STRATEGIC PARTNERSHIPS
Forging new paths for WHO in South-East Asia
STRATEGIC
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This report was commissioned by World Health Organization (WHO) Regional Office for South-East Asia based in New Delhi. The objective of the report is to identify innovative ways for the Regional Office to build new strategic partnerships which leverage WHO's leadership role in health and contribute towards scalable solutions to regional health challenges.

The Regional Office is committed to building upon regional health achievements while tackling new and emerging challenges facing its 11 Member States. Through commissioning this report, the Regional Office recognizes the untapped potential across the region for new partnerships, which can mobilize the necessary human and financial resources to build healthier societies.

This report assesses the global health landscape in order to understand the current trends as well as financials and governance challenges facing the global health regime. Furthermore, it examines the role of WHO as a global leader in health and highlights how its current ongoing reform process is attempting to tackle the said challenges. Against this backdrop, the health trends and challenges are explored specifically for WHO South-East Asia Region. Based on interviews with the 11 WHO country offices and regional staff, programming and financial challenges have been identified. Following on this assessment, the report then outlines a range of relevant financial resources and strategic and financial partnership models that the Regional Office could potentially explore. Finally, the report outlines a set of recommendations for the Regional Office to take in order to develop new partnerships to meet these ongoing and emerging challenges on the global health front.

Chapter 1 assesses the global health landscape by identifying emerging health trends, the challenges for financing global health and its effective governance. Despite progress, there remain a number of evolving and emerging global health challenges including:

- insufficient progress on child and maternal health goals
- unfinished business of communicable diseases
- double burden of nutrition
- climate change and its growing health consequences
- negative health impacts of rapid urbanization
- addressing the challenges of a growing elderly population
- noncommunicable diseases – a leading cause of death and morbidity.

The financing of global health witnessed unprecedented growth from 1990 until the most recent global economic slowdown in 2011–2012. Current resources remain stable and donors are largely committed to funding global health. However, it is predicted that there will be no significant growth beyond the nearly US$ 30 billion in current commitments.
While India is the top recipient of health aid (US$ 2.27 billion), the remaining top nine recipients are all located in sub-Saharan Africa. Thus, by region, sub-Saharan Africa receives the largest amount of health aid globally.

In the past, WHO was the primary entity addressing global health challenges. Today, however, it is no longer the singular authority, but rather one among a growing range of diverse actors seeking to affect change on the global health front. Today, combined there are over 175 initiatives, funds, agencies and donors working on global health. However, WHO is the only actor with an exclusive mandate for health as well as universal membership of all recognized states, and will therefore continue to have a critical leadership role in global health governance.

For WHO to sustain its effective leadership role, there are three main challenges it must overcome with other global leaders to foster a more effective global health system. First, the global health regime must find ways to respond to the tensions between issues of sovereignty and global health needs. For WHO, that means being an effective transnational coordinator. Second, the global health regime must find ways and means to move global health agenda from its traditional sector silo towards being effectively integrated into a broader range of sectors such as trade, investment, security, migration, etc. Third, the global health regime must address challenges related to accountability, especially the growing need for international organizations to ensure that they strike a balance between being accountable to a Member State and the people whose rights they are supposed to uphold. At a second level, accountability is a growing issue due to the expanding range of non-state actors engaged in global health. Devising ways to support effective partnerships with non-state actors will be essential in moving the global health agenda forward.

The global health system is stymied by these challenges. The current WHO reform process and its successful outcomes will be essential towards creating more effective governance and tackling these outlined challenges. The growing array of actors coupled with financial shortfalls are creating impediments for effective governance as well. In this complex scenario, no single actor can determine the global agenda or manage its governance; however, there is a compelling need for WHO to maintain its critical leadership role owing to its unique position in the global health regime.

Chapter 2 examines the role of WHO in this global health landscape and highlights the essential elements of its current reform process. WHO reform process is intended to address the challenges outlined in the previous chapter and has three objectives:

- Improved health outcomes (programme reform)
- Greater coherence in global health (governance reform)
- An organization that pursues excellence (management reform).

As part of this process, WHO has articulated six global leadership priorities:

- Advancing universal health coverage
- Health-related Millennium Development Goals
• Addressing the challenges of noncommunicable diseases (NCDs)
• Implementing international health regulations
• Increasing access to essential, high-quality and affordable medical products
• Addressing the social, economic and environmental determinants of health.

Against this backdrop, **Chapter 3 narrows the focus on WHO in South-East Asia** and explores regional health trends. Based on a survey and interviews with the 11 country offices, this chapter highlights the specific programmatic and funding challenges with respect to the above five programme work categories:

- **Communicable diseases**: Despite improvements, these remain a leading cause of mortality and morbidity.
- **NCDs**: NCDs are the most common cause of deaths in Asia.
- **Promoting health through the life-course**: The health-related MDGs remain a cornerstone of this work.
- **Health systems**: While there are innovative practices underway and some progress across the Region towards universal health coverage, challenges remain ample, especially with regard to financing.
- **Preparedness, surveillance and response**: International Health Regulations are not fully implemented across the Region and South-East Asia remains a hotspot for emerging infectious diseases.

In terms of funding for the Biennium 2014-2015, the majority of the country offices anticipate their funding levels to remain the same or increase slightly, while only three countries expect reductions. The majority of country offices prioritized NCDs and health systems as two critical needs and the ones that are largely underfunded. The four main challenges for resource mobilization are: a country may be shifting from low- to middle-income and thus losing its donor base; there may be many donors present and there is thus a competition for resources; there may be no donor presence; and other government challenges, i.e. sanctions, political tensions, etc.

Understanding the regional and country dynamics, **Chapter 4 identifies potential financial resources** for the Regional Office to explore. The chapter examines possible government donors who seem to have a growing interest in global health as well as regional intergovernmental or governmental structures that may be leveraged. The section then goes on to explore a range of global and Asian based foundations that might be appropriate for the country offices to explore as possible partners. The subsequent three sections focus on possible private sources to explore including high net-worth individuals (HNWIs), multinational corporations and corporate social responsibility (CSR). Finally, the chapter explores two types of “social investments” which might be worth exploring further in regard to health-related programming which include venture philanthropy and social impact investing.

**Chapter 5 identifies partnership models**, which the Regional Office can explore further including public–private partnerships, multi-donor trust funds and joint UN partnerships, health councils and south–south partnerships. The chapter defines these partnership
models and explores how the Regional Office could utilize these different arrangements within the region.

Finally, **Chapter 6 outlines the strategic considerations or recommendations** for the Regional Office with regard to building or catalysing new partnerships for mobilizing human and financial resources. The chapter begins with an outline of the main constraints and opportunities faced by the Regional Office towards achieving such objectives. The final section of the chapter outlines two sets of practical recommendations that the Regional Office can draw from. The first set outlines “building block” interventions, which can establish the foundation for strategic partnerships:

1. Demonstrated leadership commitment to new partnerships (Regional Director and directors)
2. Increased linkages between communications partnerships building
3. Establish linkages with regional philanthropic networks
4. Cultivate new donor relations, especially with the private sector
5. Engage anew with existing WHO donors
6. Publish “technical notes” for funding health-related programmes
7. Partnerships policy endorsed WHO headquarters
8. Identify new funding modalities or reconfigure existing funding modalities for greater flexibility
9. Country-level engagement with potential new donors, especially the private sector
10. Resource mobilization and partnerships are integrated into WHO’s biennial strategic planning process
11. CSR for health workshops
12. Building internal capacities.

