RESOURCE MOBILIZATION ORIENTATION

Participant’s Manual

World Health Organization
Regional Office for South-East Asia
CONTENTS

Introduction and basic orientation
Learning objectives

Module 1: Setting the stage
Introduction
Learning objectives
Key concepts

Module 2: Principles of resource mobilization
Introduction
Learning objectives
Key concepts

Module 3: Planning for resource mobilization
Introduction
Learning objectives
Key concepts

Module 4: Funding landscape
Learning objectives
Introduction
Key concepts
Further reading
<table>
<thead>
<tr>
<th>Module 5: Donor communications and stewardship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
</tr>
<tr>
<td>Learning objectives</td>
</tr>
<tr>
<td>Key concepts</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Module 6: Negotiation and reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
</tr>
<tr>
<td>Learning objectives</td>
</tr>
<tr>
<td>Key concepts</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Module 7: Proposal writing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
</tr>
<tr>
<td>Learning objectives</td>
</tr>
<tr>
<td>Key concepts</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Module 8: Focus on results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
</tr>
<tr>
<td>Learning objectives</td>
</tr>
<tr>
<td>Key concepts</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Module 9: WHO-specific requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
</tr>
<tr>
<td>Learning objectives</td>
</tr>
<tr>
<td>Key concepts</td>
</tr>
</tbody>
</table>
ACKNOWLEDGEMENTS

This module (Resource Mobilization Orientation – Participant’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.

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<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADB</td>
<td>Asia Development Bank</td>
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<tr>
<td>ASEAN</td>
<td>Association of South-East Asian Nations</td>
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<td>BMGF</td>
<td>Bill and Melinda Gates Foundation</td>
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<td>CD</td>
<td>Communicable Diseases</td>
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<td>CIDA</td>
<td>Canadian International Development Agency</td>
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<tr>
<td>CSR</td>
<td>corporate social responsibility</td>
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<td>DAC</td>
<td>Development Assistance Committee</td>
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<td>DFID</td>
<td>Department for International Development</td>
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<tr>
<td>EU</td>
<td>European Union</td>
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<tr>
<td>GFATM</td>
<td>Global Fund to fight AIDS, TB and Malaria</td>
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<td>GHI</td>
<td>global health initiatives</td>
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<tr>
<td>INGO</td>
<td>international nongovernmental organization</td>
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<tr>
<td>M&amp;E</td>
<td>monitoring and evaluation</td>
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<td>MDG</td>
<td>Millennium Development Goal</td>
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<tr>
<td>MOPAN</td>
<td>Multilateral Organisation Performance Assessment Network</td>
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<tr>
<td>MoU</td>
<td>memorandum of understanding</td>
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<td>MTSP</td>
<td>Medium Term Strategic Plan</td>
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<td>NCD</td>
<td>noncommunicable disease</td>
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<tr>
<td>NGO</td>
<td>nongovernmental organization</td>
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<td>NTD</td>
<td>Neglected tropical disease</td>
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<tr>
<td>OECD</td>
<td>Organisation for Economic Co-operation and Development</td>
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<tr>
<td>PEPFAR</td>
<td>US President’s Emergency Fund for HIV/AIDS Relief</td>
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<td>SWAp</td>
<td>Sector Wide Approach</td>
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<tr>
<td>TB</td>
<td>tuberculosis</td>
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<tr>
<td>UNDAF</td>
<td>UN Development Assistance Framework</td>
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<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>
<tr>
<td>Assessment sheet</td>
<td>Skill sets</td>
</tr>
<tr>
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</tr>
<tr>
<td>Global health landscape / WHO reform</td>
<td>Principles of resource mobilization</td>
</tr>
</tbody>
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**Note:** The table represents an assessment sheet with skill sets and competencies. The table is not fully visible, but it appears to be structured to evaluate various competencies related to global health and resource mobilization.
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.
INTRODUCTION AND BASIC ORIENTATION
Introduction and Expectations: Workshop on Resource Mobilization

Objectives

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

Covering objective 1. To understand context for this workshop

**WHO Mandate for Resource Mobilization**

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**

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 75Ð80%).

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.
**Mandate for Country Level Resource Mobilization**

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**

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

Outline of NEW Resource Mobilization Workshop

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

THINK ABOUT IT

What are your expectations from this Workshop?

