40% of development aid to health)
- Luxembourg (~36%)
- United States (~28%)
- Canada (~25%)
Development aid can be measured in absolute amounts, although for comparative purposes it is also expressed as proportion of national income [slide 12]. Only five countries have met the long-standing aid target of providing 0.7% of gross national income (GNI) to aid:

- Norway (1.07% GNI)
- Sweden (1.02%)
- Luxembourg (1.00%)
- Denmark (0.85%)
- United Kingdom (0.72%)

**Country programmable aid (CPA) [slide 13]**

CPA (also known as ‘core’ aid) is the portion of aid that donors assign for individual countries, and over which partner countries have a significant influence.

The ongoing global economic crisis reduced aid spending between 2009 and 2012, and funding is currently predicted to rebound to pre-crisis levels, but then remain stagnant going forward. The major increases in current CPA are projected for middle-income countries such as China, India, Indonesia, Pakistan, Sri Lanka, Uzbekistan and Viet Nam. It is most likely that the increased programming towards those countries will be in the form of bilateral and multilateral ‘soft loans’.

Interestingly, Asia region receives the largest total amount, but lowest per capita, CPA of all regions.

**Multilateral agencies [slide 14]**

As the name suggests, multilateral organizations are those established, supported and/or governed by a range of different countries in collaboration. Examples include the United Nations Children’s Fund (UNICEF), the World Bank and the Association of South-East Asian Nations (ASEAN).

Most of the resources made available to these organizations are from member state contributions or other direct bilateral contributions. Increasingly, many of these organizations are also recipients of private funds either from foundations, individuals or the private sector.

**Foundations² [slides 15 and 16]**

As independent institutions, often set up by wealthy individuals, families or corporations, foundations generally see informed grant-making as their main function. They tend to be focused on specific areas of interest and funding, and tend to be more flexible and innovative than bilateral donors.

² Also known as ‘trusts’ in some settings.
The fundamental challenges that a charitable foundation gives money to help address are usually described in its founding documents and website, reflecting the desire and interests of the original donors to the foundation. Foundations vary in size and scope, ranging from smaller nationally-focused to those with very broad interests and global coverage. They may generate their income from either endowments or through ongoing fundraising.

Foundations typically offer grants to individuals, organizations or governments to catalyze social change. Private philanthropy has become a growing influence especially in health. For example, the Bill and Melinda Gates Foundation is now the fifth largest donor to WHO.

**Foundations are established and fund initiatives according a range of motives [slide 16]:**

- Sympathy, empathy or belief: Original founders were concerned about a specific issue or challenge and/or believed in a particular approach.
- To bring about change: Belief that the funding will make a difference in the world.
- Match of interests: The founding group and/or existing leadership wants to ensure certain issues/projects are funded.
- Compelled to give: Funding is written into the organizational constitution.

**Business and the corporate sector [slides 17–19]**

Philanthropy by businesses and corporate social responsibility (CSR) are closely linked and frequently seen as synonymous. However, CSR is distinguished as business practices that integrate goals and outcomes regarded as ‘social good’. An estimated 20% of health funding comes from private sources.

Corporate giving of all kinds is well established in the United States and Europe. Given the fastest rates of economic growth and wealth accrual in the world, philanthropy is one of the newest and most rapidly growing forms of non-profit financing in Asia.

Some examples of health-related corporate philanthropy:

- Goldman Sachs and applying its financial mechanisms to help fund GAVI, the vaccine alliance.
- Coca-Cola offering its logistical capacity to distribute condoms and health messaging, in order to help combat the spread of HIV.
- GAP, American Express, Starbucks and Apple contributing a percentage of profits on specific products to the Global Fund.
Even within companies, effective and well-supported safety and health-care programmes can be of significant benefit to companies and employees, their families and communities. For example, ensuring safer working standards and healthy workplace environments can increase workers’ productivity through lower sickness and absenteeism.

Corporate giving is often less complex and faster than financing from ‘traditional’ donors. Companies may have several channels to choose from (e.g. CSR programme, dedicated foundation or marketing budgets), and are likely to place more importance on accountability, particularly in relation to finances. The private sector is also an important potential source of non-cash resources, including skills and expertise that may be made available as in-kind, short-term volunteers or other forms of capacity-based sponsorship.

Philanthropy by businesses and CSR generally depend on company performance and profit, and may be an ‘investment’ aimed at encouraging a particular perception about a firm, or influencing future profitability. Some of the many reasons companies support non-profit initiatives include [slide 18]:

- Aligns with corporate priorities and interests: A given project proposal aligns with the firm’s interest/goals.
- Improves the company image: promotes community/customer perception that the company cares about important issues, and are engaged in the community etc.
- Indirectly promotes their interest: For example, some companies support awareness-raising in specific areas of health because they sell related medicines.
- Generates direct publicity or exposure: Through brand exposure and highlighting of products to potential customers.
- Leads to tax efficiencies: Corporate donations may be eligible for tax deductions.

The top five companies supporting global health initiatives are listed in slide 19.

**Global health initiatives and public–private partnerships [slide 20]**

Following the adoption of the landmark Millennium Development Goals (MDGs) in 2000, new financing mechanisms and global health initiatives (GHI) were established to channel resources aimed at addressing the mostly ‘vertical’ health-related MDG priorities. This included: the Roll Back Malaria Partnership (established in 1998); the Stop TB Partnership (2000); the Global Alliance for Vaccines and Immunization (GAVI); the World Bank Multi-Country AIDS Programme (MAP, 2001); the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM; 2002); the US President’s Emergency Fund for HIV/AIDS Relief (PEPFAR; 2003), and UNITAID (2006).
A large proportion of development assistance for health is still channelled through GHIs, with an estimated 70% global health funding allocated to HIV, Tuberculosis and malaria. However, evolution in national eligibility criteria – coupled with the limited availability of funding for cross-cutting health priorities – means that GHI funding is concentrating in a diminishing number of low-income countries.

**International nongovernmental organizations [slides 21 and 22]**

Large nongovernmental organizations frequently have long-term funding relationships with their respective national governments and other donors, and may also raise funds directly through public appeals and other mechanisms.

Interestingly, international nongovernmental organizations and government counterparts share common characteristics [slide 22]:

- Large-scale funding and operational scope.
- Clear technical/health-related priorities.
- Narrow and well-defined eligibility criteria.
- Complex application and reporting procedures.
- Project/programme-based funding.
- Funding tends to be influenced by MDGs and other global frameworks/goals.
- Broad development focus.
- Seek partners with implementation/delivery expertise.

**2. Identifying interested donors in your country**

**Complexities of funding [slide 23]**

As the number of health-related organizations has expanded over the past decade or so, their roles in relation to global health funding/financing have differentiated into three main areas:

- providing funds;
- managing funds;
- using funds to support programme implementation.

**Resources for neglected diseases [slide 24]**

Neglected tropical diseases (NTDs) disproportionately affect the so-called ‘bottom billion’ — the 1.4 billion people who live below the US$1.25 per day poverty line. The 17 NTDs listed by WHO are prevalent in 149 countries and share many common features. These include their prevalence in poor and disadvantaged populations, and
their significant impact on child and maternal health, on global and national economic output and on progress towards global development goals.

Donors that specifically prioritize NTDs include US National Institutes of Health (NIH), Bill & Melinda Gates Foundation, the European Commission, USAID, DFID, the Wellcome Trust, the UK Medical Research Council, the Government of the Netherlands, Inserm – Institute of Infectious Diseases, Institute Pasteur, and the Australian NHMRC. Biotech and pharmaceutical companies working on innovative medicines, vaccines and diagnostic tests for NTDs may also be potential funders.

Identifying interested donors in your country [slide 25]

Potential funding sources for WHO Country Offices include: WHO headquarters, South-East Asia Regional Office; national government; bilateral donors with an interest in your country; multilateral agencies/bodies (e.g. UN, ADB, EU, ASEAN); foundations; international NGOs; foreign embassies in your country; private sector; and high-wealth individuals. One approach to identifying new donors is to actively network and meet with current supports, and other partners, to explore connections to other potential funders.

Resource mobilization depends less on what potential donors know about your work or priorities, than it does on how much you understand about potential donors. You cannot expect to align your priorities and/or programmes with potential donor interests if you have not done sufficient technical and strategic research on specific donors.

Researching possible donors [slide 26]

As highlighted throughout this module, there are many important differences between donors and their varying funding focuses. When you begin to assess a potential donor, however, there are some general types of information you should take into account:

- What are their stated funding interests and priorities?
- Are there any obvious new interest areas they focus on?
- Do they use specific terminology or ‘buzzwords’ you could tune into?
- What is their general scale of support – total and individual grant?
- Are there specific funding modalities they tend to adopt?
- What is their preferred geographical focus?
- Is their grant-making/giving history evolving or changing?
- Are they interested in particular cross-cutting themes?
- What is the application mechanism? Unsolicited or invitation only?
- Is there a clear funding ‘window’ or cycle?
Sources of information [slide 27]

With the popularization of online information sharing, it is hard to predict the optimal sources for donor information until you begin to search and follow interesting links. Here are a few suggested sources you should consider:

- Specific donor/funder web site, and those of main grant recipients.
- National/Country cooperation strategy document(s). These may have a specific section on development cooperation and partnerships, including donors active in the country.
- HQ/SEARO Donor Profiles.
- Funders of other health organizations in the country/region or with similar issue focus.

Question

1. Name different types of donors (Slide 9-23)
2. Identify key donor/s in your country.
3. Name potential donors in your country and issues they might be interested in funding. (Slide 27)

Further reading

FACILITATING
MODULE 5
Donor Communications
and Stewardship
Facilitating Module 5: Donor Communications and Stewardship

Give a brief general preamble of the module to participants:

e.g.
This module is designed to highlight the main parts of a strategic communication and communication plan, focusing especially on a donor audience. It highlights the need to identify the communication outcome, structure your message, consider the audience, and identifies how to overcome common barriers to effective communication. The module also emphasizes key steps in establishing, cultivating, and stewarding effective donor relationships.

Outline of the module/discussion [slide 2]

Go through the module outline with the participants to ensure they understand what will be covered. This should include the learning objectives and the two key concepts of this module.

Learning objectives [slide 3]

At the end of this module, participants will:

1. Increase their understanding of construct strategic communications
2. Increase their understanding of donor’s requirements
3. Learn how to build stronger relationships with donors and market WHO
4. Increase their understanding your role and communicate effectively through a good communication plan
Introduction [Slides 3 + 4]

Before your session, read this section carefully and speak to slides 2 + 3

[Slide 3]: Over the past two decades, the global public health sector has been transformed. In 1990, global health funding was around US$ 5.6 billion and the principal actor was the World Health Organization. Today, over 40 bilateral agencies, 25 UN organizations, 20 global and regional funds, and more than 90 global initiatives, focus specifically on health activities and assistance.

Funding for global health has reached around US$ 30 billion per year. The rise of public–private partnerships is likely to continue with GAVI Alliance financing as the most successful example of a sustained trajectory. The other significant example of importance is the Global Fund to fight AIDS, TB and Malaria (GFATM). Private philanthropy grew significantly during this timeframe, with the Bill and Melinda Gates Foundation (BMGF) being the notable example, and which now contributes 5% of all funding for global health assistance. Nongovernmental organizations have also had a growing and financially sustained position in the global health landscape. For example, Partners for Health, which had an annual budget of US$ 40 million in 2008, now operates in nearly 20 countries with an annual budget of US$ 120 million.

[Slide 4]: Noncommunicable Diseases (NCDs) are on the rise all over the globe (with 80% of illness and deaths from these causes occurring in in developing countries), urbanization is moving more than half of the world’s population to set up their lives in cities, and overall we have a very large aging population. There is also a large conflict-driven migrating population that is difficult to reach and prone to illness as well as incredible health security challenges as climate change effects, emerging communicable diseases and food safety concerns transcend national borders with ease. In addition, there is more competition for resources and health leadership, due to an increase in development donors and partners, private sector companies, and NGO’s. Some of these new actors are encroaching on previously held WHO areas of work (such as GAVI providing immense funding for immunizations).

As the era of high growth is reportedly ending and stagnation ensuing, the need to identify other funding sources will become critical in order to meet the rising costs of global health-care. This requires a focus on fostering current and creating new donor relationships, through effective communication and understanding the wants and needs of donors.

The Regional Director and Deputy Regional Director needs staff who are aware of donor needs, and skilled to interact with partners. They hope that you can learn about what
active relationship-building is and how to carry it out so we can deliver client-oriented service. This is through making your own contacts with donors (WR, cluster leaders, programme officer, NPO’s, etc.) and increasing dialogue with local representatives. You should feel comfortable in asking the donors what they want and need. This is all in the context of WHO reform for strategic communications. WHO has endeavoured to need change how it works to meet public expectations and interests of its supporters. This means being selective and being relevant in a changing public health and development context. We want to ensure our donors that we will listen to them and respond to their needs.

**Learning objectives (Slide 5)**

1. Understanding of strategic communications
2. Increase your understanding of donors requirements
3. Learn how to build stronger relationships with donors and market WHO
4. Understanding your role and communicate effectively through good communication plan

**Session 1: Strategic Communications (Slide 6)**

Objective: 1. Understanding of strategic communications

**Steps to being strategic in your communications [slide 8]**

There are many steps involved in strategic communication that will be elaborated on further in this module. It is important to remember that when we refer to strategic communications, we are likening it to donor communications, a type of communication that is persuasive and has a purpose. Communicating in this way will help create a roadmap for stronger partnerships with donors and subsequently more support.

To communicate strategically with donors, you must ask:

1. What is the change you want to see? *(SOCO)*
2. Who is your audience? What is their emotional reaction to your issue? *(Audience)*
3. What is your main point? What is your message? And back-up information? *(Talking points)*
4. How can you best package your content? *(Products)*
5. How can you best reach your audience? *(Delivery channels)*

**1. Get a SOCO [slide 9]**

The amount of information individuals receive on a daily basis can be overwhelming so it is important to think about your objectives beforehand and focus your communication. Ask yourself what your client/audience WANTS and NEEDS. The center of your communication, your theme, is your safe place that you come home to whenever you want to communicate for better public health.
Get to the point!