The second set outlines longer-term initiatives:

1. Integrate resource mobilization planning into Country Cooperation Strategy (CCS)
2. Develop a regional multi-donor trust fund for health
3. Publish a WHO guidebook on CSR for health
4. Cultivate HNWIs to be "champions of health"
5. Explore possible partnerships with the Asian diaspora
6. Develop a regional health campaign for an underfunded priority area
7. Facilitate as an Asian health council
8. Advance south–south cooperation
9. Convene an experts health group.
The report concludes with a summary of each country’s programme profile as part of a general annex.
## Abbreviations

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<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>ADB</td>
<td>Asia Development Bank</td>
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<td>ASEAN</td>
<td>Association of South-East Asian Nations</td>
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<td>BHTF</td>
<td>Bhutan Health Trust Fund</td>
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<td>BMGF</td>
<td>Bill and Melinda Gates Foundation</td>
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<td>CCS</td>
<td>country cooperation strategy</td>
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<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
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<td>CIDA</td>
<td>Canadian International Development Agency</td>
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<td>COIA</td>
<td>Commission on Information and Accountability</td>
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<td>CSR</td>
<td>corporate social responsibility</td>
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<td>CVD</td>
<td>cardiovascular disease</td>
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<td>DAC</td>
<td>Development Assistance Committee</td>
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<td>DALY</td>
<td>disability-adjusted life year</td>
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<td>DaO</td>
<td>Delivering as One</td>
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<tr>
<td>DFID</td>
<td>Department for International Development</td>
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<tr>
<td>ECHO</td>
<td>Humanitarian Aid and Civil Protection department</td>
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<td>EU</td>
<td>European Union</td>
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<td>GDP</td>
<td>gross domestic product</td>
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<td>GFATM</td>
<td>Global Fund to fight AIDS, TB and Malaria</td>
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<td>HNWI</td>
<td>high net-worth individual</td>
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<tr>
<td>HRITF</td>
<td>Health Results Innovation Trust Fund</td>
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<td>IDA</td>
<td>International Development Assistance</td>
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<td>IHME</td>
<td>Institute for Health Metrics and Evaluation</td>
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<td>IHR</td>
<td>International Health Regulations</td>
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<td>JICA</td>
<td>Japan International Cooperation Agency</td>
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<td>JP</td>
<td>Joint Programme</td>
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<td>MDG</td>
<td>Millennium Development Goal</td>
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<td>MDTF</td>
<td>multi Donor trust fund</td>
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<td>Acronym</td>
<td>Full Form</td>
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<td>MMR</td>
<td>maternal mortality ratio</td>
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<td>MNC</td>
<td>multinational corporation</td>
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<td>MoU</td>
<td>memorandum of understanding</td>
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<td>NCD</td>
<td>noncommunicable disease</td>
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<td>NGO</td>
<td>nongovernmental organization</td>
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<td>ODA</td>
<td>official development assistance</td>
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<tr>
<td>OECD</td>
<td>Organisation for Economic Co-operation and Development</td>
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<td>OIC</td>
<td>Organization of Islamic Cooperation</td>
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<tr>
<td>OPEC</td>
<td>Organization of the Petroleum Exporting Countries</td>
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<td>PIR</td>
<td>partnerships, interagency coordination and resource mobilization</td>
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<td>PPP</td>
<td>public–private partnership</td>
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<td>RIS</td>
<td>Research and Information Systems for Developing Countries</td>
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<td>RM</td>
<td>resource mobilization</td>
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<td>SAARC</td>
<td>South Asian Association for Regional Cooperation</td>
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<td>SARS</td>
<td>severe acute respiratory syndrome</td>
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<td>SVCF</td>
<td>Silicon Valley Community Foundation</td>
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<td>TB</td>
<td>tuberculosis</td>
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<td>UHC</td>
<td>universal health coverage</td>
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<td>UNCEF</td>
<td>UN Central Emergency Response Fund</td>
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<tr>
<td>UNDAF</td>
<td>UN Development Assistance Framework</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<tr>
<td>UNOPS</td>
<td>United Nations Office for Project Services</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<td>WFP</td>
<td>World Food Programme</td>
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<td>WHO</td>
<td>World Health Organization</td>
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Global health landscape

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. International funding for global health has reached around US$ 30 billion per year.

Evolving and emerging global health challenges

Despite progress and improved global health outcomes, a number of challenges and emerging issues require further attention and ongoing support:

- **Child and maternal health.** Significant progress has been made in these two areas. However, related targets set as part of the Millennium Development Goals (MDGs) will not be met in many countries and some fundamental challenges remain to be tackled.
- **Unfinished business of communicable diseases.** Notwithstanding increased attention and resources in recent years, a focus on infectious diseases remains necessary in order to prevent ongoing global spread and recurrence. While AIDS, tuberculosis (TB) and malaria incidence are finally decreasing, the absence of continued support could not only impede continued progress, but also fuel future re-emergence. Furthermore, there is a growing need for global health attention to epidemic-prone and/or vaccine-preventable diseases. Outbreaks of influenza, dengue, measles and many other conditions demonstrate the spontaneous and global nature of such threats.
- **Double burden of nutrition.** Undernutrition remains a major global health problem and the leading cause of child death, and drives a significant loss of human capital. In contrast, overnutrition intensifies the growing risk of diet- and obesity-related chronic conditions. This generates a double burden for nutrition and increases the urgency of tackling the complexities of food security.
- **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, an increasing array of health-related consequences will need to be minimized and addressed.

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2 Ibid
3 Ibid
4 The new global health,” EID Journal, August 2013. CDC
• **Urbanization.** "Mega cities" and other large urban areas are likely to grow even further in the future. According to latest available figures, half of the world’s population lives in urban settings and this is likely to increase to 70% by 2050. Rapid urbanization, particularly in low- and middle-income countries, creates a critical strain on already fragile environments. Urban areas are highly populated and social/health services for the urban slums are often limited.

• **Ageing population.** According to a recent United Nations Population Fund (UNFPA) report, within the next decade there will be over one billion people worldwide who are over 60 years of age. With rising life expectancies and generally decreasing fertility, proportions of senior citizens will increase faster than any other population group. The report predicts that by 2050, people over 60 years of age will make up more than 80% of the population in the developing world. This demographic shift will have consequences for health and health systems that most countries are ill-prepared for and are only now beginning to grapple with.

• **Noncommunicable diseases (NCDs).** NCDs include chronic diseases (e.g. heart, stroke, cancer, mental illness and diabetes), injuries, disabilities and diseases caused by environmental hazards. NCDs now kill more people than infectious diseases. 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 losses is US$ 47 trillion by 2030. Injuries are a leading cause of death and disability for all age groups worldwide causing around 5 million deaths each year. NCDs represent a rapidly growing disease burden for low- and middle-income countries and one which is likely to strike people in poor countries at a younger age than in wealthy ones. This rise is not only creating a burden on developing country health systems but also affecting the potential for economic development through reduced productivity and long-term increased health-care costs.