Write down your expectations on the paper provided

Goal and Objectives of the Resource Mobilization Training Workshop

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
Further reading

MODULE 1
Setting the stage
MODULE 1: SETTING THE STAGE

Module Outline

• Introduction
• Learning objectives
• Sessions

Learning Objectives

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

Introduction

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.

**Sessions**

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

**Session 1: Global Health Landscape**

Covering objectives

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

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% by 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**

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**

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’ for forseeable future. 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, link in ‘Further Reading’ section at end.]

**Governance and the Global Health Regime**

**THINK ABOUT IT**

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

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**

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**

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

Covering objective 3. Understand WHO Reform

**WHO Reform – Resource Mobilization Context**

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**

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

Covering objective 4. Understand current situation for SEAR resource mobilization and future strategy
Proportional Contributions from top 10 donors

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%
- UNFIP, 2%
- DFAT, Australia, 3%
- UNDPS, 3%
- Others, 37%

*The key thing to note in this image is that the majority of funding is received from very few donors (notably, GAVI, USA, DFID)*

**WHO South-East Asia Region – Trends and Challenges**

*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.

Shared across the region as well are the areas that are not being well-funded. **Non-communicable 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: Resource Mobilization Challenges**

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)**

Total budget: $ m
Operational budget: $ m  Resources: $ m

Of the total resources,

Carry-over from 2012–13: $ m
Mobilized during 2014–15: $ m

Total Implementation (expenditure only):
$ m (___% against available resources)

Total Utilization (expenditure + encumbrances):
$ m (___% against available resources)

VC Availability and implementation

SEARO Resource Mobilization Strategy

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

**THINK ABOUT IT**

**Reflect on the impact on your own country.**

• What are resource mobilization challenges in your country? (Try to be as specific as possible)

**Quiz**

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


MODULE 2
Principles of resource mobilization
Module Outline

• Learning objectives
• Introduction
• Sessions
• Exercise

Learning Objectives

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

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. Resource Mobilization – Key principles
2. Resource Mobilization Cycle

**Session 1: Resource Mobilization – Key principles**

Covering objective 1: Understand key principles of resource mobilization

**The impact of Resource Mobilization**

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

**It’s not just about money**

“Money spent on health is not expenditure but an investment in the lives of people.”
SEARO 2011

*Source of quote: SEARO, “Partners for Health in South-East Asia Conference Report”, New Delhi, India, 16–18 March 2011*

*Source of photo: UN PHOTO, A line of patients waiting for medical care. 27 July 2012, Citrana, Photo # 521796. A medical team, coordinated by the UN Integrated Mission in Timor-Leste (UNMIT) and Timorese military, travelled to the Oecusse District on the border area between Timor-Leste and Indonesia, to deliver health-care to the local people. 618 patients received malaria testing, vaccines, medication, and other kinds of care during the team’s visit.*
Key Principles of Resource Mobilization

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

- 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

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

**THINK ABOUT IT**

*What are some other things that can be provided as a resource? Think back to a time when you 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**

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**

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

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

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

Resource Mobilization Gaps/Needs

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

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**TOTAL RM NEEDS**

**THINK ABOUT IT**

*When drawing up the Resource Mobilization Table of Needs, reflect on the following questions to ensure accurate results:*

- 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?

Step 2: Donor Cultivation

Donor cultivation is a 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, this 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

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

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

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

- 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

- 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

THINK ABOUT IT

Now what?
Imagine you have submitted a report to a donor... Now what do you do?

Donor Stewardship

Donor Stewardship is the concept of ongoing donor relations. It includes bringing donors closer to the programme results and to the WCO/Ministry. Nurturing relationships with individual managers/decisions makers and/or with donor organizations broadly is an important aspect of donor stewardship. Ultimately, you are seeking information and opportunities to renew their support of your programmes.
Resource Mobilization Tips

- 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


Fundraising Don’ts

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


Quiz

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


MODULE 3: PLANNING FOR RESOURCE MOBILIZATION

Learning Objectives

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

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

*Why create a Resource Mobilization Plan?*

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

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

---

**Diagram:**

1. Identify Objectives
2. Prepare Plan
3. Implement
4. Agreement/Approval
5. M&E
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. **Evaluation** – periodic review of project with feedback for next project cycle.

### 1. Identify Objectives

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

Table of Needs

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<td>2b. Available</td>
<td>TOTAL RM NEEDS</td>
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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

(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 overshoots.