Scientists and experts are trained to speak about the background to their problem before they get to the point, to be logical, complete, and accurate for fear of being misunderstood. When it comes to strategic communications it is important to let the audience know the point early on, expanding as you go.

ACTIVITY:

Demonstration Interview. Lead participants through the process of preparing for an interview. Ask participants to think of a topic or project and their objective (to change, to influence, to convince, to educate, to change behaviour etc.). As the facilitator, you will represent a person of the media, a Minister, a key donor or an interviewer. Ask participants to prepare a ‘pitch’. Start with a media situation, but mix them with donor interactions – sometimes called pitches.

2. Think about the audience [slide 10]

The audience is always thinking about what pertains to them, simply put they are always wondering ‘What is in it for me?’

Example:

If you were to try and convince an American group to invest in a project that focused on providing toilets for women, what points would you highlight? Perhaps you would talk about the women using the toilet for the first time, appealing to the donor’s human dignity. Now something appeals to their emotions and to them.

ACTIVITY:

Walk participants through how they might deal with a communications strategy for a few of the following healthcare situations. You can choose a few to assign to groups of participants or go through them individually. Have the participants reflect on the audience, the main points they want to make and what emotions or facts they want to emphasize to their audience.

- NCDs and tobacco control
- TB
- making pregnancy safer
- immunization campaign with new vaccine
- child survival (diarrhoea)
- disease outbreaks (H5N1, hand, foot and mouth disease...)
- humanitarian emergencies (floods, drought, heavy rainfall)
- dengue
Types of audiences [slide 11 + 12]

You should also tailor each message to the audience it is intended for. You should focus on the material that would most benefit them, so your audience knows what is in it for them, and consider their opinions or mind-set on a specific topic. Below are four types of audiences and the communication strategies you can use with them:

1. Champions (Share your objective, support publicly/vocally)
   - Give them the information
   - Appreciate and acknowledge their contribution
   - Let them champion your case

2. Silent boosters (share your objective, support silently)
   - Educate, enable, inform and motivate
   - Energize them by involving champions they admire

3. Avoiders (do not share your objective, oppose silently)
   - Inform or ignore
   - Get critical mass of champions to influence them

4. Blockers (do not share your objective, oppose loudly)
   - Ignore if they are not influential
   - Confront if their influence is significant
   - Counteract by giving facts and enlisting champions
   - Monitor what they say and who is listening to them

Now that you know what your objective is, what kind of change do you want to affect, and among which audiences, you can set communication priorities.

ACTIVITY:

Pass around the handout of the axis of the different types of audiences and the common interests/energy invested. Let participants each take a moment to analyse each audience. Ask them to think of an example of each of the audience types in their work. This will help them formulate what they communicate about and you can review and share their communication plans for each audience.

3. Talking points [slide 13]

Once you know your SOCO and your audience, you usually want to outline the points you will present, your talking points. Talking points are key messages that provide background

facts and supporting evidence about a topic in a conversational way. Talking points are written to help speakers or interviewees to address the media and other influential audiences. Although talking points are written in a conversational matter, it is important to have strong supporting statements that provide credibility to the talking point.

The speaker plays a key role in any verbal communication. After thinking about the WHY of the communication (SOCO) and understanding his/her audience, the speaker will prepare the WHAT – the content of this communication. In Aristotle’s model of communication, the speaker:

- Discovers rational, emotional and ethical proofs;
- Arranges these proofs strategically;
- Clothes the ideas in clear and compelling words;
- Delivers the communication appropriately.²

Remember to tailor it to your audience, explaining how the donors can assist and why it is important to act now. People and money are key points that hit home to donors as well as making a personal connection.

4. Packaging content [slide 14]

Communication products should keep the audience in mind. For example, donor communications should deliver news that the donors care about, be friendly/trigger emotions, and give the donors information and products that they can then use for their audiences. Remember to be headline-driven (get to the point!) and use photos, quotes, figures/facts that humanize the problem.

5. Communication channels [slide 15]

Delivery channels depend on your audience. Consider what communication channel would be best received by your audience and do your message the most justice. This may be through electronic format, in person, video, print, etc.³

6. Communication planning [slide 16]

People remember information in the order problem, solution, and finally the response. The problem should summarize the situation or challenge, and impress why this is important now. The solution is what can be done about it (positive), what is the impact on health (deaths), economics (money saved), etc. This middle part is the most difficult


to remember for people, so make sure your points link with your SOCO. The response is WHO action, what WHO’s role in in the solution or to improve health. This part should impress upon the individual WHO’s comparative advantage, why WHO is the one who will bets solve this problem.

**Example:**

Give technical examples of the following healthcare situations:

- Immunization
- NCDs
- Disease outbreak
- Tuberculosis – Stop TB in my lifetime.

**Barriers to effective communication [slide 17]**

- Emotion
  - Too much: interferes with your credibility
  - Too little: the cold scientific approach
- Filtering: Delivering only part of the information; causes the audience to lose faith
- “TMI” (Too much information): Public health messages are hard to convey
- Cultural differences (i.e. eye contact, how to greet, etc.)
- Jargon: using too many technical words or abbreviations
- Perceived bias or imbalance

**Overcoming the barriers [slide 18]**

The key to overcoming most barriers is to know your audience and understand what they WANT and NEED. The goal is to connect with your audience. Keep in mind some of these tips to overcoming the common barriers:

- Establish your authority and credibility to build trust
- Contain emotions
- Simplify the message
- Cater to the heart and mind
- Lessen jargon, speak as though speaking to your grandmother
- Be positive, even under attack
- Seek feedback:
  - o Ask ‘Is what I said clear to you?’
- o Ask ‘How can we work together?’

- Think of your message in the 27/9/3 rule: 27 words, 9 seconds, 3 messages aka an elevator pitch

**Example:**

Perceived bias: Think of a major news story about WHO’s relationship to the food industry. People start asking if we really care about NCDs or are we “soft” on food and alcohol due to our work with NGOs, who are linked to companies like Nestle? And what about experts that set diet guidelines but Coca Cola funds some of their graduate students who could not go to school without that support? How do we respond to these queries?

If we know this is their interest, we can address it. We can safeguard our neutrality with strong review procedures. Our experts tell us their interests before they make decisions on standards and norms, and we share that openly. WHO must work with partners to achieve better public health, but we do so appropriately.

**8 principles of fundraising [slide 19]**

- Fundraising is not about money
- Fundraising and education go hand-in-hand
- Fundraising is an ethical discipline
- People give to people
- Fundraising is friend-raising
- You don’t get what you don’t ask for
- Always tell the truth – if things go wrong, say so
- Remember to say: Thank you

**Session 2. Marketing WHO [slide 20 + 21]**

*Objective 2. Increase your understanding of donors requirement*

**Knowing WHO**

In order to market WHO, you must know the organization and be a master of it. You should know the comparative advantages of WHO, and be able to speak about the ‘so what?’ of the actions it takes. You should also be able to convey the comparative advantages to a variety of audiences, such as donors, stakeholders, media, and the public. In this same vein you should be comfortable in knowing who is our competition, and how we can work together and tell a positive story. For example, WHO designs a yellow fever immunization programme yet UNICEF delivers the programme, this is a
positive story to tell. Knowing WHO also means knowing what it is not, what doesn’t fall under the mandate of the organization. If a request is not under WHO mandate, you should be able to redirect it. In your role, you should give credit to other organizations/ member states on their contributions to healthcare, but you should also feel comfortable taking credit for the successes of WHO work.

**ACTIVITY:**

Lead participants through thinking about WHO from a donor perspective. Ask participants to think about the below questions and after a few minutes of reflection, ask for participants to share some of their answers.

Put yourself in the donor’s shoes...

- What would you say about WHO?
- What do donors want? What challenges do donors face?
- What do WHO and donors have in common?

**Be client-focused**

Donors and stakeholders are vital to the work WHO does so view them as customers that you would like to keep happy and returning. They are worth your time so show them through being timely in your communication with them. Respond to issues quickly as they arise, for example, be honest if a donor report is going to be late but tell them in advance, not after the deadline has passed. You should have a set number of days to return phone calls or emails and make sure to have a voicemail on your phone that they can leave a message on should you not be available when they call. Set an out-of-office response on your emails when you are not in the office so your donors can never say that they haven’t heard from you about their concern.

**Writing a case for support [slide 22]**

A case for support is a clear statement of the health need to be addressed and the document outlines how you will address it. In this document you outline what makes WHO unique (and the best choice for this action; comparative advantage) and information about WHO (competencies, structure, experience, etc.). Elaborate on how you can assist in the solution and who would provide the service/expertise. You can also speak about your vision for the future and how yourself/ WHO ensures accountability and transparency. A case for support is different than a leaflet or brochure because it is designed to engage the reader in our work and illicit an action. It is likened to a brand strategy and is the backbone of any marketing/advertising.

You can use a case for support when:

- Drafting proposals
- Drafting publications and web content
– Drafting presentations
– Introducing WHO to others
– Ensuring a consistent message
– Engaging others in our work
– Raising funds and resources

This document must be discussed and agreed upon with senior management before use/distribution and is best when developed by and agreed upon by the whole group.

<table>
<thead>
<tr>
<th>Example:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Document</strong></td>
</tr>
<tr>
<td>Investing in Health for Africa: The Case for Strengthening systems for Better Health outcomes</td>
</tr>
<tr>
<td>Harmonization for Health in Africa</td>
</tr>
<tr>
<td><a href="http://www.hha-online.org/hso/hso/knowledge">www.hha-online.org/hso/hso/knowledge</a></td>
</tr>
<tr>
<td>(English, French and Portuguese versions)</td>
</tr>
</tbody>
</table>

**Session 3. Donor relationship-building [slide 23+24]**

*Objective 3. Learn how to build stronger relationships with donors and market WHO*

**How to cultivate a relationship [slide 25]**

Cultivating a relationship is like cultivating land as a farmer or gardener:

1. **Know the conditions (do your research)**
   - Is it a donor worth pursuing? Do our strategic priorities match well? Can we deliver? Could someone else do it better, faster, more cost-effectively? (should I broker that relationship?)

2. **Till the soil (introduce yourself to country reps)**
   - Be yourself, have a voice. Don’t assume that country representatives know WHO, the key work to be discussed, or even the topic therefore help them learn. Present background information and facts.

3. **Plant the seed (pitch the need, follow with evidence and practical ideas)**
   - Be prepared!

4. **Reap what you sow (ask for assistance)**
   - Become comfortable with asking for assistance, be specific, and have a few different ideas in mind.

5. **Forecast the next season (what is the basket of needs?)**
Propose future collaborations and projects for your partnership.

**ACTIVITY:**

Lead participants through thinking about what their donors want. Ask participants to think about real-life examples of donors or relationships they have with donors and what donors want from them. After a few minutes of reflection, ask for participants to share some of their answers. Some example answers are:

- To know you, to understand you, to form a partnership that benefits both of you
- To know the value of their investment in you
- To know the impact of the investment
- To know and understand (the ’so what?’)
- Donor challenges:
  - Busy, hard to find good projects, hard to track progress and assign credit
  - Need to please their constituencies, Board, CEOs, members, elected leaders, shareholders
  - What do they have in common with you?
  - What are their public health objectives? Do they align with yours?

**Top 5 ways to steward [slide 26]**

WHO defines stewardship as a political process that involves balancing competing influences and demands. The ‘Towards better stewardship: concepts and critical issues’ WHO report released in 2002 expands on this concept: In order to decide who to involve in relationships, the steward should have a good understanding of the main influences on health, and the positions, connections and motivations of the different stakeholders who have (formal or informal) ability to influence them. An effective steward will be versatile and pragmatic in establishing and maintaining relationships, recognizing that many important determinants of health lie outside the health system itself, and that action on a broad front is often needed to achieve sustainable health gains.

Donor stewardship involves the maintenance of donor relations and showing them the results of their investment. You should know your content (like technical expertise, why WHO, knowledge of the donor and a case for support), be yourself, and have a dynamic approach (listen and ask strategic questions, try and find common ground to engage upon). Small actions like thanking them for their contribution (a simple phone call or email), asking for their advice, inviting them to WHO events and staying in contact (recommended to find at least two opportunities a year to communicate personally with the donor/country representative) go a long way to being a good steward for WHO.
**Session 4: Communication Plan [slide 27]**

*Objective 4. Increase your understanding of your role and communicate effectively through a good communication plan*

**Your role [slides 28 and 29]**

Briefly introduce the role of the participants in representing WHO in various ways, using the text below and slide 29.

You are a front-line WHO messenger in a public health environment that is rapidly changing. With such an evolving global health landscape, maintaining WHO reputation is paramount. As an organization, WHO needs to reach across sectors and engage with NGOs and private sector in a careful and appropriate fashion, so as to continue telling a positive story of the role of WHO in global health.

In this story of partnerships and donors, you serve of combination of many positions. You are:

- A diplomatic officer (you find common values and interests with donors) and;
- A communicator (you focus on your audience when delivering a message) and;
- A fund-raiser (you reach out to potential donors and raise the question) and;
- A technical advisor (you provide evidence to back-up your communication).

The many players and voices in the global health arena make it difficult to be heard. Today people are subjected to more information in a day than they were in the Middle Ages during their entire life. There is information, sources, contradictions, and distractions coming from different sources.

**Other actors affecting your message [slide 30] and WHO feedback [slide 31]**

Prior to showing slides 30 and 31, they can be introduced/prompted using the following questions to participants:

*Slide 30: What actors or groups take your message and amplify it or erode the level of trust associated with your message?*

*Slide 31: What kind of feedback about WHO have you heard from partners/donors? Positive and negative?*
There are other people who will take your message and add to it, in a positive or negative way.