### Financing global health

The past decades witnessed an increased commitment by donors towards global health. Since 1990, international financing for global health has reached unprecedented levels, with a historic high in 2010. Development assistance for health fell in 2011 for the first time since resources have been tracked. However, the decline was relatively small, which is promising and appears to be contained at current levels. Over recent decades, according to the Institute for Health Metrics and Evaluation (IHME) *Financing global health 2012* policy report, there have been three phases of health financing. The first was from 1990 to 2001, which experienced a “moderate” annualized growth at 5.9%, from US$ 5.7 billion to US$ 10.8 billion. The second phase was from 2002 to 2010, and was considered a phase of

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7 Ibid
“rapid” annualized growth at 11.2%. The third phase, which began in 2010, is considered the “no growth” phase and as of 2012 resources are constant at around US$ 28.1 billion. 11

The top five recipients of international health assistance for the 2008 to 2010 period were as follows:

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

The next five largest recipients are all located in sub-Saharan Africa. In 2010, expenditures were broken down by health-related themes roughly along the following lines:

- HIV and AIDS: 30.5%
- Maternal, newborn and child health: 23.3%
- Malaria: 8.4%
- Health sector support: 5.3%
- TB: 4.9%
- NCDs: 0.8%

During this time frame the ten largest donors were (in descending contributions): the United States, the United Kingdom, Spain, Norway, the Netherlands, Japan, Germany, France, Canada and Australia. However, according to IHME analysis, bilateral assistance is likely to continue to drop while multilateral assistance continues to grow moderately. The rise of public–private partnerships (PPPs) 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 time frame, with the Bill and Melinda Gates Foundation (BMGF) being the notable example, and which now contributes 5% of all funding for global health assistance. 12 Nongovernmental organizations (NGOs) 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.

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11 Institute of Health Metrics and Evaluation Financing global health 2012: The end of the golden age. Seattle. (The data presented in this section are drawn from this report unless otherwise noted).
However, the era of high growth is reportedly over and it is predicted that the phase of “no growth” will continue for the foreseeable future. Donors are considering to what extent international development assistance (IDA) mechanisms such as the GFATM will be replenished. There are many countries also graduating to lower-middle and middle-income status, such as Bhutan, India and Maldives, rendering them ineligible for certain future funding streams. While 80% of the IDA-eligible countries are in sub-Saharan Africa, any retreat financially from middle-income countries will need to be monitored carefully since three quarters of the world’s poor reside within those countries.

Furthermore, according to this analysis, if the stagnation continues the need to identify other funding sources will become critical in order to meet the rising costs of global health-care.

**Governance and the global health regime**

As outlined in the previous two sections, global health is entering a new era. The dynamic, complex challenges are further complicated by rising costs, the growing inequities between countries and societies, and stagnant resource levels.

In order to provide the essential and robust responses to these complexities, global health requires effective governance at all levels. Global health governance is defined in a number of ways and there is some debate whether the emphasis should be on the health challenge or on geography. However, it seems global health encapsulates all these facets, the world’s population and the relationship of interdependence between actors – whether they be states, countries, civil society movements, ethnic groups, etc. \(^{13}\)

Global health governance can be deconstructed as follows:

When thinking about health in populations, we must analyse two essential dimensions: health conditions (e.g. disease and risk factors) and the way in which a society responds to those conditions. This framework can be applied at both the national level and the global level. Faced with a set of health conditions, a country articulates a response through its national health system. At the global level, the key concept in understanding the pattern of health conditions is the international transfer of health risks – that is, the way in which the movement of people, products, resources, and lifestyles across borders can contribute to the spread of disease. Globalization has intensified cross-border health threats, leading to a situation of health interdependence – the notion that no nation or organization is able to address single-handedly the health threats it faces but instead must rely to some degree on others to mount an effective response. The organized social response to health conditions at the global level is what we call the global health system, and the way in which the system is managed is what we refer to as governance.

This concept of governance includes the formal establishment (e.g. international and national laws and standards) and informal mechanisms (e.g. voluntary codes and principles established within the private sector) by which societies organize and collectively manage its affairs.\textsuperscript{14} Global governance is distinct from the traditional state form in that there is no actual government functioning at a global level and there are no typical mechanisms for financing (i.e. taxation) or enforcing of laws and policies. In the aftermath of World War II, governments recognized the need for coordinated action on international public health challenges and in 1948 the World Health Organization (WHO) was created.\textsuperscript{15} WHO currently has 194 Member States and is responsible for managing and coordinating global health challenges alongside a growing range of actors seeking to affect change on the global health front.

WHO is the only organization that has universal memberships of all recognized states and therefore fills a critical leadership role in health. Also central to this system are other relevant international agencies, such as the United Nations Children’s Fund (UNICEF), UNFPA, the World Bank and regional development banks, for example. Civil society and NGOs are also playing increasing roles. Novel financing mechanisms such as GAVI, UNITAID and the Global Fund support innovative approaches to fight global health challenges. Finally, the global health landscape also includes a growing range of private philanthropies, corporations and academic and research institutions, which combine to form an estimated 200 or so initiatives, funds, agencies and donors in the global health architecture.\textsuperscript{16}

Three main global health governance challenges have been identified in the areas of sovereignty, sectoral challenges and accountability.\textsuperscript{17} Firstly, national sovereignty complicates efforts of transnational coordination, defining global rules and responsibilities, and in balancing the dynamic distribution of health risks and available resources. National responsibility remains the cornerstone for a functioning health system, but in a globalized world there is a deepening of health interdependence. Secondly, owing to the scale of global health challenges, there is a growing and urgent need for cross-sectoral policies that transcend the traditional health sector to include trade, investment, security and migration, for example. Thirdly, there are two levels of challenges related to accountability: legitimacy of international organizations that are accountable to Member States rather than the people whose rights they aim to uphold; and the lack of accountability for the growing number of non-state actors engaged in the global health arena. In effect, there is a lack of institutional governance of this powerful, and growing, influence.\textsuperscript{18}
There are four key functions of the global health system and each is impacted by the above governance challenges. According to WHO Consultative Expert Working Group on Research and Development, one of the key functions of the global health systems is the production of global public goods such as international standards and guidelines for health practices. The production of global goods requires sustained access to resources, which can be difficult to generate and those who might benefit most may not necessarily contribute. Effective governance arrangements such as core funding for WHO may be a means to overcome this challenge and ensure sufficient production of global public goods.19

The second function is the prevention and mitigation of negative global health outcomes.20 This involves the deployment of effective surveillance systems, coordination mechanisms and information-sharing networks that can support management of risks and provide a timely response to pandemics, pollutants or other harmful threats. With the challenge of sovereignty and lack of accountability mechanisms, this can create vulnerabilities, such as a country not reporting or regulating cross-border health threats.

The third function is the mobilization of “global solidarity”,21 which has mostly happened through international health aid transfers. This function arises out of the need to address the unequal distribution of health problems and resources. When a national government is unable or unwilling to take responsibility for its own population, the global health community can step in to respond to this gap.

The fourth function is the “stewardship” that provides the overall strategic pathway for the global health system, and allows all components to co-exist and complement one another. This includes examples such as convening, negotiating, consensus building, setting priorities and rules. These tasks are met with challenges if states do not feel the issues and/or solutions at hand are in their best interest.

Meeting these governance challenges is essential to strengthening health systems. Clarity of roles and responsibilities is a particular requirement where there are overlaps of missions and mandates. The challenges are not new, but the need to address them effectively has grown more important and complex as new entities enter the health sector, and given the current flattening in funding for global health. Health systems are often stymied by this combination of challenges, and global governance arrangements need to be examined, evaluated and revised accordingly. The current WHO reform process and its successful conclusion is essential to helping create more effective governance of global health and tackling related challenges.

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19 Ibid
20 Ibid
21 Ibid
The role of WHO

In this current, complex scenario no single actor can determine the global agenda for health. There is, nevertheless, a compelling need for WHO to maintain a critical leadership position and mandate. The overall purpose of WHO reform process\textsuperscript{22} is to ensure that the organization evolves in a manner that allows for effective navigation through these transformative times in global health. The reform process has three objectives:

- improved health outcomes whereby global priorities are established, focusing on actions where WHO has a unique function or comparative advantage (Programme reform);
- greater coherence in global health with WHO playing a leading role (Governance reform); and
- an organization that pursues excellence that is effective, efficient, responsive, transparent and accountable (Management reform).