2. **Prepare a Resource Mobilization Plan**

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 (ie. 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**

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

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<td>Cat 1-5 Allocated AC</td>
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<td>Carry-forward VC</td>
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<td>New VC known</td>
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<td>Shortfall Cat 1-5 at start</td>
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4. Implement

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

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

**WHO Reform, financing dialogue, and implications for Resource Mobilization**

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

**THINK ABOUT IT**

Reflect back to WHO reform and think about its implications on resource mobilization.

**Implications for Resource Mobilization**

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?

- 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
Quiz

Read the questions below and try to answer them without looking back through the handbook. The answers can all be found in this document.

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

MODULE 4
Funding landscape
MODULE 4: FUNDING LANDSCAPE

Learning objectives

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 knowing about potential donors, rather than how much they know about your organization.

At the end of this module, you 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.

Introduction

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.

The top five recipients of development assistance for health (DAH) from 2008 to 2010 were as follows:

• India (US$ 2.27 billion).
• Nigeria (US$ 2.25 billion).
• Tanzania (US$ 1.89 billion).
• Ethiopia (US$ 1.74 billion).
• South Africa (US$ 1.7 billion).
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.

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.

Key concepts

Who is funding global health?

International aid, and DAH in particular, is voluntary and generally takes two forms:

- **Emergency aid** (also called ‘humanitarian aid’). Mobilized in response to natural disasters, wars or famines. The aim is to address immediate and/or short-term challenges and relieve human suffering.
- **Development aid.** Longer term in its goal and aimed at addressing the ‘root causes’ of poverty and inequity. The main current framework for development aid is the Millennium Development Goals (MDGs), although these will be superseded in late-2015 by a new framework, the Sustainable Development Goals (SDGs).

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

**Bilateral agencies**

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.

**Government aid agencies**

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**

Many potential motivations exist for countries to provide development aid:

- For recognition: Helps to build standing among global nations.
- To build a relationship: Aid can be part of bilateral agreements that include trade or security agreements, for example.
- 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 may help them meet those goals.
- Economic 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:
• 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. Only five countries have met the longstanding 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) (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**

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.
Foundations

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. 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:

• 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

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.

Also known as ‘trusts’ in some settings.
• 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:

• 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.

**Global health initiatives and public–private partnerships**

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 Multicountry 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**

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:

- 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.

**Resources for neglected diseases**

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.

**Planning resource mobilization for your country**

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**

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**

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.
QUIZ

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

MODULE 5
Donor communications and stewardship
MODULE 5: DONOR COMMUNICATIONS AND STEWARDSHIP

Learning Objectives

This module is designed to breakdown the communication structure when speaking to donors and when promoting WHO. It highlights the need to identify the communication outcome, structure your message, consider the audience, and identifies common barriers to effective communication. The module also emphasizes key steps in establishing, cultivating, and stewarding effective partnerships.

This module will:

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

Introduction

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.
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.

Session 1: Strategic Communications

**Objective 1. Increase your understanding of construct strategic communications**

**How to be strategic**

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)
6. What resources? Timeline? How to measure outcomes? (Planning)

**NOTE:**

The starting tool is the Country Cooperation Strategy and how we achieve those public health objectives.

**Step 1 - SOCO: Have a Single Overarching Communication Outcome**

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.

**PERSONAL ACTIVITY:**

Think about a current problem/situation/challenge you have and you were standing in front of someone who could help you with it, how would you explain your problem to them in a way that they would feel compelled to help you with it?

**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.

**Expera speak like this**

Long, complete, logical explanation

**People listen like this**

The POINT

Reasons, evidence, explanations follow

---

**EXAMPLE: Text about WHO**

**What NOT to write:**
WHO is the United Nations agency for health. It was founded in 1948 to ensure health for all. It is governed by 194 Member States. We have a headquarters in GVA, 6 regional offices and more than 150 offices around the world. We set the health agenda based on evidence and the health priorities of Member States. We gather health information and set technical advice to handle diverse health problems in communicable and noncommunicable diseases, maternal and child health, health protection during emergencies. Our advice, actions and priorities are based on evidence. Working with countries and partners it is our mandate to achieve better health for all. There is no other organization like WHO...