Message amplifiers:

- Media
- Politicians
- Lobbyists
- Private sector

Those who can contribute to an erosion of trust:

- Health experts
- Institutions
- Governments

**WHO Feedback [slide 31]**

In general the perceptions of WHO are still strong and trust continues with donors. However, there is always an opportunity to build on this relationship and squander our reputation would be harmful in terms of public trust and financial support. In order to create new donor relations and foster existing ones, we must translate what we do to others (strategic communication).

**Feedback from donors:**

- Slow
- Always takes more time and more costs than estimated
- Mysterious (unclear how we work between CO, RO and HQ)
- Unclear about key WHO functions in country
- Unsure of who to call to have questions or concerns answered
- Candid assessment of barriers to success
- Convey what is lost if WHO is missing
- Listen to donor more, know their strategic priorities

**Feedback from media:**

- Hard to understand
- Too technical
- Slow to respond
- Hard to reach
- Talk to my audience, please
Tips:

• Convey what is lost if WHO is missing
• Listen to donor more, know their strategic priorities
• Talk to the audience Convey comparative advantages (they are not better defined and reform is aiding)
• Show relevance (WHO must change at the same pace the world is changing, making our message more relevant, properly explain it, and be more accessible or ‘customer-friendly’ to our key audiences)

Briefly introduce the role of the participants in representing the WHO in various ways, using the text below and slide 29.

Communication planning, dividing communications plans, and putting it all together [slides 32+33]

Planning either public or donor communications relies on a lot of the concepts discussed in this module. It is recommended to build on the Strengths, Weaknesses, Opportunities, and Threats (SWOT) of your project/proposal and always explain your comparative advantage and why you are better fitted when compared to the competition. Your plan should affect change (attract and keep donors) and bring programme officers and communications officers together. Your communication plan should:

• Segment your communications outreach: divide your public communications from your donor communications
  – Public communications
    ▪ Use all channels to recognize donors
• Donor communications and stewardship
  ▪ Personal contact
  ▪ Information products
  ▪ Stay connected (frequency)
  ▪ Establish norms: focal points, ground rules

• Segment your donors by tier: the larger the donors, the more personalized and active the plan
• Have a donor communications plan for each segment
• Have a follow up poll for your donors: after 6 months ask your donors for feedback. Find out if you provided enough information or too much. Inquire in to what worked and what did not work
Parting communication tips [Slide 34]

- Personal touch/activities:
  - Personal thank you’s, regular in-person or email contact
  - Monthly coffee
  - “Push” email: find a hook to keep in touch
  - Invites to events
  - Site visits

- Communications tools
  - “Leave behind's” (one-pagers, fast facts, fact sheets)
  - Success stories (photos and captions)
  - Annual report of progress
  - Brief progress bulletins (e.g. Health matters)

**ACTIVITY:**

Walk participants through a scenario that depicts delegations preparing for a dialogue about financing. Split the participants into two groups and select a programme area or a funding gap. Have the participants on one side develop talking points for the pitch presentation. This group, the spokespersons, will present their ‘pitch’ and the other group, the donors, will ask questions. Ask the participants for feedback on the exercise and then switch the roles.

**Questions?**

*Make sure to encourage any questions from participants to ensure they understood what was covered. This should include ensuring they understand the learning objectives and the two sessions of this module.*
Quiz

Go through the questions outlined on the slide/below for the quiz. Refer back to the slide numbers in the parentheses for the answers.

1. What are the 4 roles you serve when communicating? (Slide 9)
2. Name 3 message amplifiers and 2 actors that can contribute to an erosion in trust. (Slide 10)
3. What are the 6 steps to being strategic in your communications? (Slide 13)
4. What is a SOCO? (Slide 14)
5. Name the 4 types of audiences. (Slide 16)
6. Name 3 barriers to effective communication. (Slide 22)
7. Name the 8 principles of fundraising. (Slide 24)
8. Name 3 instances when a support for case is useful? (Slide 27)
9. What are the top 5 ways to steward? (Slide 31)

Further reading


FACILITATING MODULE 6

Negotiation and reporting
This module is designed to familiarize you with the concepts of negotiation and report writing. It will define and highlight the main parts of a negotiation and walk you through the process and steps to take in negotiating. You will become comfortable in handling a situation where you receive a ‘no’ from your donor and learn how to explore their refusal further. The module also emphasizes why donor reporting is critical to resource mobilization and outlines the things to keep in mind when performing effective reporting.

Outline of the module/discussion [slide 2]

Go through the module outline with the participants to ensure they understand what will be covered. This should include the learning objectives and the two key concepts of this module.

Learning Objectives [Slide 3]

1. Understand the key principles and basic process of negotiation
2. Become comfortable with what to do when a donor says “no”
3. Understand why reporting is critical to resource mobilization
4. Learn techniques to report more effectively to your donors

Introduction [Slides 4+5]

Give a brief preamble of the module to participants
In 2005 the World Health Organization endorsed the Paris Declaration on Aid Effectiveness and was the first UN agency to adopt a Resolution on the Paris Declaration, which articulated a clear approach to harmonization at the country level. Since its adoption in 2005, the Secretariat has reported to its WHO’s Governing bodies on the progress made/monitoring of WHO’s adherence to the Paris Declaration. The declaration outlined the five following principles:

1. **Ownership**: Developing countries set their own strategies for poverty reduction, improve their institutions and tackle corruption.

2. **Alignment**: Donor countries align behind these objectives and use local systems.

3. **Harmonisation**: Donor countries coordinate, simplify procedures and share information to avoid duplication.

4. **Results**: Developing countries and donors shift focus to development results and results get measured.

5. **Mutual accountability**: Donors and partners are accountable for development results.

**Session 1: Negotiation [Slides 6-14]**

Objectives

1. Understand the key principles and basic process of negotiation

2. Consider what to do when a donor say ‘no’

**What is Negotiating? [Slide 7]**

Negotiating is a process of offer and counter offer, an exchange of concession and compromise. Through these methods, both parties reach an agreement. The purpose or role of the negotiator is to persuade the other party, and at the same time find a solution to the problem that both parties can agree to.

**Leading principles of negotiating [slide 8]**

- **Planning**: Planning is the most important element, and something that will help you to be a better negotiator and reach better outcomes. Be comfortable with the uncertainty that is part of the early stages of a negotiation.

- **Content**: Make sure to tailor your negotiations, different people want different things (the amount of funding is not always the most important topic for negotiation). Never narrow negotiations down to just one issue and take note that directly discussing an issue can lead to its resolution.

- **Outcome**: Negotiation requires a commitment from both parties (or multiple parties) involved. Remember, it’s not always about “winning” – but about finding a satisfactory outcome that is acceptable to both parties.
**Negotiate up front [Slide 9]**

**ACTIVITY:**

Ask participants why the below saying may be true?

It is better to negotiate with a donor at the beginning, before an agreement is signed, then agree and then fail to deliver.

Encourage discussion and sharing of examples/advice.

**The people factor [Slide 10]**

- The successes of funding arrangements are influenced by the leadership and individual personalities involved.
- The attitudes of senior staff, project managers, donor and senior Ministry of Health figures all have had a crucial impact on the project (and funding structure).
- You need to understand the incentives that shape the actions of donor staff (and other key stakeholders).

**Process of Negotiation [Slide 11]**

**Preparation**

- Research and understand the motivations, programmes, and restrictions of the donor
- Ensure you are expert on the programme being discussed
- Think about the agenda – set it if you can
- Establish ahead of time the “bargaining range”: be balanced in what you demand and what you are prepared to give
- Think about what you may be able to “give up” (concession trading)
- Know what approvals must happen, or establish this beforehand

**Steps to take in a negotiation [Slide 12]**

1. **Basic information:** No two negotiations are the same; so do your homework and find out what the donor may be expecting and how they make funding decisions etc. Find out about their policies and decision-making processes. This also means that you should have information to share about your work and programmes.

2. **Level of authority:** Find out the level of authority of the person/people you are talking to. Can they negotiate or make decisions, or are they limited to an informational role? This step avoids false expectations or assumptions. How will the results of your discussion be taken up in the other organization?
3. **Compatibility check:** Ask questions (even if you may already know some of the answers) which enable you to find out about the donor’s values, constituencies, policies, aid programmes, relationships it has with other organisations in the country (or regional/global that you also partner with), source of their funding etc.

4. **Explain your needs:** Explain what programmes you already have, and the donors to them, and what you are looking for.

5. **Listen and clarify:** Listen to the donor’s response and clarify if you have any questions (to avoid misunderstanding).

6. **Get to practicalities:** What are the practicalities involved in a funding relationship? What commitments can be made during the meeting or what needs to be deferred, checked, clarified, re-worked, etc.

7. **Next steps:** Determine what the next steps are, who should take them, what the deadlines/timeframe may be. **NOTE:** Ensure you follow-up accordingly and in good time.

**Overcoming barriers: Reasons why donors say no [Slide 13]**

**ACTIVITY:**

This slide only holds the reasons why donors would say ‘no’. Engage your audience by asking them to suggest ways to turn a ‘no’ into a ‘yes’ before reading the suggestions below.

There are many reasons, but these are some of the most common reasons for a donor saying “no” to your ask

1. **Wrong time:** The donor may say that there is no more budget, they missed a grant cycle, etc. Asking at another time may be better (find out when!), or, maybe the donor needs more information and more time to think about it before they can decide.

2. **Wrong project:** The donor is supportive of WHO, and wants to support you, but the particular programme or project that you have asked them to support does not align with their priorities. Explore what project/programme would be better aligned.

3. **Wrong amount:** It is possible that you have asked for too much or too little. Or, you have asked for funding and they can only give other resources. Ask some follow-up questions to try to understand the grant amounts that are possible or ways that you can pool funds, ask for in-kind resources, etc.

4. **Wrong conditions:** What is it they really want and can you ethically provide it? For example, a corporate donor may want their logo on a brochure about a health programme, etc.

5. **Wrong donor representative:** The person you are speaking to may not be able to take these kinds of decisions, or needs to get approval from others.
6. **Wrong asker:** This is often the most difficult issue to identify, but it's possible that your donor was expecting to meet with someone else. Try to be as intuitive as possible about this, it may have to do with status, decision-making power, feeling more comfortable speaking to someone “like them” etc.

> Sometimes, a ‘no’ really is a ‘no’ and there is nothing to do. In that case, thank the donor for their time and inputs, and ensure that you do not ‘harass’ them later.

**Turning a “No” into a “Yes” [Slide 14]**

The most important thing to find out is why your donor said ‘no’, so ask them! Find the core problem and answer any questions they have. A ‘no’ is an opportunity to explore, build the relationship, ask more questions, and encourage engagement.

**ACTIVITY:**

Ask participants to reflect on a situation where they have been met with a ‘no’ and how to overcome this obstacle:

> So, you’ve prepared, you’ve practiced, and you have met with your donor. Despite everything, they say “no”. Now what do you do? How do you know when “no” really means “no”? Should you take an initial “no” as a final “no”? When you are trying to raise resources, it is very important to try to turn a “no” into a “yes”, whenever possible. Don’t take “no” as your first answer!

**Reflect and Learn**

- After any experience with a donor, always try to extract lessons learned so that you can improve the outcomes the next time you interact with them
  - Keep records!
SESSION 2: DONOR REPORTING [SLIDES 15-28]

Importance of Reporting [Slide 16]

Reporting in the Resource Mobilization Cycle

- Why is reporting important for resource mobilization?
  - All donors will require reports to find out the quality of fund utilization.

Effective Reporting [Slide 17]

In reporting, the key to success is planning – that is, writing a good outline. A good outline will enable you to structure and organize your thoughts in a logical way. Reporting should be according to the stipulations in the MOU/Agreement.

Report on two things:

- Results of activities, outputs and IMPACT (Narrative Report)
- Progress/spending of project funds (Financial Report)

*Note: These two reports must match*

Things to keep in mind when reporting:

- Keep all of the donor’s conditions in mind
- Use simple words and sentences to explain results
- Be clear and up-front about deviations from what was agreed to in the proposal/grant contract
**ACTIVITY:**

Ask participants to reflect and share their thoughts on the following statement: 
*What kind of deviations should we tell the donor about?*

---

**Reporting tips [Slide 18]**

When writing any report, use a logical format: tell a story from beginning to end, each section building on the one before it. Some report-writing tips are:

- Focus on impact, not activities
- Use the donor’s language
- Follow exactly the donor’s form
- Write clearly, and in fluent English
- Be as brief as possible
- Don’t use jargon!!
- Be logical
- Spend extra time on the introduction

---

**Reporting DON’Ts [Slide 19]**

- Don’t list results in a confusing way – link them back to the original proposal and/or log frame
- Don’t overstate the results
- Don’t report on activities that are not within the reporting period
- Don’t report on activities that are not funded by the grant/funder in question
- Don’t work alone – teamwork is vital
- Don’t submit the report late

---

**ACTIVITY:**

Ask participants the following question and encourage a dialogue/sharing of stories/advice: 
*What can you do if you think the report will be late?*

---

**Report Format [Slide 20]**

Most donors have their own format for narrative reports but outlined below is a generic format for narrative report.
Title Page [Slide 21]

Use a specific title for the Project (same as the one used for the Proposal) and refer to any Grant # or other ID used by the donor. Include reporting period, date report submitted and your logo, address, and main contact person.

Executive Summary [Slide 22]

Write the executive summary last. Make sure it is brief and only mentions the main points in the report. State the report purpose and include main conclusions and recommendations. This section may include sub-headings as it makes it easier to read.

Purpose of the Report [Slide 23]

Briefly state the purpose of the report and specify if it is a mid-term, interim, or final report. Ensure to reference specific grant number in this section.

Monitoring Procedure [Slide 24]

In this section, describe the monitoring process and be specific in your description. Answer questions such as ‘how was the project managed?’ and ‘how were problems/issues addressed?’

EXAMPLE:

*Be specific in your writing in this section, ex “75 village women were interviewed over 3 days by WHO MMR staff”, not “women in the community were interviewed.”*

Results [Slide 25]

Outline the information you have about the outcomes of the project in this section and help the reader understand (don’t assume their knowledge about the situation, avoid
jargon and acronyms). Try to present your results without interpretation at this stage and use facts and figures, tables, charts etc., as appropriate.