Programme reform

The purpose of programme reform is to ensure that the organization is prepared adequately to tackle global health challenges. As part of this process, WHO detailed six core functions describing the nature of WHO’s work:

- providing leadership on matters critical to health and engaging in partnerships
- sharing the research agenda
- setting norms and standards, and promoting and monitoring their implementation
- articulating ethical and evidence-based policy options
- providing technical support, catalysing change, and building institutional capacity
- monitoring the health situation and assessing health trends.

These core functions are then broken down in relation to the roles and responsibilities at the three organizational levels: country office, regional office and headquarters. The country offices take the lead in developing country-level strategies, implementing agreements, conventions, etc. at the national level. The regional office is to coordinate and provide support across the region, while the role of the headquarters is to develop corporate guidance for these processes. By contrast, headquarters takes the lead in formulating norms and standards, and the country and regional offices support adaption and monitor implementation. As part of the programme reform, WHO is considering how to realign financing with programme priorities and ensuring a strategic response to the changing environment.

At a meeting in February 2012, Member States agreed that WHO’s work would be organized around a limited number of categories: five technical categories and one corporate enabling

\textsuperscript{22} The following section is drawn from various WHO reform and implementation documents from 2013
In essence, these categories provide the organizing framework of the programme budget and the results chain.

1. **Communicable diseases**: Reducing the burden of communicable diseases, including HIV/AIDS, TB, malaria and neglected tropical diseases.
2. **NCDs**: Reducing the burdens of NCDs, including heart disease, cancer, lung disease, diabetes and mental disorders as well as disability and injuries through health promotion and risk reduction, prevention, treatment and monitoring of NCDs and their risk factors.
3. **Promoting health through the life-course**: Reducing morbidity and mortality and improving health during pregnancy, childbirth, the neonatal period, childhood and adolescence; improving sexual and reproductive health; and promoting active and healthy ageing, taking into account the need to address determinants of health and internationally agreed development goals, in particular the health-related MDGs.
4. **Health systems**: Supporting the strengthening of health systems with a focus on the organization of integrated service delivery; financing to achieve universal health coverage (UHC) strengthening human resources for health; health information systems; facilitating transfer of technologies; and promoting health systems research.
5. **Preparedness, surveillance and response**: Supporting the preparedness, surveillance and effective response of disease outbreaks, acute public health emergencies and the effective management of health-related aspects of humanitarian disasters to contribute to health security.
6. **Corporate services/enabling functions**: Organizational leadership and corporate services that are required to maintain the integrity and efficient functioning of WHO.

**Governance reform**

WHO needs to improve the effectiveness of its roles related to global health governance. WHO has a multilateral convening role in bringing countries together to negotiate conventions and/or regulations, develop technical strategies and support their implementation. The organization also has a responsibility to bring greater coherence and coordination to the global health system.

**Management reform**

The managerial components of WHO reform strive to create a more flexible and responsive organization that can rapidly address global health needs and challenges. This section of reform is intended to occur at two levels. Firstly, in structural terms, the objective is to improve support to countries through strengthened, accountable and resourced WHO country offices. Secondly, the reform has attempted to articulate clear roles and responsibilities for the three levels of the organization, as well as in seeking alignment around common policy and strategic issues. These various reform elements include human
resources, results-based management planning, financial controls, risk management, monitoring and evaluation and communications.

**Priority setting**

As part of the reform process, WHO has articulated what is refers to as “leadership priorities” – areas of specific focus in which WHO’s leadership is of primary concern, seeks to shape global debate and aims to secure country involvement. These are distinct from the programming results chain categories in that they are identifying issues and topics that stand out from the totality of WHO’s work.

- Advancing UHC
- Health-related MDGs
- Addressing the challenge of NCDs
- Implementing International Health Regulations
- Increasing access to essential, high-quality and affordable medical products
- Addressing the social, economic and environmental determinants of health.

Advancing UHC combines access to services that are required to achieve good health with the financial protection that prevents ill-health from resulting in poverty. This is a powerful unifying concept to guide and improve health outcomes as well as advance health equity in the coming years. WHO leadership is a central factor in achieving UHC and the organization will focus on health service integration across the health-care continuum, and away from more vertical programming.

Health-related MDGs include critical ongoing health challenges. While substantial progress was made in the past decade towards the MDG targets (including the health-related ones), much remains to be achieved after 2015. The unfinished agenda of the MDGs is a leadership priority for WHO. The continued commitment to the health-related goals are an essential contribution towards poverty reduction, and WHO is working towards securing a significant place for health-related goals in the post-2015 development agenda.

Addressing the challenges of NCDs and mental health, violence, injuries and disabilities is a priority because of the growing magnitude of these challenges. In the next six years, WHO will focus on combating four major NCDs (cardiovascular diseases, cancers, chronic lung conditions and diabetes) and their major risk factors (tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol). In terms of mental health, violence and injuries, there will be a continued focus on information, surveillance and broadening the evidence base for response.
The International Health Regulations (2005) constitute the key legal instrument needed to achieve health-related security. Their successful implementation is paramount to protect and mitigate future global health problems and thus is an important leadership priority for WHO.

Increasing access to high quality, effective and affordable essential medical products is critical to meeting many of the world’s most pressing health needs. WHO leadership focuses on ensuring the “access” component and the “affordable” component as the two cornerstones of ensuring UHC.

Addressing the social, economic and environmental determinants of health as a means of reducing health inequities within and between countries is not new to WHO. The work on social determinants has been given renewed emphasis as a result of the high-level meeting of the General Assembly on the Prevention and Control of NCDs in September 2011, the Commission on Social Determinants of Health, and the World Conference on Social Determinants of Health held in Rio de Janeiro, Brazil in October 2011. This approach is a way of thinking about health that requires explicit recognition of the wide range of social, economic and other determinants associated with ill-health as well as with inequitable health outcomes.
WHO in South-East Asia – Regional trends

The countries supported by WHO Regional Office for South-East Asia include only three of ten countries that are officially part of South-East Asia as defined by the Association of South East Asian Nations (ASEAN). The SEARO region also includes a number of countries from South Asia as well as East Asia, giving rise to a diverse group of nations that includes Bangladesh, Bhutan, the Democratic People’s Republic of Korea, India, Indonesia, the Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor Leste. This WHO region is home to 25% of the world’s population and bears about 30% of the global disease burden.23 The Region is vastly disparate in terms of political, social and economic conditions, with some countries fairly well developed and others experiencing a slower rate of development. Nevertheless, there are a set of general trends and challenges that are shared across the Region with respect to global health and development. The following highlights select health trends according to WHO programme areas.

Communicable diseases

Communicable diseases continue to be a leading cause of mortality and morbidity, especially for the less developed countries in the region. Despite improved policies and practices to prevent and control these conditions, most countries have failed to eradicate vaccine-preventable diseases. There have been recent recurrences of “older” diseases such as meningitis, malaria and TB, and some emerging infectious and parasitic diseases are rapidly increasing in some countries. At present, the Region contributes 27% of the global disease burden due to communicable diseases.

- In 2011, there were an estimated 28.6 million children immunized in the 11 South-East Asia Region countries, and while there has been progress the estimated coverage in the Region remains stagnant at around 75%. This means an estimated 9.5 million children are not routinely immunized in the Region.24
- HIV began relatively late in the Region compared to much of the world but by 2012, 3.4 million people were living with HIV, including about half of these in India. In 2012, 230,000.