**Instead write this:**
WHO is the world’s trusted voice for public health and we want to achieve health for all. There is no other organization with its REACH – with offices in nearly every corner of the world – its NEUTRALITY, because our work is based on evidence, or its CAPACITY (to provide technical advice, help countries respond to health threat, or bring people and partners together to meet public health objectives)

This includes initiatives such as the Harmonization for Health in in Africa (HHA), the global framework to reduce tobacco exposure, and the International Health Regulations (IHR) that helps protect countries from health risks that start in one part of the world but can travel to our front door in just a few hours...

What does this mean to me?
• Knowing what vaccines to take when I travel (do you use Intl Travel and Health)
• Having safe water to drink
• Having growth standards to recognize if a child is malnourished
• Knowing what medicine to take, and how much, and for how long to cure TB or prevent HIV/AIDS...

We are supported by our Member States but we cannot achieve our goals without your support!
Step 2 – Think about your audience

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 appeal to their respect for human dignity by describing the women using a toilet for the first time, how they fear being exposed as a woman. This would illicit an emotional response, they can relate to how that might feel.

**Types of audiences**

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

---

No 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.

### Energy invested

<table>
<thead>
<tr>
<th>Share your objective</th>
<th>Energy Invested</th>
<th>Communications strategy</th>
</tr>
</thead>
</table>
| Champion             | YES             | Support publicly/vocally | • Give them information  
|                      |                 |                         | • Appreciate + acknowledge their contribution  
|                      |                 |                         | • Let them champion your cause  |
| Silent booster       | YES             | Support silently         | • Educate, enable, inform and motivate  
|                      |                 |                         | • Energize them by involving champions they admire  |
| Avoiders             | NO              | Oppose silently          | • Inform or ignore  
|                      |                 |                         | • Get critical mass of champions to influence them  |
| Blockers             | NO              | Oppose loudly            | • Ignore if they are not influential  
|                      |                 |                         | • Confront if their influence is significant  
|                      |                 |                         | • Counteract by giving champions  
|                      |                 |                         | • Monitor what they say and who is listening to them  |

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**Step 3: Talking points**

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.4

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.

**EXAMPLE:**

You would like to continue support for water and sanitation for people who lost their homes in tsunami (your SOCO). The facts are that toilets and water points in India for hand washing for the first time for women and girls. The 'so what?' or talking points are that the intervention promotes better health, dignity, safety and a start of a better life.

**EXAMPLE:**

**Text for donors:**

There was a recent plea to fill the funding gap for TB care and control on World TB Day. We have made such progress (attaining the MDGs globally) but not in Africa due to the deadly combination of HIV-TB co-infection. And the rise of MDR strains makes the situation even more seriously. We must have the tools to prevent and treat TB and HIV or we could lose the battle here. We have some tools in hand and more to come but they won’t reach people who need them without funding. We have turned the tide against TB before, but that tide could turn again and drown us.

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Step 4: Packaging your content

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.

IDEAS:

Consider creating a regular e-bulletin made up of 1 or 2 sentence paragraphs, using photos with captions to capture attention. Let the people tell the story. Make it as light a job as you can for staff. Make the communication simple and brief – take the opportunity to forward a story done on the website, or a news release. When you write up proposals, consider asking for funds to produce a video or hire a journalist to tell the story (typical in BMGF grants). Donor reports are the only materials that need be in-depth. The rest should be short and to the point.

Step 5: Reaching your audience (Delivery channels)

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.⁵

Step 6: Communication Planning

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 the solution or to improve health. This part should impress upon the individual WHO’s comparative advantage, why WHO is the one who will bet solve this problem.

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Common barriers to effective communication

- 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

How to overcome common barriers to effective communication

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:
  - Ask 'Is what I said clear to you?'
  - 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:

We worry about emergencies, and that makes sense, but there is a new urgent situation – 80% of illness and deaths from NCDs in developing countries and many populations are aging. Is this a ticking time bomb we should be worried about and planning? Yes!

NOTE:

Be aware of non-verbal communication!
Session 2: Marketing WHO

**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.

**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**

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.

**EXAMPLE:**

<table>
<thead>
<tr>
<th>Document</th>
</tr>
</thead>
<tbody>
<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**

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

**Relationship-building and cultivating**

Research shows that the principal reason for stopping donor support is the donor no longer feels personally connected to the organization/cause/project. This one reason accounts for nearly 60% or 2 out of every 3 donors who stops their support. It is important for WHO to make every donor feel personally connected and we need to do that through you; you are the connector.

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? Doe 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.