Conclusions [Slide 26]

This section is where you interpret the results. Explain to the readers what went right, as well as highlighting what went wrong (be honest). Include reference to any major change in context/environment.

Recommendations [Slide 27]

This section is where you can list things that should be done in the future based on the results and conclusions in the report. Write as factual statements as this is not your personal opinion. You can also recommend what should not be done.

Appendices [Slide 28]

This section is an opportunity to include more detailed information. Include materials that help demonstrate impact of the project.

Financial Reports

This section must be done by an accountant or financial officer and for larger grants, are usually audited financial statements. Submit this together with the narrative report.
QUESTIONS?

Make sure to encourage any questions from participants to ensure they understood what was covered. This should include ensuring they understand the learning objectives and the two sessions of this module.

QUIZ

Go through the questions outlined on the slide/below for the quiz. Refer back to the slide numbers in the parentheses for the answers.

1. What are the 5 principles of the Paris Declaration on Aid Effectiveness? (Slide 5)

2. Is negotiating about winning? What is it about? (Slides 7+8)

3. What are some of the preparatory steps you need to take when negotiating? (Slide 11)

4. Name 3 reasons a donor could say ‘no’? What should you do to overcome this ‘no’ or learn more? (Slides 13+14)

5. What two types of reports should you be writing? (Slide 17)

6. Name 3 reporting ‘don’ts’. (Slide 19)

7. What are the 8 parts of a report? (Slide 20)

FURTHER READING

FACILITATING
MODULE 7
Proposal writing
MODULE 7: PROPOSAL WRITING

Give a brief general preamble of the module to participants:

This module is designed to help WHO country and regional staff to explore how to develop concept notes about their projects and programme activities to present to potential donors. It then describes all the critical elements needed to draft an effective funding proposal. Finally, it highlights how the inclusion of particular features could make their proposal more attractive to funders — including programmatic innovations and how the proposal addresses certain critical issues in global health.

Introduction [slides 2–4]

Before showing slides 2-3, ask participants to identify a project and programme activities that they would pursue if they had adequate funding.

[Slide 2] Most donors receive more proposals than they can possibly fund. Only a fraction of proposals succeed in securing funding.

According to a survey of donors performed in 2004 by the Foundation Center (a nonprofit dedicated to strengthening health and social welfare in the United States and globally by providing access to information about philanthropy), the majority of funding proposals are rejected either because the request doesn’t match the donor’s giving interests or the applicant didn’t follow the application guidelines.1 When donors are overwhelmed by requests, the quality of the proposal is critical.

[Slide 3]: Crafting a proposal that makes a convincing case that your project deserves to be funded requires research, thought and careful planning. Since most regional and WHO country offices (WCO) in the South-East Asia Countries (SEARO) do not have a dedicated communications team responsible for formulating concept notes and writing

---

1 Foundation Growth and Giving Estimates, 2004 Preview.
proposals, programme staff need to develop these skills for themselves to raise support for their projects.

**Outline of the module/discussion [slide 4]**

Go through the module outline with the participants to ensure they understand what will be covered. This should include the learning objectives and the two key concepts of this module.

**Learning objectives [slide 5]**

At the end of this module, participants will be able to:

- Define the key components of concept notes and proposals
- Compile the kind of content most proposals will require
- Distinguish between a good and a bad — or just mediocre — proposal
- Prepare and write better proposals that are more likely to be funded

**Key concepts [slide 6]**

- Concept notes
- How to draft a successful funding proposal

**Concept notes [slide 7]**

Our first topic is how to develop a brief ‘concept note’ for your projects or programme activities.

Long before a funding proposal can be drafted, it is useful for the programme team to begin to organise their thoughts about the programme activity or project in question. First, some background information needs to be gathered. [slide 8]

- What is the programmatic need or gap that the project seeks to address? Has a needs assessment been performed or is there supportive documentation that illustrates the need?
- Exactly what activities and/or interventions are being proposed in the project being planned? What is your objective? Is it realistic?
- What are the expected outcomes, and how will these outcomes be measured? Donors want to see evidence that their contributions have had an impact. How will data be gathered and analysed as the project progresses?
• Why is your team qualified to run this project? What experience do you have in this area? What are your unique qualifications? How does this project fit within your mission?
• What is the anticipated project timetable? Who will be involved in its implementation? What are the staffing needs — will any current staff need to be redeployed or new staff hired?
• While it will not be possible to prepare a budget until more details about the project are worked out, it helps to have some rough idea of what the budget might look like.

All of this information will be refined over time, but gathering data at an early stage will help the programme determine whether the project is practical — and potentially fundable — or whether it will need to be scaled back. In addition, it will make preparing concept notes and proposals much easier.

Exercise (5 to 10 minutes): Ask participants to discuss whether they have this information about their project. To the extent possible, they should prepare a brief outline of a concept note addressing these questions. Stress that this outline should be just a short sketch — they will have a chance to expand it over the course of the session.

A concept note is a brief summary of the project that captures all the critical information about the project’s purpose and objectives. [slide 9] Many donors request one instead of/or before requesting a full proposal — so the concept note should present as clear a picture of the project to the reader as possible.

Unless guidelines are otherwise specified in a request for concept notes, most donors do not have a set format for contact notes. Generally, they should contain a cover letter containing the name of the organisation, the title of the project and the potential donor to whom it is addressed. The core of the concept note is the technical narrative (roughly one to three pages long), which should briefly explain the context where the project will take place; the project’s rational, goals and objectives; the project’s activities and their expected results — and if there is anything innovative to distinguish this from other or earlier projects. It should also include a monitoring and evaluation (M&E) overview. Finally, as the plan for the project has been worked out in more detail, it should be possible to prepare a better budget, which should be attached on the final page, along with your contact information. All together, the concept note generally should be no more than five pages long.
The technical narrative [slides 10–12]

On some occasions, a donor will solicit concept notes and publish a set format for what they expect to see in them. The following example, adapted from one call published by 2013 USAID for nutritional interventions in Mali, provides a good example of what should be in the technical narrative.

The narrative should outline the following: [slide 10]

• A brief background on the proposed programme areas selected including the challenge or need in programming, the geographic range and the targeted population.

• The proposed approach, including goals, objectives and a short description of the activities to be undertaken for the duration of the project. List the partnerships, if any, which will be involved in the project. Describe how the proposed project and activities will contribute to addressing the programmatic need in the target geographic zones. Include any innovative methods or approaches and how the applicant is well suited to achieve the proposed programme. Include a discussion of any key issues that are of particular interest to funders (e.g. how its design incorporates gender concerns or key populations) will be addressed. [slide 10]

• A clear timeline and anticipated results, as well as the proposed mechanisms to measure and monitor progress (a summarised M&E plan). [slide 11]

• A discussion on how the programme will be sustainable.

• A description of the applicant organisation’s technical and administrative experience and capabilities — including the staffing — and a description of related work that has been completed or is ongoing.

There are a number of advantages to preparing concept notes for each of the programmes potential projects. [Slide 12] First, it can help to clarify your own thinking and furthermore provides a framework for organizing project details. In addition, it provides an ideal opportunity to capture all the correct information from the programme team and other stakeholders — which could also increase their engagement in the project. As the project plan is being mapped out, a clearer budget should be prepared, which will help to establish a fundraising goal.

The concept note can be shared internally for comment, and can be adapted or changed based upon the funder before being submitted. Having concept notes on file can help your team quickly respond if a funder shows interest. They also can serve as the basis for developing full-fledged proposals, should funders publish a request for proposals.
Session 2: Writing a winning proposal (Slide 13)

Objective 2 Recognize the kind of content most proposals will require and equip with knowledge and tools to write better proposals

Key Concept 2 [Slide 14]

Proposal Design

Although the concept note can provide an excellent foundation from which to work, it is critical for formal proposals to be targeted to the specific donor. [Slide 15] Keep in mind that the proposal will form the basis of your programme’s interaction with the funder over the course of the proposed project. Your proposal should show that you understand and share their interests — and that your proposal will have a significant impact that addresses their concerns.

Never send the same proposal to more than one donor or simply cut and paste large portions of the content from one proposal to another. This does not mean that you cannot have more than one funder for parts of a project, but each proposal should be tailored to the donor.

By this point, programme staff should have identified and initiated relationships with potential funders. When designing a proposal, consider your link to the funder. Where do their interests overlap with yours? This may require more research and time spent reviewing the donor’s online site and documentation. Note: Developing a one-on-one relationship between team members with the funder can also be critical, because their most current interests may not always be reflected in their printed materials.

Finally, what is the appropriate amount of funding to request from the donor? Your request should be in-line with the donor’s funding capacity. Foundations that give large grants to large ambitious projects may not be interested in proposals for smaller pieces of work.

Even though every funder will have their own proposal format and criteria, the following general areas are covered in all proposals: [Slide 16]

1. About you
2. The programme justification
3. Your goal and objectives
4. The amount required
5. Format and writing
6. Monitoring and evaluation
7. Sustainability
8. Other Resources
9. The workplan and budget

1. **About you [slide 17]**

Your proposal will need to show that your programme has the technical expertise and capacity to implement the project. In particular, it may need to show the donor what is unique about your programmes efforts; what value added does the WCO offer? The programme staff should consider why a donor should fund a WHO office rather than a government or nongovernmental organisation. What partners can or will you bring to the project? What are your organisational strengths? What have been your past successes and where have you shown leadership on the issues addressed by this proposal?

2. **Programme justification [slide 18]**

The programme (or project) justification is the most critical part of the proposal. It describes the need of the specific population you and the donor are both concerned with and should convince the donor why it is important to fund this particular project. The proposed solution should describe the ways in which the project will help achieve the goals and objectives for health in the specified country or region.

**How to write the programme justification [slide 19]**

First, try to identify the root causes of the problem or of the issue that the proposal will address. Analyse any other projects or activities from your programme that addressed the problem or research the successes of similar projects addressing the same issue in other settings.

The first sentence of the programme should clearly state, in the simplest of terms, what the project is about and what is its main goal. Then, describe the factors that are contributing to the problem — and briefly provide data to support your conclusions. Explain how the interventions in your project can and will address these issues — and back this up with the evidence that you have gathered.
The project justification should be grounded in the context of the targeted population and it needs to show how the project will benefit real individuals in the community. Where possible, it should include short case studies or examples from real life to create a compelling and consistent narrative.

**Exercise (15-20 minutes):** Ask participants to examine and find the related information in their existing rough concept sheet, and write their programme justification, following the described format. Allow time to discuss results amongst the group.

### 3. The difference between goals and objectives

It is important to understand the difference between your goals and the project’s objectives. A goal is broader, more general — and really about the final impact or outcome that the project wishes to bring about. In the case of goals for a grant proposal, make sure the goal is linked back to your needs statement. Use words such as decrease, deliver, develop, establish, improve, increase, produce, and provide.

An example of a goal is ‘to reduce neonatal mortality in rural communities.’ It is not something that your project or organisation can accomplish on its own, but something that the project will contribute too.

In contrast, an objective is more precise, concrete, and can be more easily measured. For example, *by the end of year one, provide 45,000 mothers in (State/districts) with a 2-hour training programme that will provide health and nutrition information.*

The **SMART** method is useful when writing about your objectives, which should be:

- Specific: Describe what you want to achieve
- Measurable: Quantify/measure
- Achievable: Is it really attainable?
- Realistic: Available resources sufficient?
- Timeframe: When will the objectives be reached?

---


3 Browning BA. Grant writing for dummies. 4th Edn., Wiley. 2011.
Some recommendations for writing your objectives include\textsuperscript{4,5} [slide 22]

- Tying the objectives to your needs statement
- Quantify the objective whenever possible
- If there is no way to measure it – consider re-writing
- Should be about the result, not process or method
- Identify the community being served – be specific
- Objectives need to be realistic
- Can be accomplished within the grant period (better than asking for a no-cost extension)

**Exercise (5-10 minutes):** Ask participants to review and analyse how they have written the goals and objectives of the project in their concept sketch. Have them redraft these using the SMART method and the other recommendations.

---

**4. Amount required [slide 23]**

By the time a full-fledged proposal is being prepared, a detailed budget for the project should be ready and included in the proposal appendixes. It should include the resources already on hand that the programme is bringing to the project, contributions in-kind (donated goods or services) or financial support from partners or other sources, and, of course, the amount that is being asked of the funder.

**5. Format and language [slide 24]**

Don’t waste time and energy submitting a rushed and poorly thought-out, or poorly written application. Read and follow the donor’s requested format. Don’t leave out anything that they suggest needs to be addressed. In addition, take note of the donor’s language/buzzwords and where possible, use that language within your proposal.

However, avoid jargon — write in a clear and engaging way, using simple sentences that make concrete points. Avoid repetition, complex phrasing, or rhetorical questions. Make the proposal as concise as possible.

Be convincing that the programme answers the need. Use a logical format that tells a story from beginning to end — each section should build on the one before it. Spend


extra time on the introduction and add the “human” story to the proposal—show how the problem may affect one person, or one family.

Once the proposal has been drafted, seek feedback. When it is finalized, be sure to proofread and check carefully before submitting. It is easy for errors to be overlooked in editing or layout, but if the mistakes make it into the final proposal, the funder may question your competence.

Finally, don’t miss the donor’s deadline.


Funders will want to see how the project is progressing over the course of the project. Furthermore, the information is important to your success and future funding, since a programme that doesn’t reach early benchmarks, or that cannot provide any evidence of having an effect is unlikely to receive further funding. However, a thorough M&E programme can increase the chances that an effective programme can be replicated and funded.

For every expected measureable outcome in the project, the performance indicators need to be described. What will be the source of the data in the programme, and what data collection methods will be used? How often will analysis and reports be necessary? Finally, remember that M&E activities can place an additional burden of workers in the field — who will do the work of data collection, recording and reporting? The time spent on M&E activities needs to be included in your workplan and staffing budgets.