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new HIV infections and 200 000 related deaths occurred in the Region and Asia is now second to sub-Saharan Africa in terms of numbers of reported HIV infections.25

- TB is one of the most widespread infectious diseases in Asia and over 5.2 million cases occurred in 2012 in the Region. Forty per cent of the world’s TB burden is found in South-East Asia. Bangladesh, India, Indonesia, Myanmar and Thailand are still categorized as TB “high burden” countries. India is estimated to have the largest incidence with 2.8 million new cases in 2012.26

- Malaria remains endemic in 10 of 11 Member States in WHO South-East Asia region where around 1.6 billion people live in areas with endemic malaria transmission. The number of confirmed malaria cases reported in the Region decreased from 2.9 to 2 million between 2000 and 2012. Three countries accounted for 96% of reported cases in 2012: India (52%), Myanmar (24%) and Indonesia (22%).27

- Diseases such as dengue pose substantial disease burden in South-East Asia and continue to expand. One study estimated an annual average of 2.9 million dengue episodes and 5906 deaths, which amounts to an estimated annual cost per capita of US$ 1.65 and a disease burden of 372 disability-adjusted life years (DALYs) per million inhabitants. This rate is higher than that of 17 other conditions including respiratory infections and hepatitis B.28 In 2012, a total of 257 204 cases of dengue and 1229 deaths were reported from the Region.

- The South-East Asia Region accounts for the highest burden of lymphatic filariasis in the world with 63% of the regional population at risk. There are an estimated 100 000 cases of kala-azar per year in the region with over 147 million people being at risk. Other neglected tropical diseases such as schistosomiasis, trachoma, yaws, soil transmitted-helminthiasis and Japanese encephalitis, are important public health issues in some countries of the Region.

Communicable diseases contribute slightly more of the total DALYs lost in the Region (42%) than the world as a whole (40%).29 The proportion of total DALYs lost due to communicable diseases is higher than the Regional average in Bangladesh (48%), India and Bhutan (44%), Myanmar (46%) and Nepal (49%).

**Noncommunicable diseases**

NCD are the most common cause of death in Asia. They are responsible for, on average, two thirds of all deaths across 20 Asian countries.30 NCDs affect a younger age group in Asia compared to their counterparts in Organisation for Economic Co-operation and Development (OECD) countries. This is true for both chronic disease and injury-related deaths.

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• Mortality rates from cardiovascular disease (CVD) are 70% higher in Asian countries than in OECD countries. Cardiovascular mortality in India in the 30–59 years age group is twice that of the same age group in the United States, due to the occurrence of CVDs among younger people in the former.\textsuperscript{31}

• Cancer deaths are less common in the region compared to OECD rates but that is changing. In a five-city study in India, nearly 50% of cancer mortality was reported among those below 55 years of age.\textsuperscript{32}

• Of the ten countries worldwide with the largest number of people with diabetes, five are in the Asia Pacific region. India has over 60 million people with diabetes and Bangladesh has an estimated adult prevalence of more than 10%. It is predicted that there will be over 300 million people living with diabetes in the Asia Pacific region by 2030.\textsuperscript{33}

• It is estimated that injury caused 2.9 million deaths in the Asia Pacific region in 2008, which is more than 50% of global injury deaths.\textsuperscript{34} The causes of injury deaths vary across the South-East Asia region and a significant number are the result of road traffic accidents. For example in Thailand, over 40% of injury deaths are due to road accidents, and India has one of the highest numbers of road traffic deaths worldwide.\textsuperscript{35}

Latest projections suggest that NCD deaths are expected to rise 21% over the next decade. NCDs are now considered a health and developmental emergency in the Region by virtue of being the largest cause of premature deaths, exacerbating poverty and threatening already weak health systems. NCDs are largely attributable to a few preventable risk factors such as tobacco use, unhealthy diet, lack of physical activity and harmful use of alcohol.\textsuperscript{36}

### Promoting health throughout the life course

Reducing morbidity and mortality, and improving health during pregnancy, birth, neonatal period, childhood and adolescence, sexual and reproductive health, and healthy ageing are the essential elements that comprise approaches to health throughout the life course.

• The infant mortality rate is one of the most important indicators for measuring the general health of a given population. It reflects the effect of economic and social conditions on the health of mothers, newborns, as well as the effectiveness of health systems.\textsuperscript{37} Infant mortality rates have fallen dramatically across the Region in the past 30 years, and in countries such as Thailand rates have fallen by three quarters. However, in other countries such as India, Myanmar and Nepal, the rates remain greater than 40 per 1000 live births.\textsuperscript{38}

• The under-five mortality rate is another sensitive indicator and globally in 2010, 7.6 million children died before their fifth birthday; 2.6 million (one third) occurred in the

\textsuperscript{31} Ibid
\textsuperscript{32} Ibid
\textsuperscript{33} Ibid
\textsuperscript{34} Ibid
\textsuperscript{35} Ibid
\textsuperscript{36} World Health Organization. NCDs in the South-East Asia Region: Burden, strategies and opportunities. New Delhi: World Health Organization, 2011.
\textsuperscript{37} OECD. Health at a glance; Asia/Pacific. Paris: Organisation for Economic Co-operation and Development (OECD), 2013.
\textsuperscript{38} Ibid
Asia Pacific region. Mortality rates in India and Myanmar, for example, are in excess of 50 per 1000 live births, and while rates have improved across the region, much of the decrease is for infants older than four weeks. There is very little reduction in the neonatal mortality.\textsuperscript{39}

- Maternal mortality in an important indicator of women’s health and status. In developed countries, the maternal mortality ratio (MMR) averages around 11 deaths per 100 000 live births. In countries such as Bangladesh, India and Indonesia the MMR is equal to or above 200 deaths per 100 000 live births.\textsuperscript{40}
- A major risk for maternal and neonatal deaths is the lack of access to skilled care at birth. In Bangladesh, less than 30% of births are attended by a medically trained provider and only 15% of births take place in a health facility. Home delivery also still dominates in Nepal, India and Indonesia.\textsuperscript{41}
- Populations are rapidly ageing across the region and this trend is likely to continue. The South-East Asia Region alone will register a 447% increase in elderly population from 30.2 million in 2005 to 135 million in 2050.\textsuperscript{42}

While there has been significant progress towards improving infant and maternal mortality rates and improving the life course across the region, critical challenges remain to be addressed.

Health systems

While health systems vary greatly across the Region, there are a number of shared pressures, challenges and priorities facing many countries. During the 1990s, most countries began to open up and experience growth through expanding market economies. The financial crisis in 1997–1998, and the recent global recession, encouraged many countries to strengthen their social protection mechanisms and essential health services. Countries such as India and Thailand have established pro-poor financing schemes as part of the health system development. Others, such as Indonesia, have created public–private mixes of services that are self-financing.\textsuperscript{42} To ensure increased coverage and affordability, some governments are passing laws to establish a form of national health insurance or mandated universal coverage.\textsuperscript{43}

However, implementation of such policies across countries is proving to be problematic. A recent report of health financing reforms in seven countries in South-East Asia reviewed the way countries seek to reduce dependence on out-of-pocket payments for patients, increase pooled health financing, and expand service use as steps towards universal coverage.\textsuperscript{44}

While there are some innovative approaches in use, health systems generally remain fragile in the Region.

\textsuperscript{39} Ibid
\textsuperscript{40} Ibid
\textsuperscript{41} Ibid
\textsuperscript{43} Ibid
In addition to financing, ensuring quality services and human resources are also important in order to achieve UHC. This remains a shared challenge across the Region.