**Being a Steward**

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

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

Context

You are a front-line WHO messenger in a public health environment that is rapidly changing. 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).

Your role

With such a changing 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 in your message

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

**Feedback about WHO**

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)

Planning Communications

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

Quiz

Read the questions below and try to answer them without looking back through the handbook. The answers can all be found in this document.
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


LEARNING OBJECTIVES

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

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.
1. Negotiation

What is negotiation?

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 negotiation

- 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.

NOTE:

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

The people factor

- 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**

**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**

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**

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.

**NOTE:**

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”**

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.
THINK ABOUT IT:

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!

2. Donor reporting

Importance of Reporting

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

In report-writing, 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

THINK ABOUT IT:
What kind of deviations should we tell the donor about?

Reporting tips:
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
• Don’t submit the report late
• 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
Report Format

Most donors have their own format for narrative reports but outlined below is a generic format for narrative report.

1. Title page
2. Executive Summary
3. Terms of Reference/Purpose
4. Monitoring procedure
5. Results
6. Conclusions
7. Recommendations
8. Appendices

Title Page

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

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

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

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?’

Results

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

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

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

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.

Quiz

Read the questions below and try to answer them without looking back through the handbook. The answers can all be found in this document.

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

MODULE 7
Proposal writing
MODULE 7: PROPOSAL WRITING

Learning Objectives

This module is designed to help WHO country and regional staff to explore how to develop concept notes about your 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 the types of special additions that could make your request more attractive to funders — including your innovations and how your proposal addresses certain key issues in global health.

At the end of this module, you should be able to:

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

Introduction

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. When donors are overwhelmed by requests, the quality of the proposal is critical.

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 proposals, programme staff need to develop these skills for themselves to raise support for their projects.
Key concepts

Developing brief concept sheets for projects/programme activities

How to draft a successful funding proposal

Concept notes

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.

• 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.

A concept note is a brief summary of the project that captures all the critical information about the project’s purpose and objectives. 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

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:

• 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.

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

• 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. 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.

**Key Concept 2**

**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. 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:

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**

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**

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**

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.

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?

Some recommendations for writing your objectives include

1 Fritz, J. How to write goals and objectives for your grant proposal. HYPERLINK “http://nonprofit/about.com/od/foundationfundinggrants/a/goalsobjectives.htm” – accessed 11 Jan 2016
3 Fritz, J. How to write goals and objectives for your grant proposal. HYPERLINK “http://nonprofit/about.com/od/foundationfundinggrants/a/goalsobjectives.htm” – accessed 11 Jan 2016
• 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)

4. Amount required

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

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.

6. Monitoring and Evaluation

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 report backs 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. 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**

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** 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. Some funders may specifically address 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.

**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)

**Further Reading**

• CIVICUS Toolkits:
  – Writing a Funding Proposal
  – Writing Effectively and Powerfully

http://www.civicus.org
MODULE 8
Focus on results
PARTICIPANT MODULE 8: FOCUS ON RESULTS

Learning Objectives

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 your work for developing objectives, workplans and funding proposals.

At the end of this module, you should:

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

Introduction

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?

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.

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.

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Session 1: Your Results and Resource Mobilization

Objective:

1) Understand why a focus on results is critical for resource mobilization
2) To be able to describe your organisation’s impact in terms of results

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. 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, your organisation needs 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 you write stronger proposals that could mobilize more resources.

Using a results-focused framework to conceptualise a project usually 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. 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 your 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 your project makes it easier to design performance monitoring and evaluation plans and data collection systems that can demonstrate the project’s results. 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.
Session 2

Results-Based Management (RBM)

Objectives: To understand the key elements of results-based management

Results-based management (RBM) is a management philosophy and approach that emphasizes 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). 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. 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*

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:**

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**

![Results Chain Diagram](http://www.who.int/countryfocus/cooperation_strategy/WHO-CSS_Guide2010_Eng_intranet_24sep10.pdf)

**Inputs:**

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**

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 to: 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.

**Output**

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.

**Outcome**

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:

- 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**

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**

<table>
<thead>
<tr>
<th>Impact (long term result): An effective immunization programme in Country X leading to reduced morbidity and mortality from polio.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcomes (medium term result): Increased immunity to polio and 25% fewer cases and deaths in targeted areas.</td>
</tr>
<tr>
<td>Output (short term result): 1,000 children vaccinated against polio in 15 targeted areas.</td>
</tr>
<tr>
<td>Activity: Vaccine for polio administered through National Immunization Days (NID) in 15 targeted areas.</td>
</tr>
</tbody>
</table>

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

**Session 3**

**The theory of change**

**Objective 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 your 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 your theory.