7. Sustainability is a particularly important criterion for funders. [slide 26] What will happen at the end of the project? Can your organisation withdraw from the project in a way that will allow the benefits to be retained? Will structures be put in place that will allow local organisations or other stakeholders to take over the work? Will continued funding be required and if so, who will fund it?

It is important to consider the people who will be involved, the skills that they have acquired and the processes that were set up during the project. It is important to have discussions about sustainability with staff members and stakeholders while the proposal is being prepared.

8. Other Resources [slide 27]

In addition to determining the amount that will be needed from a funder, it is important to document what other resources you and your partners are bringing to bear as evidence of your commitment to the project, as well as the support and trust you have earned among the community and other partners. Is there a chance of your receiving matching funds if the funder accepts your proposal? What are your own inputs in terms of staff/human resources; co-financing, in-kind, materials, equipment, etc.? This can also demonstrate your capacity to develop the proposal and implement the project.
9. Develop a detailed workplan and budget [slide 28] that refers back to the activities described in your project plan summary. Decide upon a sequence: What activity comes first? Who will do each activity? How long it will take? You will need to budget for the resources needed to complete each activity.

Finally, in today’s funding environment, there are a number of issues or features that could greatly enhance your proposal’s appeal to the funder [slide 29]. Some funders may specifically address that these issues be addressed in your proposal.

- Innovation: Describe any innovations in your project’s design, in terms of greater efficiency, or greater impact using existing techniques
- Scalability: can the programme be replicated or expanded, and how easily? At what cost?
- Gender: what is the impact of the programme on men and women, or how are men and women included in the design?
- Disability: project does not discriminate, or shows consideration/design for PWDs
- Environmental: compliance to donor’s policies, or project designed with environmental impact in mind
- Community-centred: addresses the range of influences on an individual, or looks at how the programme can be tailored for a specific region/language/ethnicity etc.
- Research and evidence based: with reference to best practice, existing intervention methods etc.
- Complimentary to existing programmes/fill in the gaps
- Start-up time: can you “hit the ground running”?

Again, the exact structure and format of the proposal varies depending upon the funder’s specifications, but it can be a useful for the programme team to flesh out these key issues, to get a head start on your application for funding.

**Question**

![Question Icon]
QUIZ

1. The technical narrative should contain a number of elements. List 4. (slides 9 through 11).

2. What are some of the advantages of developing a concept note? List 4. (Slide 12)

3. What information about your organization should be included in your proposal? List 4 things. (slide 16)

4. The proposal’s programme justification should create a consistent narrative containing what components? (slide 18)

5. What are ‘SMART’ objectives? (slide 20)

6. List five features that could increase your proposal’s appeal to funders. (slide 28)

For further reading

- CIVICUS Toolkits:
  - Writing a Funding Proposal
  - Writing Effectively and Powerfully
  http://www.civicus.org
FACILITATING MODULE 8

Focus on results
e.g.

This module is designed to show members of health-related organisations why a focus on results is critical for resource mobilization — and why it is important to include results-focused language in their funding proposals. It asks participants to consider their organisation’s impact — and what evidence to there is to document it. It then describes how ‘results-based management’ can be used to help an organisation achieve results and mobilize resources. Finally, it shows how a ‘theory of change’ can be used to frame the organisation’s work for developing objectives, workplans and funding proposals.

Module outline [slide 2]

Go through the module outline with the participants to ensure they understand what will be covered. This should include the learning objectives and the three sessions to be covered in this module.

- Introduction
- Learning objectives
- Sessions

Introduction [slides 3–5]

Before showing slides 3-5, ask participants to keep in mind projects their organisation would like to see funded.

[Slide 3] Over the last few decades, there have been changes in the way funders assess whether development aid has been well spent, which, in turn, has changed how they evaluate funding proposals.
In the 1990s, funders (spurred on by their taxpayers and/or contributors) began to demand increased accountability of the organisations that they funded — requiring more transparency about how resources were spent, the services provided or activities performed, and the project’s outputs over the course of the funding cycle. More recently, there has been a shift to focus on projects’ results, or impact achieved beyond the short-term outputs. In other words, is there evidence that the funding made a difference in the health or lives of the participants or the community served?

[Slide 4]: For instance, a non-governmental organization that has received funding to conduct an HIV prevention project might have previously had to show the funder that activities were performed, such as interventions to promote behaviour change in the population, or the project’s outputs, such as the fact that condoms were purchased and distributed. Today, funders expect organisations to be able to show that their funded project has resulted in an outcome such as a behaviour change that reduces risk, or, better yet, achieved an impact such as a reduction in HIV incidence.

[Slide 5] Similarly, bilateral donors have begun to require evidence of impact from the international non-governmental organisations (INGOs) and multilateral organisations, such as WHO, for the core and non-core activities that they support. In 2011, the sixteen member countries of the Organisation for Economic Co-operation and Development (OECD), Development Assistance Committee (DAC) were surveyed to better understand how countries allocate multilateral aid in the health sector. The survey found that DAC members relied on a variety of different sources of evidence to help them inform their aid allocation decisions.

Factors or sources of evidence cited by at least 9 DAC members:

- Relevance to donor priorities and interests;
- Relevance to the aid architecture (importance of mandate, positioning, comparative advantage);
- Evidence, which includes perceptions, of the organisation’s effectiveness; and
- Performance assessments (e.g. MOPAN, COMPAS).

The Multilateral Organisation Performance Assessment Network (MOPAN), hosted by OECD, is a network of donor countries with a common interest in assessing the organisational effectiveness of the major multilateral organisations they fund (see http://www.mopanonline.org/). The sixteen surveyed DAC countries are also members of MOPAN, and indicated that they use the common MOPAN approach to complement

---

other assessments and criteria for determining multilateral aid allocations. Since 2012, the assessment of results focuses on the degree to which progress is being made towards the organisation’s stated objectives.

Another performance assessment used by DAC country members to determine whether a multilateral organisation was worthy of funding is COMPAS, the Common Performance Assessment System. COMPAS was designed in 2005 as a framework that a multilateral development bank (MDB) could use to track its capacity to apply and improve its operational processes in order to achieve results on the ground.

Both performance assessment methodologies assess whether the institution seeking funding has management practices in place, such as ‘results-based management’ (see session 2) that increase the likelihood of delivering results in future.

**Learning objectives [slide 6]**

At the end of this module, participants will:

1. Understand why a focus on results is critical for resource mobilization
2. Be able to describe an organisation’s impact in terms of results
3. Understand the key components of ‘results based management’
4. Know how to use a theory of change to help frame your work

**Session 1: Results and Resource Mobilization [slide 7]**

<table>
<thead>
<tr>
<th>Objectives:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Understand why a focus on results is critical for resource mobilization</td>
</tr>
<tr>
<td>2. Be able to describe an organisation’s impact in terms of results</td>
</tr>
</tbody>
</table>

Funding proposals should be targeted to the funder — so it is important to consider that most international donors are now using some sort of results-focused framework in order to demonstrate to their contributors and taxpayers that they are getting value for money and that the funder is making prudent use of its human and financial resources. [slide 8] This can be readily seen by the use of terms like ‘results’, ‘impact’, or ‘outcomes’ by MOPAN and COMPAS, as well as in the documentation or on their web sites of most international donors.

Consequently, organisations need to be able to present proposals (and reports) in the same results-focused language. Adopting a results-focused framework at the very start, when conceptualising a project, can make it easier to describe the project using
results-focused terms. Furthermore, focusing on the desired results could improve the project’s design, which will help the staff team to write stronger proposals that could mobilize more resources.

Using a results-focused framework to conceptualise a project starts by thinking about and defining the project’s desired end result or impact — the primary objective — making certain that it is something that is measurable. [slide 9] The project’s other outcomes should be considered at multiple levels. What intermediate outcomes or results must first be accomplished in order to achieve the impact? Is there a direct causal connection between the intermediate outcomes and the objective? Are the results within the power of the organisation or its partners to influence? What factors or conditions outside of the organisation’s control are likely to affect the achievement of results? Could the project’s results have the potential to influence policy? Could the results be duplicated if the project were scaled up and out to the rest of the country or region?

Developing a results-focused framework for the project makes it easier to design performance monitoring and evaluation plans and data collection systems that can demonstrate the project’s results. [slide 10] Being able to provide evidence of results is important for an organisation’s credibility and shows accountability to beneficiaries, project, donors, community and taxpayers. Tracking results also allows organisations to adjust their activities based on a continuous learning process. Making strategic and programmatic decisions based on actual data about results can help an organisation improve performance and effectively communicate their effectiveness to funders. This may be a marked departure from how organisations typically describe themselves and their projects — in terms of activities and processes.

**Exercise (10-15 minutes): Show slide 11**

**WHO – What is the Impact?**

*WHO is the directing and coordinating authority for health within the United Nations system. It is responsible for providing leadership on global health matters, shaping the health research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to countries and monitoring and assessing health trends.*

Referencing the example of WHO in the slide, which is framed in terms of activities/processes – ask participants how they would frame what WHO does in terms of results?

Ask participants to work in groups to think about how they would present the results of their organisation’s or their country office’s work, collect the examples and present back to the group.
Session 2 [slide 12]

Results-Based Management (RBM)

Objectives:

3. To understand the key elements of results-based management

Results-based management (RBM) is management philosophy and approach that emphasises actual development results in planning, implementation, learning and reporting—moving from focusing on how things are being done (processes) to what is being achieved or accomplished (the outcomes of projects and programmes). [Slide 13]

Many funding proposals are based on RBM concepts, which must be used to submit an application. However, the purpose of RBM is fundamental, as it helps to clarify, from very early on, the purpose of a project—and whether it is worth pursuing (likely to have an impact).

According to the Canadian International Development Agency’s Results-based Management Policy Statement 2008, RBM focuses on achieving outcomes, implementing performance measurement, learning, and adapting, as well as reporting performance. [Slide 14] This means:

• Defining realistic expected results based on appropriate analyses;
• Clearly identifying programme beneficiaries and designing programmes to meet their needs;
• Monitoring progress towards results and resources consumed with the use of appropriate indicators;
• Identifying and managing risks while bearing in mind the expected results and necessary resources;
• Increasing knowledge by learning lessons and integrating them into decisions; and
• Reporting on the results achieved and resources involved.

RBM terminology [slide 15]

The definitions of the terms used in RBM are somewhat different than common parlance, and even vary somewhat between stakeholders and UN agencies.

What are results?

In RMB, results are defined as describable or measurable development changes resulting from a cause and effect relationship. Development results involve changes in power relations, how resources are distributed, improvements in the well being of a local
population, or organization, changes in attitudes and behaviours of people, among other things.

The UN Development Group adds that there are three types of such changes—outputs, outcomes and impact—that can be set in motion by a development intervention. The changes can be intended or unintended, positive and/or negative.

**The results chain:** [Slide 16]

A results chain is a depiction of the causal sequence or logical relationships between the inputs, activities, outputs, and outcomes of a given policy, programme, or initiative (see figure 1, for an example of WHO Extended Results Chain). The results chain stipulates the necessary sequence to achieve desired results – beginning with inputs, moving through activities and outputs, and culminating in individual outcomes and those that influence outcomes for the community, goal/impacts and feedback. It is based on a theory of change (see session 3, below), including underlying assumptions.

**Figure 1. WHO (Extended) Results Chain** [Slide 17]

Inputs: [slide 18]

Inputs are the financial, human, material and information resources used by development interventions to produce outputs. Examples include: money, equipment, staff, consultant, in-kind donations, community leaders, vehicle, computers, etc. Note: funding proposals can target different donors for each type of input needed to meet a programme’s funding needs.
Activities: [slide 19]

Activities are actions taken or work performed through which inputs, such as funds, technical assistance and other types of resources are mobilized to produce specific outputs. Examples include: deliver training to..., conduct research on..., design programming on..., construct wells, schools..., negotiate partnership with..., monitor/evaluate programme results..., provide care services to..., allocate funds to..., distribute food aids to..., etc.

Outputs [slide 20]

An output is a direct, tangible and immediate product or service that results from the completion of activities within a development intervention under the control of the organization of an organization, policy, programme, or initiative. Examples include: pamphlet produced, research completed, water treatment plan completed, training sessions provided, food aid delivered, partnership established, funding provided, schools built, bug nets distributed, etc.

Outcomes [slide 21]

Different development partners and UN agencies define outcomes (and impact) slightly differently. An outcome is essentially a change that is directly attributable to the outputs of an organization, policy, programme or initiative. Outcomes may be short term, medium term and, sometimes, long term outcomes (usually referred to as impact).

UNDG defines outcomes as changes in the institutional and behavioural capacities for development conditions that occur between the completion of outputs and the achievement of goals. CIDA notes that short-term outcomes are usually at the level of an increase in awareness/skills of... or access to... among beneficiaries, while medium term are usually achieved by the end of a project/programme and usually when there is a change of behaviour or practice level among beneficiaries.

Outcome examples include: [slide 22]

- Increased awareness of women in X community, on availability of basic essential obstetric care (short term)
- Improved access to clean water in the community (short term)
- Increased usage of clean water in community X (medium term)
- Greater trust and confidence in the justice system (medium term)
**Impact [slide 23]**

An impact represents the highest level of positive or negative changes produced by a development intervention, in a causal manner—the consequence of one or more medium term outcomes (long term).

UNDG’s RBM handbook of 2012 states that “Impact implies changes in people’s lives. This might include changes in knowledge, skill, behaviour, health or living conditions for children, adults, families or communities.”

Examples of impact include: improved health status of women of Sokoto, Nigeria; or reduced vulnerability of conflict-affected women, men, girls, and boys in the country.

**Figure 2: Results Chain – example [slide 24]**

<table>
<thead>
<tr>
<th>Impact (long term result):</th>
</tr>
</thead>
<tbody>
<tr>
<td>An effective immunization programme in Country X leading to reduced morbidity and mortality from polio.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcomes (medium term result):</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Increased immunity to polio and 25% fewer cases and deaths in targeted areas.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Output (short term result):</th>
</tr>
</thead>
<tbody>
<tr>
<td>- 1,000 children vaccinated against polio in 15 targeted areas.</td>
</tr>
</tbody>
</table>

**Activity:**

- Vaccine for polio administered through National Immunization Days (NID) in 15 targeted areas.