- The number of doctors per capita varies widely, with the Democratic People’s Republic of Korea having the highest number with 3.3 doctors per 1000.\(^{45}\)
- Countries such as Nepal have the lowest number of physicians per capita, and these are associated with low-level health expenditure. On average the number of doctors in the Region is less than half the average in OECD countries.\(^{46}\)
- The number of nurses per capita remains low across the Region, with countries such as Bangladesh, Myanmar and Nepal where the number is about 0.5 nurses per 1000 population, or less.\(^{47}\)
- The number of nurses per capita is also relatively low in India with less than one nurse per 1000 population.\(^{48}\)

**Preparedness, surveillance and response**

The experience of severe acute respiratory syndrome (SARS) in 2003 highlighted the critical need for preparedness, surveillance and response across countries in order to ensure a rapid detection and control of an emerging infectious disease. It also facilitated the momentum to complete the updating of the 1969 IHR, which were successfully revised in 2005 and adopted by WHO Member States in 2007.\(^{49}\) A 2011 assessment found that considerable progress was made in the implementation of the IHR but it was still not fully achieved in some countries in South-East Asia.\(^{50}\) In addition to the revision, adoption and ongoing implementation of the IHR, a second essential trend for global surveillance is the emerging new global health networks designed to systematically and continuously collect, monitor, analyse and disseminate information about emerging public health events of international concern.

According to a 2011 article:

> South-East Asia is a hotspot for emerging infectious diseases, including those with pandemic potential (and the reasons why the region is at risk are complex). The region is home to dynamic systems in which biological, social, ecological, and technological processes interconnect in ways that enable microbes to exploit new ecological niches. These processes include population growth and movement, urbanization, changes in food production, agriculture and land use, water and sanitation, and the effect of health systems through generation of drug resistance.\(^{51}\)

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\(^{46}\) Ibid

\(^{47}\) Ibid

\(^{48}\) Ibid


\(^{50}\) Horby PW, Pfeiffer D, Oshitani H. Prospects for emerging infections in East and Southeast Asia 10 years after SARS. Emerging Infectious Diseases (2013); 19:853.

• South-East Asia is a Region experiencing rapid changes socially, environmentally and demographically.
• Governance of infectious disease across the region remains an ongoing challenge.52
• While there has been substantial investment in surveillance capacity, it remains weak in many countries.53
• Practical research in the region is scarce.54

Common country programming challenges

As indicated above, there are great variations between the countries in the region politically, economically, culturally and environmentally that contribute to divergent health needs and capacities. Nevertheless, there are a number of shared priorities, challenges and gaps as outlined below.55

Communicable diseases: This programme area is considered a medium to high priority across the Region with highest priority placed on TB (with the exception of Sri Lanka) and vaccine preventable diseases (with the exception of Thailand and Sri Lanka). Across the Region, countries are grappling with these two ongoing issues and consider both a high priority within this general area. Furthermore, in a handful of countries there remain ongoing concerns about neglected tropical diseases, malaria and sustained attention to HIV. The main donors supporting WHO communicable disease programmes in the region are Australia, the BMGF, GAVI, the Global Fund, the Sasakawa Foundation, the UK Department for International Development (DFID) and the United States Agency for International Development (USAID). Over half of the countries in the Region assert that they are adequately funded for work in this area. WHO works mainly on communicable diseases with respective ministries of health in the Region, and in some circumstances works in partnership with UNAIDS, national universities, research institutes, national NGOs and civil society groups.

Noncommunicable diseases (NCDs): This programme area is considered a medium to high priority throughout the region. In relation to NCDs, number of countries acknowledge increases in the older segments of their populations.56 With the exception of a handful of small donors supporting specific NCD programmes, there are very few donors supporting work on NCDs in the Region, reflecting the funding situation globally for this group of conditions. Bangladesh, India, Indonesia and Thailand receive funding from the Bloomberg Foundation for anti-tobacco programmes. All 11 countries in the Region recognize a lack of funding for this programme priority and are frequently reliant on core funds from WHO headquarters for joint projects. Some ministries cite additional challenges when mobilising resources for programmes that go beyond a single issue or condition such as diabetes or

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52 Ibid
53 Ibid
54 Ibid
55 The data is based on a survey responses from the 11 WHO country offices in the Region, and included inputs from either WHO Representative or the Resource Mobilization Focal Point.
56 As a group, older people have various health–care needs and are also included in the health through the life course section of this publication.
tobacco. NCD programmes reach beyond supporting ministries of health, however, and must include a broad range of stakeholders – adding the challenge of coordinating efforts across a range of private and public partners. In this light, several WHO country offices have identified the need for expanding collaborative arrangements with national NGOs research institutes and national universities.

**Promoting health through the life course:** Most countries in the region allude to health through life course as a high priority area, particularly regarding the health-related MDGs. With the exception of Thailand, all countries listed reproductive health, and maternal and newborn health, as the highest priorities in this area. In addition, several countries cite ageing populations as a growing priority. About half of the countries regard this programme area to be underfunded, while the remainder indicate that available resources are at an adequate level.

The main donors funding work in this programme area include Australia, the Canadian International Development Agency (CIDA), the Commission on Information and Accountability (COIA), DFID, UNDP-administered Multi-Donor Trust Funds (MDTFs), the Organization of the Petroleum Exporting Countries (OPEC), the Republic of Korea and USAID. In addition, this category of work also appears to leverage resources from partnered arrangements particularly with UNICEF and UNFPA owing to the complementary mandates on the health related MDGs.

**Health systems:** Most countries regard health systems as a critical programme priority and one that requires additional resources. In particular, countries prioritized delivery of integrated health services (10 countries) and national health policies (11 countries) as the two main priorities. There are few donors directly supporting health systems development through WHO. The main donors include the European Union (EU), GAVI and the World Bank in addition to funding from WHO headquarters and Regional Office for South-East Asia. The World Bank, the United Nations Office for Project Services (UNOPS) and USAID are the other main actors focusing on health system development in the Region. While WHO collaborates with these partners, a prevailing view maintains that these actors help to fill a gap that represents a missed opportunity for WHO, especially in Myanmar.

**Preparedness, surveillance and response:** Most countries in the region recognize that this remains a priority programme area. The two related areas given highest priority are alert and response capacities (IHR implementation) and emergency risk reduction and management (with the exception of India). The main donors for this category are the traditional “emergency response” donors including Australia, the European Commission Humanitarian Aid and Civil Protection department (ECHO), Germany, Japan, Norway, USAID and the UN Central Emergency Response Fund (UNCERF). Additionally, there is a limited regional disaster fund, the South-East Asia Regional Health Emergency Fund, for the Regional Office to use as supplemental funding in the initial stage of emergency responses. All 11 governments of the region have contributed to this fund. Most countries regard this programme area to be adequately funded and believe the current donor base will continue to support this work.
Funding

As part of the 2013 WHO South-East Asia Region country office survey, information was also received about ongoing resource mobilization status, needs and challenges. The following section highlights the main points identified.

In relation to health-related external funding levels for the biennium 2014–15, country offices anticipate funding to:

<table>
<thead>
<tr>
<th>Reduce</th>
<th>Remain the same</th>
<th>Increase</th>
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<tr>
<td>Nepal, Sri Lanka and Thailand</td>
<td>Bhutan, the Democratic People’s Republic of Korea, Indonesia, Myanmar and Timor Leste</td>
<td>Bangladesh and the Maldives</td>
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Survey participants were also asked: “If WHO country offices were to receive funding for only two programme areas, which two of the five programme areas would be prioritized?” While all programme areas are acknowledged to be a priority, the following were identified as relative priorities:

- communicable diseases – no countries
- NCDs – eight countries (Bangladesh, Bhutan, India, Indonesia, Myanmar, Nepal, Sri Lanka and Thailand).
- health through the life course – three countries (Sri Lanka, Thailand and Timor Leste).
- health systems – nine countries (Bangladesh, Bhutan, the Democratic People’s Republic of Korea, India, Indonesia, the Maldives, Myanmar, Nepal and Timor Leste).
- surveillance, preparedness and response – two countries (the Democratic People’s Republic of Korea and the Maldives).