**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).

**Further Reading**

MODULE 9

WHO-specific requirements
PARTICIPANT MODULE 9: WHO-SPECIFIC REQUIREMENTS DIRECTING AND MANAGING RESOURCE MOBILIZATION

Learning objectives:

This module is to help technical officers and programme managers at WHO country offices 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.

Introduction

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.

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.

**Session 1:**

**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

**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:

- 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 WHO secretariat over the next six years covered by the 12th GPW, in each respective category of work.
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. Using the technical framework allowed each country office to focus on the highest priority programme areas for their respective countries (see Table 9.b)
Table 9.6 2014-15 H, M, L technical prioritizations at country level:

<table>
<thead>
<tr>
<th>Category 1 (CDS)</th>
<th>Program 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>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>Not</td>
<td>Not</td>
<td>High</td>
<td>Medium</td>
<td>High</td>
<td>Not</td>
<td>High</td>
<td>Medium</td>
<td>High</td>
<td></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>Not</td>
<td>High</td>
<td>Medium</td>
<td>Medium</td>
<td>High</td>
<td></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>Not</td>
<td>Low</td>
<td>High</td>
<td></td>
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</tr>
<tr>
<td>Category 2 (NCD)</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<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>Low</td>
<td>Medium</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.2 Mental health</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>High</td>
<td>High</td>
<td>Medium</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>Not</td>
<td>Low</td>
<td>Low</td>
<td>Medium</td>
<td>High</td>
<td>High</td>
<td>High</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>Not</td>
<td>Medium</td>
<td>Low</td>
<td>High</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Category 3</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<td></td>
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<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>Medium</td>
<td>Low</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>Medium</td>
<td>Not</td>
<td>Low</td>
<td>Not</td>
<td>Not</td>
<td>Low</td>
<td>Medium</td>
<td>Medium</td>
</tr>
<tr>
<td>Category 4</td>
<td></td>
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<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>High</td>
<td>Medium</td>
<td>Medium</td>
<td>High</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>Medium</td>
<td>High</td>
<td>High</td>
<td></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></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>
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<tr>
<td>Category 5</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.1 Alert and Response Capacities (IHR)</td>
<td>High</td>
<td>Medium</td>
<td>High</td>
<td>High</td>
<td>Medium</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>Medium</td>
<td>High</td>
<td>High</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>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. 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). The planning process begins with country consultations between 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. A similar process is underway for the next biennium.
**Figure 9.b**

Forthcoming Planning Cycles

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
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. 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.

Figure 9.d

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.

Figure 9.e explains the different checks at each level.

**Figure 9.e**

- **Programme Budget Allocations**
  - 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**
  - Planned cost in workplans must be within PB allocations at SO and Budget Centre (absolute control)

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

- **Spending**
  - 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.

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.

**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 been 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. This will be covered in more detail later in the session.

**Figure 9.f**

- **Stage One** – Donor Agreement is signed;
- **Stage Two** – An award is created/activated; Award Manager is identified (Director/WHO Representative)
- **Stage Three** – An award is distributed to the Budget Center level
- **Stage Four** – Workplan funding is done
- **Stage Five** – A ward Budget is done

Funds lying between stages two and three are called “Undistributed Funds”

Funds lying between stages three and four are called “Un-budgeted Funds”

Implementation begins
**Awards Vocabulary**

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

**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.

**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. 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:

- **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**

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. PIR/SEARO should be consulted for clearance in either case.

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.

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

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).

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.

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:

- 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.

- Send thank you letter to the donor.

- Ensure compliance with reporting schedule.
WHO has its own standard template for donor agreements. 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**

- 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.

**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
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:**

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.

Figure 9.h shows the different award request forms, which are available at: http://Intranet.who.int/homes/lam/voluntarycontributions.

**Figure 9.h**

- To activate an award or record initial distributions...
- To record additional distributions...
- To request a final CFS...
- To amend an award...

An Award may be recorded as either a simple pledge or a conditional pledge.

**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. 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.

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.

Case Study Exercise

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.

Case Study Questions

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 instalment (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

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.

QUIZ

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?