Figure 2 illustrates an abbreviated result chain, and provides more specific examples of activities, outputs, outcomes and impact. Note that the figures in this example are only representative.

**Exercise 2 (10-15 minutes):** Ask participants to work in groups practicing how to develop a results chain, using the figure 2 example as a guide, for the projects they are working on.
Session 3 [slide 25]

The theory of change

Objectives:

4. To learn how to use a theory of change to help frame your work

A theory of change is simply a tool — a series of exercises — to help organisations develop and articulate a roadmap for change. It can be a narrative or visual demonstration of what change the organisation’s programme wants to bring about. When applied to a new project, the desired impact should first be determined, and then team members should work backwards to identify all the preconditions, outcomes and activities that are necessary for the impact to be achieved.

Conducting a theory of change exercise to frame a project or programme, provides team members with an opportunity to think through broad strategic challenges without constraints. When deciding upon what change the organisation wants to bring about, the discussion should not be limited by what the organisation can do on its own or what can be done with existing financial constraints. The change should be articulated in a few sentences and be very precise and practical in the wording (i.e. do not use meaningless jargon). Once the change or desired impact has been agreed upon, team members should then think through all that is needed to achieve that impact without limitations (those will be considered later in the process).

Steps to Create a Theory of Change

1. Identify the desired impact or goal.
2. Conduct "backwards mapping" to identify the preconditions necessary to achieve that goal.
3. Identify the interventions that the project will perform to create these preconditions.
4. Develop indicators for each precondition that will be used to assess the performance of the interventions.
5. Write a narrative that can be used to summarize the various moving parts in the theory.

Exercise 3 (10-15 minutes): If there is time, ask participants to work in groups, practicing the first few steps of using a theory of change for a project. After, articulating the desired impact or goal is most critical, ask participants to identify some of the preconditions and interventions that might be needed to achieve that goal, keeping in mind that there may be more than one way to accomplish that goal.

---

Question

QUIZ

1. List the four reasons why it is important to demonstrate results? (Slide 10)
2. List four aspects of results based management. (slide 14)
3. Define what is a results chain. (slide 16)
4. What is the difference between an output and an outcome? Give an example of each. (slides 20-22)
5. A theory of change is a tool that helps us do what? (Give at least one definition). (slide 26)
6. List four of the five steps needed to create a theory of change (slide 28).

For further reading:


FACILITATING
MODULE 9
WHO-specific requirements
Give a brief general preamble of the module to participants:

This module is to help technical officers and programme managers at WHO country offices involved develop a clearer understanding of WHO-specific requirements in relation to resource mobilization. It reviews how WHO priorities are set under the Twelfth General Programme of Work (12th GPW). It also describes how the programme budget is used as a framework to develop more detailed workplan budgets and manage spending. It also explains WHO requirements pertaining to donor agreements and award management. At the end of the module, participants will work through a case study exercise in how to manage an award from a donor.

Module outline [slide 2]

Go through the module outline with the participants to ensure they understand what will be covered. This should include the learning objectives and the four sessions to be covered in this module.

- Introduction
- Learning objectives
- Sessions

Introduction [slides 3–4]

[Slide 3] Over the last 15 years, major economic, demographic, environmental and political changes have transformed the global public health sector.

Many low- and middle-income countries have experienced rapid development. Several countries have moved so far up in income bracket that they are no longer eligible for external development aid. But while better economic performance has dramatically improved the living standards for much of the population, income inequality has also
grown. Three quarters of the world’s poorest people now live in middle-income countries. Malnutrition and food insecurity persists.

Urbanization has also increased — more than half of the world’s population will soon live in an urban setting. In many cities, population growth will outstrip the development of water and sanitation infrastructure and healthcare services.

At the same time, the world’s population has been aging. By 2050, 80% of the world’s older people will be living in what are currently low- and middle-income countries. This demographic shift will have consequences for health and health systems worldwide.

While there continues to be much unfinished business addressing long standing health issues such as the control of communicable diseases, and reaching maternal, new-born and child health targets, in many developing countries, changes in lifestyle and diet have led to a dramatic increase in noncommunicable diseases (NCDs) including chronic diseases (e.g. heart, stroke, cancer, mental illness and diabetes), and injuries.

Communities are also increasingly vulnerable to weather-related natural disasters, the frequency and severity of which is expected to worsen due to climate change. Environmental crises could also threaten water supplies, and increase food insecurity.

There has, however, been an increased awareness of the interconnectedness of global health issues, and of the need to support effective responses at global, regional and national levels. This has led to a dramatic increase in the number of actors in the global health arena, with over 40 bilateral agencies, 25 UN organizations, 20 global and regional funds, and more than 90 global initiatives now focused on providing health activities and assistance. However, global funding for health, which increased dramatically during the first several years of the century, has now levelled off. In light of increased competition for more limited resources for health, it is essential for each organisation to focus on areas where it can have the greatest impact.

[Slide 4]: Consequently, a process of extensive reform has been underway at WHO to better equip the Organization to effectively respond to the increasingly complex challenges of health in the 21st century. These changes include programmatic reforms to achieve improved health outcomes, governance reforms to enhance WHO’s leadership role in global health, and managerial reforms in pursuit of Organizational excellence.

The reform process at WHO has also changed the way that financial resources are mobilized and deployed to achieve results at each level of the organization. As noted in earlier chapters, country office team members must now be actively engaged in the mobilizing the resources for the projects that warrant funding. However, programme managers and technical officers also need to have a clear understanding of WHO-specific requirements in relation to resource mobilization, including how WHO priorities should be set, the budgetary control framework, and guidelines related to agreements with donors, and award management.
Learning objectives [slide 5]

At the end of this module, participants will:

1. Know how WHO priorities are set under the 12th Global Programme of Work, and how are linked to results-based management
2. Understand how the programme budget is used as a framework for workplans and monitoring
3. Know WHO’s requirements regarding donor agreements; and
4. Be able to manage awards according to WHO requirements

Session 1: [slide 6]

WHO Priorities

Objective 1: Develop a clear understanding of how WHO priorities will be set over the 12th General Programme of Work (GPW) across the technical categories and programme areas, particularly at country level, and how these priorities are linked results based management, resource mobilization, subsequent planning and performance assessments

Before starting this session, refer participants to the list of abbreviations and definitions at the beginning of the participant manual related to programme budgets, donor agreements and award management.

WHO priorities

The programmatic reform process led to the selection of WHO’s priorities for the coming years with a focus on areas where the Organization has a unique function or comparative advantage. This is reflected by the Twelfth General Programme of Work (12th GPW), which describes the high-level strategic vision for the work of WHO for the period 2014–2019, as well as by the subsequent WHO Programme Budgets.

The 12th GPW lists six health priorities where WHO leadership is most needed, in order to: [slide 7]

- Advance universal health coverage to ensure that all people obtain the health services they need without suffering financial hardship;
- Address unfinished and future challenges of the health-related Millennium Development Goals (MDGs) and accelerate their achievement up to and beyond 2015, including completing the eradication of polio and other selected neglected tropical diseases;
• Prevent and control noncommunicable diseases, violence and injuries, and address mental health conditions and disabilities;
• Implement the International Health Regulations (IHR) to increase global public health security;
• Increase access to essential, high-quality and affordable medical products – medicines, vaccines, diagnostics and other health technologies;
• Address the social, economic and environmental determinants of health to reduce health inequities within and between countries.

In order to implement the 12th GPW, these new priorities were integrated into upcoming WHO programme budgets — the first of which was for the years 2014-2015. These programme budgets are organized around five technical and one managerial categories of work:

• Communicable diseases
• Noncommunicable diseases and mental health, violence, injuries and disabilities
• Promoting health through the life-course
• Health systems
• Preparedness, surveillance and response
• Corporate services/enabling functions

Table 9.a provides an indication of the broad changes in human and financial resource emphasis in the WHO secretariat over the next six years covered by the 12th GPW, in each respective category of work. [slide 8]

Table 9.a

<table>
<thead>
<tr>
<th>Category</th>
<th>Broad financing trends noted in GPW</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Communicable disease</td>
<td>Reduction</td>
</tr>
<tr>
<td>2. Noncommunicable disease</td>
<td>Increase</td>
</tr>
<tr>
<td>3. Promoting health through the life-course</td>
<td>Modest increase</td>
</tr>
<tr>
<td>4. Health systems</td>
<td>Increase</td>
</tr>
<tr>
<td>5. Preparedness, surveillance and response</td>
<td>Level</td>
</tr>
<tr>
<td>6. Corporate services/enabling functions</td>
<td>Effort on cost efficiencies and savings</td>
</tr>
</tbody>
</table>

The reform process at WHO also mandates improving strategic planning and resource coordination — at global, regional and country level. There should be a robust process in place to identify the health needs and priorities for WHO technical cooperation at the country level as country offices will need to align income and expenditures with the priorities and health needs of the Member States. In addition, a results-based management framework is needed to measure performance in each technical category programme area.
Together, the 12th GPW and the Programme Budget 2014-15 would set the foundations for subsequent planning and performance assessments, establishing:

- **A technical programming framework**: In addition to organizing WHO’s work into the five technical categories and in the corporate services categories, the categories of work were further divided into 30 programme areas — which provide the organizing framework for the programme budget.

- **A clear results reporting structure**: The 12th GPW and subsequent programme budgets incorporated a clear results chain for WHO with defined outputs, deliverables, impacts, and outcomes that show the links between the work that WHO will do and its contribution to the improvement of the health of populations. To increase the reliability of the evidence base, WHO should work with national partners to strengthen the collection, analysis and use of national health data including strengthening country information systems. This will require the of existing methods and mechanisms, especially national systems and existing programmes and system’s reviews, to assess whether the organization has achieved the desired outcomes and impacts.

- **A performance framework**: The results chain provides the main instrument through which WHO’s performance will be assessed henceforth. Indicators, baselines and targets have been set for each outcome for the entire 6-year cycle of work. Monitoring involves a systematic assessment, during each two-year programme budget period, of whether the allocated resources were used to deliver the outputs defined in the respective programme budget, and, as a result, was there measurable progress in relation to the agreed outcomes and impacts to which WHO’s work contributes. There would be an annual mid-term review after the first year of each two-year programme budget, and a more comprehensive programme budget performance assessment is to take place following the close of each biennium. Note: the results of monitoring and evaluation should be used to take corrective action to address under-performance, or to adapt activities as needed to achieve the desired results, as well as to guide the next planning cycle.

- **A budget framework** against which resources are to be managed. The 12th GPW and Programme Budget 2014-15 signalled changes in the way that financial resources would be deployed in order to achieve results. This involved alignment of income and expenditures within the approved programme budget by the major offices at each level, by category and programme (more in Session 2).