The majority of countries prioritized NCDs and health systems as two critical, underfunded needs. Country offices also stated that health systems development is not well funded. The World Bank and the EU are two main funders, with the latter phasing out in some countries. GAVI is growing in importance as a regional funder, as it recently added support to health systems as part of the broader funding for vaccines. However, country offices assert that without strengthening health systems, all other categories of work are not sustainable.
In general terms, countries describe four main challenges to resource mobilization:

1. Given country is shifting from low- to middle-income status, and donors are decreasing support
   • Bhutan, India, the Maldives, Sri Lanka, Thailand and Timor Leste

2. When many donors are present, it creates an element of competition for resources
   • Bangladesh, Indonesia, Myanmar and Nepal

3. Minimal or no donor presence in country
   • Bhutan, the Democratic People’s Republic of Korea, the Maldives, Sri Lanka and Timor Leste

4. Other government challenges:
   • the Democratic People’s Republic of Korea – sanctions
   • Sri Lanka – political tensions
   • Bhutan – WHO country office cannot be perceived as mobilizing resources in competition with the Ministry of Health.
Financial resources – Asia potential

There is a core health-related donor base in the South-East Asia Region that creates a degree of predictable funding for WHO Regional Office for South-East Asia. While this is not a static group of donors, there is some consistency in relation to principal donors.

The most consistent donors across the region and programmes are Australia, USAID, GAVI and the Global Fund. Other significant donors include:

- Japan International Cooperation Agency (JICA)
- DFID
- EU
- The Republic of Korea
- The BMGF
- India (for Bhutan)
- Islamic Development Bank and Kuwait Fund (loans for the Maldives)
- Thailand (as its own, domestic primary financer of health).

There also is a small group of donors that have substantially funded specific programme areas in one or two countries, and they are not included here (e.g. Rotary International for the polio eradication campaign in India, or Sasakawa Foundation for leprosy).

While negotiations with these donors are often conducted annually in consultation with WHO headquarters, an opportunity remains for country offices (and to a lesser extent the Regional Office) to engage with these donors and attempt to leverage those partnerships at the national level.

Government donors with potential

The following section highlights changes and reconfigurations of existing WHO donors. Owing to current trends, there might be the possibility to engage with these donors in new ways.

UK: The annual DFID budget is planned to increase to £10.1 billion by 2015. The UK is committed to global health and is expected to remain a strong supporter into the foreseeable future.\(^{57}\) While DFID agreements are largely negotiated at the headquarters level, it is a decentralized agency. With a large presence in Asia, there is room to leverage additional support particularly at the country level.

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**Norway:** Norway remains one of only five countries in the world to exceed the UN target of 0.7% gross domestic product (GDP) allocated to official development assistance (ODA) and has done so for more than 30 years. The 2013 aid budget doubled from 2004 to reach NOK 30.2 billion (US$ 3.7 billion) including a NOK 650 million (US$ 79 million) increase in global health funding. Norway will provide NOK 3 billion (US$ 368 million) for global cooperation on women and children’s health up to 2020, which will be delivered mostly through multilateral channels. In terms of additional support for health-related MDGs, Norway is a possibility to explore at the regional and national levels.

**Brazil:** Development assistance in 2010 was US$ 1.2 billion. This is a 20% increase over the past five years. Brazil is forecast to have a continued commitment to global health issues with emphasis on South–South exchange, and has demonstrated interest in exchanges with Asia, and in particular India.

**The Republic of Korea** was committed to increase its ODA to 0.25% of its gross national income by 2015. Politically, the Republic of Korea is proving to be an effective link between the OECD Development Assistance Committee (DAC) members and the BRICS countries (Brazil, Russia, China, India and South Africa). In 2002, the Republic of Korea put forward US$ 279 million in ODA and by 2012 it was raised to US$ 1.86 billion with health as an increasing priority. Health aid in 2011 was US$ 44.65 million with 70% towards improving access to health services. The Asia Pacific Region was the recipient of nearly 60% of this aid (US$ 30 million) shared across 32 countries. The Republic of Korea has the potential to be a more significant resource in the region, both financially and through knowledge exchanges. Furthermore, in September 2013, the Republic of Korea committed US$ 6.3 million to WHO to improve medical services in the country and is one of the few significant bilateral donors to that country office.

**Japan:** Asia remains a main recipient of ODA from Japan. Japan typically supports multilateral agencies, such as WHO, and this is traditionally channelled through assessed contributions. However, there seems to be room to cultivate a partnership with Japan that might focus on their role as a source of expertise, including in relation to providing UHC and reductions in maternal and infant mortality.

**Russia:** Russia remains a stable contributor at US$ 450 million annually but is increasingly engaging in the global health agenda especially in relation to NCDs. NCDs is a likely area in which Russia could be encouraged to demonstrate leadership following their commitments to fight NCDs during the 2011 UN General Assembly meeting on NCDs. Russia has already provided some moderate resources to WHO Regional Office for work to this end.

**Indonesia:** Various upcoming diplomatic events are positioning Indonesia to take a lead role on the global health stage. In June 2013, the Minister of Health took over as the chair of the Global Fund. The President is co-chairing the high-level panel advising the UN Secretary General on the global development agenda beyond 2015 in September. In addition, in

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58 Ibid
September 2013, Indonesia hosted the Asia Pacific Finance and Health Ministers Conference to discuss funding UHC in the region. The latter was the first grouping in 24 years to discuss sustainable and equitable health-care financing, and how to prioritize health-care budgeting. The goal of the meeting was to develop a series of guiding principles for financing health-care in Asia Pacific. In 2013, Indonesia also hosted the Islamic Conference of Health Ministers in which they ratified the Organization of Islamic Cooperation (OIC) strategic health programme action plan for 2013–2022. Included in this agenda was a discussion about self-reliance in production of medicines and vaccines. Outcomes of these meetings and Indonesia’s current leadership are opportunities to be leveraged, especially by WHO country office.

**India:** India is currently in the unusual position of being the world’s largest recipient of global health aid as well as a global health aid donor. India is Bhutan’s largest single donor in this respect and also contributes to Bangladesh, Myanmar and Nepal. India has the capacity to increase its regional support to health, and as WHO Regional Office is located in New Delhi, adopting a larger leadership position in the region might be something the Government of India might consider.

**United Arab Emirates:** The countries of the United Arab Emirates continue to increase their foreign assistance contributions. While humanitarian relief constitutes a large part of the contributions, global health appears to be a growing commitment. However, the geographic commitment is largely the Middle East and Africa, with some support across Asia. The countries are also providing increasing amounts to the Global Fund, GAVI and for support to MDGs. While not a significant donor in the region, there it might be a possibility of interest in the work of Indonesia and the Maldives owing to the religious connections.

**Regional bodies with potential for enhanced partnerships**

There are a number of regional bodies of growing influence and resources that share geographical representation with a number of the South-East Asia Region countries. These organizations are all potential partners for WHO Regional Office and should be explored both as potential donors as well as possible sources of political leadership.