Table 9.b illustrates the prioritizations (high, medium or low) in the 2014-2015 PB across the technical categories and programme areas at country level in the SEARO region. [slide 10] Using the technical framework allowed each country office to focus on the highest priority programme areas for their respective countries (see Table 9.b) [slides 11 & 12]
<table>
<thead>
<tr>
<th>Category</th>
<th>Programme Areas</th>
<th>Bangladesh</th>
<th>Bhutan</th>
<th>DPRK</th>
<th>India</th>
<th>Indonesia</th>
<th>Maldives</th>
<th>Myanmar</th>
<th>Nepal</th>
<th>Sri Lanka</th>
<th>Thailand</th>
<th>Timor Leste</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Category 1 (CDS)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1 HIV/AIDS</td>
<td>Low</td>
<td>Medium</td>
<td>High</td>
<td>Low</td>
<td>High</td>
<td>Low</td>
<td>High</td>
<td>High</td>
<td>Low</td>
<td>Medium</td>
<td>High</td>
<td></td>
</tr>
<tr>
<td>1.2 Tuberculosis</td>
<td>High</td>
<td>Medium</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>Low</td>
<td>Medium</td>
<td>High</td>
<td></td>
</tr>
<tr>
<td>1.3 Malaria</td>
<td>High</td>
<td>Medium</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>Medium</td>
<td>High</td>
<td>Medium</td>
<td>High</td>
<td>Low</td>
<td>Medium</td>
<td>High</td>
</tr>
<tr>
<td>1.4 Neglected Tropical Diseases</td>
<td>Medium</td>
<td>Medium</td>
<td>Not</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
<td>Not</td>
<td>High</td>
<td>Medium</td>
<td>Medium</td>
<td>High</td>
<td></td>
</tr>
<tr>
<td>1.5 Vaccine-Preventable Diseases</td>
<td>High</td>
<td>Medium</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>Not</td>
<td>Low</td>
<td>High</td>
<td></td>
</tr>
<tr>
<td><strong>Category 2 (NCD)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1 Non Communicable Diseases</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>Not</td>
<td>Low</td>
<td>High</td>
<td></td>
</tr>
<tr>
<td>2.2 Mental health</td>
<td>High</td>
<td>High</td>
<td>Not</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
<td>Not</td>
<td>Low</td>
<td>High</td>
<td>Medium</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.3 Violence and injuries</td>
<td>Low</td>
<td>Medium</td>
<td>Not</td>
<td>Not</td>
<td>Low</td>
<td>Low</td>
<td>Not</td>
<td>Low</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td></td>
</tr>
<tr>
<td>2.4 Disabilities and rehabilitation</td>
<td>Low</td>
<td>High</td>
<td>Not</td>
<td>Low</td>
<td>Not</td>
<td>Low</td>
<td>Not</td>
<td>Low</td>
<td>Not</td>
<td>Not</td>
<td>Not</td>
<td></td>
</tr>
<tr>
<td>2.5 Nutrition</td>
<td>Medium</td>
<td>High</td>
<td>High</td>
<td>Not</td>
<td>Low</td>
<td>Low</td>
<td>Not</td>
<td>Medium</td>
<td>High</td>
<td>Low</td>
<td>High</td>
<td></td>
</tr>
<tr>
<td><strong>Category 3</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.1 Reproductive, maternal, newborn, child and adolescent health</td>
<td>High</td>
<td>Medium</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>Medium</td>
<td>High</td>
<td>Low</td>
<td>High</td>
<td></td>
</tr>
<tr>
<td>3.2 Healthy Ageing</td>
<td>High</td>
<td>High</td>
<td>Not</td>
<td>Not</td>
<td>Low</td>
<td>Low</td>
<td>Not</td>
<td>Low</td>
<td>Medium</td>
<td>Low</td>
<td>Low</td>
<td></td>
</tr>
<tr>
<td>3.3 Gender, equity and human rights mainstreaming</td>
<td>Low</td>
<td>Medium</td>
<td>Not</td>
<td>Medium</td>
<td>Medium</td>
<td>Low</td>
<td>High</td>
<td>Low</td>
<td>Medium</td>
<td>Medium</td>
<td>Low</td>
<td></td>
</tr>
<tr>
<td>3.4 Social determinants of health</td>
<td>Low</td>
<td>High</td>
<td>Not</td>
<td>High</td>
<td>Medium</td>
<td>High</td>
<td>Not</td>
<td>Low</td>
<td>Not</td>
<td>Medium</td>
<td>Medium</td>
<td></td>
</tr>
<tr>
<td>3.5 Health and the environment</td>
<td>High</td>
<td>High</td>
<td>Not</td>
<td>High</td>
<td>Not</td>
<td>Low</td>
<td>Not</td>
<td>High</td>
<td>Not</td>
<td>Not</td>
<td>Low</td>
<td>Medium</td>
</tr>
<tr>
<td><strong>Category 4</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.1 National health policies, strategies and plans</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>Medium</td>
<td>Medium</td>
<td>High</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.2 Integrated people-centered services</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>Low</td>
<td>Medium</td>
<td>High</td>
<td>High</td>
<td>Medium</td>
<td>High</td>
<td>High</td>
<td></td>
</tr>
<tr>
<td>4.3 Access to medical products and strengthening regulatory capacity</td>
<td>Medium</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>Low</td>
<td>High</td>
<td>Not</td>
<td>Medium</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td></td>
</tr>
<tr>
<td>4.4 Health system information and evidence</td>
<td>Low</td>
<td>High</td>
<td>Not</td>
<td>Medium</td>
<td>Medium</td>
<td>High</td>
<td>Not</td>
<td>High</td>
<td>High</td>
<td>Not</td>
<td>High</td>
<td></td>
</tr>
<tr>
<td><strong>Category 5</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.1 Alert and Response Capacities (HFR)</td>
<td>High</td>
<td>Medium</td>
<td>High</td>
<td>High</td>
<td>Medium</td>
<td>High</td>
<td>High</td>
<td>Medium</td>
<td>High</td>
<td>High</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.2 Epidemic- and pandemic-prone diseases</td>
<td>Medium</td>
<td>High</td>
<td>Not</td>
<td>Low</td>
<td>High</td>
<td>Low</td>
<td>Not</td>
<td>High</td>
<td>Not</td>
<td>Medium</td>
<td>High</td>
<td></td>
</tr>
<tr>
<td>5.3 Emergency risk management and crisis management</td>
<td>Medium</td>
<td>High</td>
<td>High</td>
<td>Not</td>
<td>High</td>
<td>Medium</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>Medium</td>
<td></td>
</tr>
<tr>
<td>5.4 Food safety</td>
<td>Low</td>
<td>Medium</td>
<td>High</td>
<td>Not</td>
<td>Low</td>
<td>Medium</td>
<td>Not</td>
<td>Low</td>
<td>Not</td>
<td>Low</td>
<td>High</td>
<td></td>
</tr>
</tbody>
</table>
### Table 9.c Programme area priorities by country demonstrated focus

<table>
<thead>
<tr>
<th>Country Office</th>
<th>CO Budget</th>
<th>Priority Programme Areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>BAN</td>
<td>15.1 m</td>
<td>1.2 TUB, 1.5 VPD, 2.1 NCD, 3.1 Reproductive and MNCAH health, 3.5 Health and the environment, 4.1 National health policies, strategies and plans, 4.2 People-centred health services (49%, 79%)</td>
</tr>
<tr>
<td>BHU</td>
<td>3.7 m</td>
<td>2.1 NCD, 2.5 Nutrition, 3.5 Health and the environment, 4.2 People-centred health services, 4.3 Access to medicines and health technologies (67%, 77%)</td>
</tr>
<tr>
<td>KRD</td>
<td>8.9 m</td>
<td>1.2 TUB, 1.3 MAL, 1.5 VPD, 2.1 NCD, 4.2 People-centred health services, 4.3 Access to medicines and health technologies (65%, 85%)</td>
</tr>
<tr>
<td>IND</td>
<td>20.9 m</td>
<td>1.1 HIV, 1.2 TUB, 1.5 VPD, 3.1 Reproductive and MNCAH health, 3.5 Health and the environment, 5.2 Epidemic- and pandemic-prone diseases (45%, 66%)</td>
</tr>
<tr>
<td>INO</td>
<td>24.6 m</td>
<td>1.2 TUB, 2.1 NCD, 3.5 Health and the environment, 4.1 National health policies, strategies and plans, 4.2 People-centred health services, 4.3 Access to medicines and health technologies, 4.4 Health system information and evidence (52%, 79%)</td>
</tr>
<tr>
<td>MAV</td>
<td>2.3 m</td>
<td>1.2 TUB, 2.1 NCD, 3.5 Health and the environment, 4.1 National health policies, strategies and plans, 4.2 People-centred health services, 4.3 Access to medicines and health technologies, 4.4 Health system information and evidence (52%, 79%)</td>
</tr>
</tbody>
</table>

Once the country office’s priority programme areas are in focus, and a preliminary budget is estimated, the country office staff will need to make certain there are adequate resources to cover the planned costs. [Slide 13] This will require a clear understanding of the allocations for all the financial resources — known and forecast — in order to better align resources to the results and the deliverables in the approved programme budget. This includes assessed contributions (AC) — the generally predictable and flexible funding already allocated by the member states — as well as the voluntary contributions (VC) some of which may be carried over from the last biennium’s programme budget but most of which will have to be mobilised by WHO staff (see Table 9d). Note: too often, when planning for resource mobilization, the country office does not take into account the assessed contributions and other flexible funds — which can lead to significant miscalculations.

<table>
<thead>
<tr>
<th>Item</th>
<th>Amount (m)</th>
<th>Amount (m)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 1-5 Planned costs, Country X</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Category 1-5 Allocated AC</td>
<td></td>
<td>2.5</td>
</tr>
<tr>
<td>Carry-forward VC</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>New VC known</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Shortfall Category 1-5 at the start</td>
<td></td>
<td>5.5</td>
</tr>
</tbody>
</table>

The GPW also established how to conduct upcoming planning cycles — which should be performed early in the year prior to the start of the next two-year programme budget (see figure 9.b). [slide 14] The planning process begins with country consultations between the WHO country offices and all stakeholders that contribute to or influence the health sector in the country, setting priorities in line with the GPW and the country’s particular needs. During this stage of planning, the country office should assess the cost of outputs and deliverables. The goal should be bottom-up planning where country priorities are captured and costs assessed early on.

The needs and priorities in countries should then inform the regional and global priorities, all of which need to be consolidated in the organization-wide programme budget and approved by the World Health Assembly. Once approved, the programme budget can be used as a tool for resource mobilization, and to guide the development of operational plans and workplans. As these plans are implemented, there should be ongoing monitoring and evaluation in order to assess and report on the programme’s performance and impact. The lessons learned should help inform the next planning cycle. Figure 9.c illustrates the high-level programme budget development process for 2016-2017. [slide 15] A similar process is underway for the next biennium.
**Figure 9.b Forthcoming Planning Cycles**

- **Planning Country Consultations-priority setting**
- **Development of plans and costing of outputs and deliverables**
- **Technical and Financial Reporting**
- **Consolidation and organizationwide agreement of Programme Budget**
- **Implementation of plans**
- **Approval of PB by WHA**

Desired result is bottom-up planning where country priorities are captured and costed early.

**Figure 9.c**

**High-Level Timeline Programme Budget 2016-17 development**

Approach to process for PB 2016-17 and agreement on criteria for strategic allocation of resources

**Between Jan 2014 and June 2015:**

- **Identification of a limited set of 3 to 5 country priorities** discussed with MS - consistent with the GPW leadership priorities, impacts and outcomes
- **Development bottom-up budget** based on standard costs Jan to May 2014 in each country office
- **Global category and programme review of country priorities**
- **Strategic allocation** of resources based on agreed criteria (under development)

Development and approval of PB 2016-17
[Slide 16] Session 2

Budgetary Control Framework

Learning Objective 2: To understand how the programme budget is used as a framework for workplans and monitoring

Budgetary Control Framework

The Global Management System (GSM) is the tool that WHO uses to execute its process of results-based programme management, from planning to reporting. [slide 17] The programme budget is built into the GSM, and based upon results, which guide the system and its approvals. The programme budget is allocated to Budget Centres to deliver results (allocations = budget ceilings). The Budgetary Control Framework means that the programme budget is used as a framework to develop more detailed workplan budgets and monitor spending.

Figure 9.d provides an overview of how the programme budget guides workplans and spending. [slide 18]

(Go over this quickly, there is more detail on the next slide.)

Figure 9.d

- Allocate the Approved PB to Budget Centres by OWER and Fund – GL Budget
- Allocate funds within total planned cost for that workplan and PB ceilings
- Fund workplan within total planned costs, and within PB allocations for the Budget Centre
- Encumbrances and expenditures must remain within the three constraints above
From top to bottom is the process of developing the budget, moving from the high-level programme budget down to the details in the workplan, and from the beginning of the budget process, to the moment when we implement the money.

In box one, after we approve the programme budget at the World Health Assembly, we **allocate** the budget to Budget Centres to implement. This tells budget centres what results they are responsible for, and what ceiling they have for implementation. In Box 2, during operational planning, we plan **within** the programme budget allocations. For our approved workplans to be approved, they must be within the ceilings. In Box 3:

Once workplans are approved, we can fund them. Award budgets (funds available for each top task in the workplan) must be **within** planned costs, and **within** programme budget allocations. In Box 4: We implement. When we implement, we spend within funds available.

Or, from the bottom up, when an obligation/encumbrance is raised, funds check looks to see if the expenditure is **within** the award budget, and therefore within the planned cost and General Ledger budget.

This ensures that the programme budget guides implementation.

[Slide 19] Figure 9.e explains the different checks at each level.

**Figure 9.e**

- **Region** approves shifts within their Major Office, SO, Segment and Fund
- **HQ** approves shifts across SO, Major Office, Segment or Fund, or increases

- Planned costs must be **within** PB allocations at SO and Budget Centre (absolute control)

- The total award budget must be **within** the total planned costs for that workplan and total award budget for all workplan in the budget centre be within the PB allocations for the budget centre by SO and Fund

- Each encumbrances / expenditure is checked against award budget at top task level (advisory), award budget at workplan level (absolute), and GL budget ceilings
In Box 1, the allocation from the programme budget to Budget Centres is by OWER (Organization-Wide Expected Results) and Fund. Fund is at higher-level, i.e., assessed contributions and voluntary contributions.

FAQ: is this real money?

No, this is your hypothetical budget, your budget ceiling. This is both your target for fund-raising and spending, and your limit. It also represents a commitment by the organization to find and distribute funds to you up to the level of the ceiling – and the whole organization is responsible for that resource mobilization.

Box 2 shows that the planned costs must be within programme budget allocations for your Budget Centre, by Strategic Objective (SO). Business rules and agreements in your cluster may well imply that you should stay within the OWER allocation, or even within an amount authorized by the ADG or Department Director for your OSER (Office-Specific Expected Results) or product. However, the system check is at the high-level: the amount for the whole SO for your Budget Centre. This allows some management flexibility.

FAQ: Can one Budget Centre use another Budget Centres allocation?

No. The allocation is by Budget centre, and the system check for planned cost is by SO and Budget Centre.

In Box 3: Award Budgets are checked at two levels: the total award budget must be within planned costs for the workplan. This check is not by SO; it is simply the total costs for the workplan. In addition, the total award budget for all workplans in the budget centre must be within the programme budget allocations for the budget centre by SO and Fund.

Finally, in Box 4, each obligation is checked against three things:

1. The award budget for the task (advisory)
2. The award budget for the workplan (absolute)
3. The programme allocations for the Budget Centre (absolute).

The third check is very high-level – it covers the entire SO budget for the Budget Centre.

[Slide 20] Several monitoring and reporting tools are built into the GSM to makes sure that costs stay within allocations.

Planned Cost vs. Share of Allocation

“Share of allocations” is a tool to assign a portion of the programme budget allocation to individual workplans. It helps to ensure that the planned costs of a workplan are within the apportioned amount. GSM checks for variances — whether the total planned costs for all projects of a Budget Centre are within the programme budget allocations at budget centre and category level.
DBI Reports

DBI (Daily Business Intelligence) reports offer easy to use and easy to read graphic displays (coloured pie and bar charts) of implementation information, and include the tables on which the charts are based. DBI is essentially an on-line query tool to support monitoring and analysis, especially in relation to Programme Budget implementation and expenditures analysis. There are five Daily Business Intelligence (DBI) reports available in GSM. The five reports are in order of level of detail: the first, Programme Budget Implementation, shows a high-level budget view including the original approved programme budget and the current allocations. Each successive report allows access to greater and greater levels of detail, including workplans, expenditures categories and funds. The two most useful reports to senior management are likely to be programme budget implementation by Fund, which provides a good overview by Budget Centre, SO and OWER or Fund of implementation figures, including planned cost, award budget and expenditures, and Workplan Budget Implementation, which accesses project-level information.

Finally, WHO Organization-wide Budget Implementation Analysis Report provides a comprehensive status of budgets, resources and implementation by Budget Centre, SO/OWER, fund, workplans and awards.

[Slide 21] Session 3: Awards: Donor agreements and Award Management

Learning Objective 3. To be familiar with WHO’s requirements regarding donor agreements; and

Learning Objective 4. Be able to manage awards according to WHO requirements

The entire purpose of this manual has be to assist country office team members who must now be actively engaged in the mobilizing the resources for their projects and to achieve results. Now, managers and officers need to be aware of WHO requirements when it comes to donor agreements and managing awards.

Figure 9.f briefly describes the Award Implementation Cycle, from the point where the donor agreement is signed and an award is created, on to disbursement, management and implementation. [slide 22] This will be covered in more detail later in the session.
Awards Vocabulary

First, however, it may be useful to review some of the new terminology related to Awards in the GSM. [slide 23]

An Award is defined as a contribution to support an activity or set of activities. It starts with confirmed funding (e.g. signed donor agreement) and ends when the final financial reporting is completed. Objectives are generally accomplished within a given timeframe. Note: All funds are recorded as awards, whether Voluntary or Assessed Contributions or Special Purpose funds.

The Award Manager takes overall managerial responsibility and authority for establishing and administrating the award in accordance with the terms and conditions of the donor agreement. The Award Manager is responsible to the donor and WHO for ensuring that the funds are utilized appropriately.

[Slide 24] An Award Distribution is the internal management decision identifying which Strategic Objective (SO), Organization Wide Expected Result (OWER), Major Office (MO) and Budget Centre (BC) should participate in the implementation of the award. The initial distribution is done through an AAR (Award Activation Request) by IAM/HQ. Additional distributions can be done using the ADR (Award Distribution Request) form.
**Workplan Planning:** Within the Budget Centre level, funding can be requested to any of the Projects (workplans) of that Budget Centre (Note: The words project and workplan are used interchangeably in GSM). A GSM Project Funding Request should be created which requires specifying the award number and the USD amount requested.

**Award Budget** means funds budgeted within a workplan at the top task (product) level.

*Note that award terminology will change to reflect the change from SOs to categories.*

**Voluntary Contributions:** As noted earlier, there are two types of award sources: Assessed Contributions (AC) from WHO member states, and Voluntary Contributions (VC) from donors. [slide 25] Presently, VCs account for about 75% of WHO’s total resources. Their inflow is ‘unpredictable’ and uncertain. They are also ‘specified’—i.e. to be incurred on specified set of activities as agreed upon in the donor agreement. They are also normally time bound in nature—i.e. activities must be completed by a specific date as stated in the signed agreement, and reporting (both technical and financial) to donors is required in most cases.

**There are three types of awards.** [Slide 26]

**In Cash Awards** are the standard award type where the donor transfers cash contributions to cover the cost of the activity.

**In Kind Contributions** are donations of goods such as medicines, computer equipment, vehicles or contributions for the use of office.

**In Service Contributions** are non-reimbursable secondments of staff such as medical research and field.

Both In-Kind and In-Service Contributions are distributed and funded (both workplan funding and award budgeting) as all other awards; however, there is no cash contribution. Expenditure is recognized only by way of an expenditure batch. No PSC is levied and there is no billing event created. As there is no PSC, 100% of the contribution is distributed to programmatic workplans. *(For additional reference, especially on related expenditure batches, refer to the GSM Guidance Note In-Kind and In-Service Voluntary Contributions.)*

**Donor Agreements** [slide 27]

The Award Cycle begins with negotiating and signing the donor agreement, in line with the programme budget and workplans. Then the Regional Director (RD) delegates authority to WHO representative (WR) based on twin criteria: 1) The LAC mechanism plus, 2) a contribution amount of up to US $50,000 under a standard exchange of letters (letter of acceptance) with the donor agency. [slide 28] PIR/SEARO should be consulted for clearance in either case.

[Slide 29] A fixed percentage is then charged on each voluntary contribution (in accordance with WHO’s "Operational Guide to PSC") to support the leadership and
administrative functions of the Organization. These are called ‘WHO Programme Support Costs’ and are transferred to the Programme Support Cost Fund.

[Slide 30] Then, first level checks should be confirmed by the country office or technical unit:

- The implementation period should be clearly stated
- The arithmetical accuracy of the budget should be checked
- Confirm that any Annexures are in place and are correctly referenced in the text
- Confirm that the three Non Negotiable Clauses: (1) The Interest Clause, (2) The Audit Clause, and (3) Programme Support Costs are as per WHO regulations.
- While responding to RO issues, confirm that all queries have received a response. If a suggestion/recommendation cannot be complied with, the reasons should be stated with a justification.

There are a number of common reasons for delay [slides 31 and 32]

1. The single window for entry (for SEARO clearances) and exit (after SEARO clearances) of donor agreements is the external relations officer (ERO). A draft sent to any other unit in SEARO may entail delivery delays.

2. Draft Agreement substantially deviates from WHO’s Standard donor agreement format in ‘letter’ and/or in ‘spirit’.

3. Some of the clauses in the draft are completely new and deserves to be vetted by HQ/LEG (examples are: anti-terrorism clause, anti-corruption clause, termination rights solely vesting with the donor, etc).

4. In cases where private sector companies, NGOs or Foundations are involved these need to be reviewed and cleared by HQ.

5. PSC rate is lower than what is recommended by the “Operational Guide To PSC“ thereby necessitating prior approval by the Comptroller, WHO.

6. The draft is not accompanied by all the relevant annexures which form an integral part of the proposed agreement (e.g. Annex 1 – Project Proposal, Annex 2 – Budget, etc). [slide 32]

7. Detailed budget not attached or there are errors in budget/PSC calculations.

8. Initial review points communicated to WCO are not addressed in the revised draft received subsequently from the country office.

9. After the donor and WHO have agreed to a draft, the contents are revised/modified again in the final version received for clearance in SEARO.
10. Signed Agreement is received in SEARO without AAR or incorrectly filled in AAR.

The following points should help avoid common relays [Slides 33 and 34]

- The draft should be based on WHO standard donor agreement or should not deviate from it substantially in its ‘essence’.
- Deliver all draft agreements to the Partnerships Interagency Coordination and Resource Mobilization (PIR) team with a usual follow up.
- Ensure that the complete package is sent with all relevant annexes attached.
- AOs must vet the entire package before it is sent for RO clearances.
- Annexes/Attachments are equally important. While reviewing to ensure that the draft conforms to WHO’s standard template, give as much importance to annexes/the proposal document as to the main draft. These might contain conditions that are supported by WHO rules and regulations.
- Ensure that the basic math in the budget is correct. Deliver all draft agreements to PIR with a usual follow up
- Ensure to keep adequate provision for staff and other administrative costs.
- While sending the revised draft after addressing RO’s issues, please ensure to assign a reason for those that could not complied with.
- Always remember to send AAR (properly filled and duly signed) to BFU along with a copy of the signed agreement. **Please do not wait for the receipt of installment from the donor; WHO provides funding on the basis of signed pledge.**
- Send thank you letter to the donor
- Ensure compliance with reporting schedule.

WHO has its own standard template for donor agreements. [slide 35] Agreements that are developed along the lines specified in the standard donor format are likely to get speedier clearance by the PIR and the BFO. See Standard Donor Agreement Format. Also, standard templates exist for some specific donors, which should be made use of for expeditious processing:

- European Commission (EC)
- World Bank
- UNOPS
- AusAID
- Global Fund
- GAVI
In addition, the following documents are used frequently [slide 36]

- The Standard Donor Agreement Format
- The Letter of Acceptance of Contribution (LAC)
- The Operational Guide to PSC
- The Donor Agreements Check List

Award management

Other aspects of award management are referenced in the Award Cycle Summary in Figure 9.g. [slide 37]

Figure 9.g

1. Negotiate and sign agreement

2. Record and activate award in GSM

3. Distribute award to three levels

4. Budget Centre funds workplans

5. Workplan assigns funds to top tasks

6. Implement and manage activities

7. Close award

[Slides 38 and 39] Briefly, the award cycle begins with the negotiation and signing of the donor agreement, and the appointment of the Award Manager as already described.

In the second step, the award manager should fill in the Award Activation Request (AAR) form, and the Income and Award Management (IAM) unit/Budget and Finance Officer (BFO) should then record the award in GSM based on the AAR and signed donor agreement. The Award Manager should then receive notification that the Award has been activated.
The third step involves the distribution of the Award (funds) to the recipient (Major Office, SO/OWER and Budget Centres), based on the Award’s AAR/and Award Distribution Requests (ADRs). The distribution is then logged into the GSM by IAM/ HQ/BFO.

The fourth step is the Project Funding Phase. This is initiated when the project administrator from the technical unit (TU) raises a workplan funding request in GSM. The BFU processes the request to fund the workplan, based on distributions received in the award.

The fifth step is the award budget phase in which the project manager applies award funding to top tasks within the workplan for implementation.

In the sixth step, activities are implemented as per the terms of the agreement and by the award end date.

In the seventh and final step of the cycle, the award must be closed. HQ/ACT, HQ/IAM, Award Manager, Project Manager with support from BFU and PIR are responsible for reporting on the award and processing refunds (if any).

**The Responsibilities of an Award Manager:** [slides 40 and 41]

1. To negotiate agreements with donors that suit the needs of WHO and its PB/Workplans.
2. To submit the duly completed AAR as soon as the agreement is signed.
3. To ensure timely and effective distribution of the award to the third level.
4. To monitor implementation and take appropriate action as required.
5. Tracking the ‘Receivables’ and following up with the donor to ensure timely receipt of funds.
6. Timely reporting to the donor on implementation.
7. Renegotiating with the donor for a no-cost-extension in exceptional cases or in case there is a need to divert from the agreement.
8. Ensure timely completion of activity, submission of final reports to the donor and closure of award.

Workplans may be either by funded by multiple awards, or one award may fund one or multiple workplans. [slide 42]. Figure 9.h shows the different award request forms, which are available at: http://Intranet.who.int/homes/lam/voluntarycontributions.
An Award may be recorded as either a simple pledge or a conditional pledge. [Slide 43]

**Simple Pledge**

- Example: $500K will be released on signing of the donor agreement (Total Contribution Amount, say $1.5 million) by both the parties and the balance on submission of six monthly reports with a projection for next six months.
- Outcome: Award will be recorded with full amount ($1.5 million) allowing distributions for the entire biennium.

**Conditional Pledge**

- Example: $500K will be released on signing of the donor agreement (Total Contribution, say $1.5 million) by both the parties and the balance on submission of six monthly reports with a projection for next six months. However, release of installments by the PR is subject to availability of funds by the donor.
- Outcome: Award will be recorded only with $500K allowing distributions for $500K or an amount pertaining to the biennium, whichever is less. Further distributions (and the corresponding increase in award amount) will be recorded as and when the subsequent installments are received.

Once again, reports will need to be submitted on every award from donors. [slide 45] These reports include Certified Financial Statements, which can be either ‘Interim’
or ‘Final’, and Technical and Management Financial Reports. Final Certified Financial statements are issued only after the close date and/or when all encumbrances have been settled/cleared. Certified financial statements of income and expenditure are issued by FNM/ACT and can only be signed by the Chief Accountant. The Award Manager must request the Final Certified Financial Statement (FCFS) by filling the official request form.

Technical and Management Financial Reports are narrative reports on all activities. The Award Manager signs these to ensure implementation is consistent with the project document. These are often given to donors in advance or on an ad-hoc-basis in lieu of an interim certified financial statement. Any financial information in these reports must be cleared by the BFO.

[Slide 46] Reports must be filed in a timely manner as required by the terms of the donor agreement. Technical reporting and management financial reporting is the responsibility of the respective award manager. The financial reports should be vetted by the BFO; and a copy of every financial/technical report sent to PIR. These reports should be prepared in accordance with WHO Financial Regulations and Rules, with data drawn from the Organization’s official accounting database (GSM). There should be an audit trail available to support the reported figures.

Critically, reporting on WHO work funded by voluntary contributions is vital to the credibility of the Organization and to maintaining the commitment of donors.

CDS/SEARO has signed a donor agreement with the donor ABC for HIV activity. The contribution amount is $100,000. 50% was to be paid on signing of the agreement and the balance 50% around 15th Sept ’11.

The implementation period is from 1 June 2011 to 31 Dec 2011. The donor allowed six months after the award end date to settle all encumbrances and produce a final certified financial statement.

Questions for exercise [Slide 48]

1. What is the award end date?
2. What is the award close date?
3. Which request form is required to be filled in for activating the award?
4. It is expected that the donor will be depositing the first installment (in WHO’s bank account) in about two week’s time. Can the award manager start implementation on the award? Why?
5. What is the timeline for submission of a final certified financial statement by WHO and which form is required to be filled in for requesting the same?
6. Technical unit wants to raise an APW with an implementation period of 15 May 2011 to 31 July 2011. Can this be done using the above award?
7. Technical unit wants to raise an APW with an implementation period of 15 November 2011 to 5th January 2012. Can this be done using the above award?

Case Study Answers [Slide 49]

1. End Date: 31 Dec 2011
2. Close Date: 30 June 2012
3. AAR (Award Activation Request)
4. Yes. On the basis of signed pledge – Accrued income concept per IPSAS.
5. 30 June 2012. FCFS request form needs to be filled in.
6. No because the start date of the APW falls outside the award period (June 2011 to Dec 2011).
7. No because the end date of the APW falls outside the award period.

QUESTION (Slide 50)

QUIZ (Slide 51)

1) What is the difference between Award End Date and Award Close date?
2) How do I ascertain the close date while filling up an AAR?
3) What is FCFS form? When is it required?
4) What is the difference between Funds Utilization and Expenditure?
5) Can the implementation be started before actual cash is received from the donor?
6) Can an encumbrance be raised with end date stretching beyond the award end date?
7) Can an encumbrance be raised with start date preceding the start date of the award?
Partnerships Interagency Coordination & Resource Mobilization
World Health Organization
Regional Office for South-East Asia
World Health House, I.P. Estate
New Delhi, India
Tel. +91 11 23370804
www.searo.who.int/en