**South Asian Association for Regional Cooperation (SAARC):** Six of the seven SAARC countries are within the South-East Asia Region. As of 2011, the SAARC development fund had US$ 300 million in core funds. There is no specific category of “public health” as an area of cooperation, but there are others that are relevant, such as science and technology, poverty alleviation and biotechnology. There are also indications that maternal and child health is an area of concern.

**ASEAN:** Only three South-East Asia Region countries are part of ASEAN (Indonesia, Myanmar and Thailand). There is an ASEAN Foundation, which funds national and regional projects, some of which are health related. However, the fund is relatively limited with core resources.

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61 Ibid
62 Facts drawn from UAE web site.
of about US$ 4.3 million. There remain a number of other reasons to cultivate a possible strategic partnership with ASEAN and leverage its network.

**Asia Development Bank (ADB):** ADB’s headquarters are in Manila, Philippines and represents 10 of the 11 South-East Asia Region countries with the exception being the Democratic People’s Republic of Korea. ADB administers loans and grants for specific categories of countries in the region as well as funds on behalf of bilateral donors for specific thematic areas of work. Health and social protection is a category of ADB support and the sub-components include early child development, health systems, health finance and nutrition. ADB supports a large number of projects across the Region focused on these areas. ADB is a potential partner for WHO Regional Office for South-East Asia as a possible avenue of resources, knowledge sharing and exchanges, and a possible financing vehicle.

**Global foundations**

**Bill and Melinda Gates Foundation:** BMGF is the largest donor, having invested US$ 13 billion in global health since 1994, comprising 5% of all global health assistance. BMGF is one of the most substantial donors to WHO. As negotiations for resources are conducted between BMGF and WHO headquarters, there is not much space remaining for garnering additional resources. However, as the foundation is a significant health donor with visibility across the Region, it might still be a partner to link with for regional leverage on specific initiatives or programmes.

**Rockefeller Foundation:** The Rockefeller Foundation has a regional office located in Thailand and global health is a significant component of their giving in the region. In 2013, the Rockefeller Foundation hosted a Regional meeting focused on emerging health issues, and predicted some of the critical needs for health in the Region. The outcomes of the conference informed their new strategy for funding in the region in the coming years. The Foundation currently supports WHO (through HQ) but owing to its regional presence, it is worth exploring the possibility for further engagement.

**Bloomberg Foundation:** Bloomberg currently supports South-East Asia Region countries for work on tobacco and road safety. NCD-related interventions are the cornerstone of Bloomberg’s public health support. While there is minimal public information about working with Bloomberg, it is an organization that focuses on quality of life issues, including NCDs, in major urban areas. As such it is worth exploring possible linkages with the foundation to address similar critical challenges in the region.

**Ford Foundation:** The Ford Foundation has two Asian offices: one in India (also covering Sri Lanka and Nepal), as well as one in Indonesia. The main health-related programme area for Ford is sexual and reproductive rights and health. There is probably not much to gain from reaching out to this funder but nonetheless, they are a steady and active funder on sexual and reproductive health and rights, which is of major relevance to the Regional Office Ford Foundation might be useful to connect with for knowledge exchanges and tapping their expertise in this issue in the Region.
**MacArthur Foundation:** This Foundation does not have a physical presence in the region but does support global health-related work in Asia. They are currently supporting a large grant in India focused on maternal mortality. Migrant health is another category the Foundation prioritizes but this support is so far limited to the United States. This foundation might be appropriate to pursue with a specific programme that would be relevant to their current portfolio of work. One potential area of resonance is migration and health since this is a priority area for them.

**Wellcome Trust UK:** Wellcome supports research and strengthening research capacity in low- and middle-income countries on public health-related topics, including in Asia. For example, the Trust currently supports a project on affordable health-care in India. The potential for a partnership with the Trust is not clear but is worth exploring further owing to the connections with WHO’s work.

**Skoll Global Threats Fund:** The Fund already supports work in the Region and the main health-related category is “pandemics” and to a lesser extent “climate change”. This potential partner is worth exploring specifically for the Regional Office work on surveillance, preparedness and response.

**David and Lucile Packard Foundation:** Supports global health issues, although in Asia their work is largely limited to India and it is not clear whether there are possibilities for support elsewhere in the Region. They typically fund global health issues in Africa but might be worth exploring to ascertain possible interest in Asia-focused initiatives.

**Kellogg Foundation:** This foundation does not work in Asia and it is not clear whether there is a possibility for regional collaboration as they do support child health, nutrition and NCD-related programmes. As one of the only foundations that supports work on NCDs, it might be worth exploring possible interest in seed funding innovative programmes on NCDs in the region.

**NIKE Foundation:** The Foundation focuses the majority of their support on girls. They support health-related interventions in selected South-East Asia Region countries and it may be worth exploring to learn about partnership possibilities.

**Diaspora-owned foundations:** There is a growing group of foundations and philanthropy-related work through which the global Asian diaspora are funding programmes, including public health initiatives, across Asia. While not substantial as yet, it is one of the fastest-growing areas of giving in the US, for example. There are now a number of intermediaries being established to help Asian Americans effectively invest their philanthropic giving in Asia. The following provides a brief outline of a few structures promoting this type of giving:

- **Kordant Advisors:** A group that specializes in helping Asian Americans invest in Asia for social change.
- **American India Foundation:** A US-based foundation that has funded over US$ 80 million to 225 NGOs across 22 states in India including for work on health.
• Wadhwani Foundation: A venture-based philanthropy organization established in 2000 funded by an Indian residing in the US who supports social entrepreneurs in India seeking innovative solutions for social change.
• Give2Asia: Regional advisory services for individual and corporate philanthropists interested in investing in Asia.

Asian foundations

Asian foundations are relatively new to the arena of philanthropy especially in comparison to their counterparts in the US and Europe. However, as opportunities for economic growth and wealth expand, a growing number of foundations are being developed across the Region. Many of these foundations either begin as an arm of the founder’s business or are led by the family of the business owner and are using corporate profits for the foundation. Available information about these foundations is limited but their work is relevant to WHO. It may be worthwhile for country offices to explore possibilities with these foundations and trusts.

India

Many successful businesses in India have established an in-house trust or foundation influenced by the founder of the company or a close family member. While some of the longer-standing trusts began as a charity arm in their respective locales, many are slowly evolving towards independently managed organizations focused on longer-term strategic giving goals, and with larger sums of money. The following examples remain leaders in this area. Most corporate/family foundations in India receive between 0.5% to 1% of profits (either pre- or post-tax) from the respective company, carry out a combination of grant-making and direct implementation, and focus the majority of their resources towards education, health and the environment in the localities where the companies operate.

• Tata Trusts: The most established foundation in India is the Sir Dorabji Trust and the Allied Trusts, Sir Ratan Tata Trust and Navajbai R. T. Trust, and the JN Tata Endowment. The various trusts control 66% of the shares in Tata Sons, the promoter holding group. The wealth that accrues from this asset funds the work of the trusts, which support a range of interests primarily through the giving of grants that tend to focus on education and health initiatives. The Navajbai R. T. Trust has a specific health focus and its core work areas are: rural health, special health-care services, human resources and health system development, and clinical establishments. The thematic areas of focus are: reproductive and child health, communicable diseases, NCDs, disasters and human resources and health system development.

• Godrej Trust: Another long-standing example of giving in India by a corporate/family trust is the Godrej Trust, which has been involved in philanthropic giving for nearly a century. Twenty-five per cent of the shares of the Godrej Group’s holding company (Godrej and Boyce) are held in trust that invests back into education, health-care, the environment
and heritage projects. The trust both implements its own work and provides grants to NGOs to provide services in their areas of focus.

- **GMR Varalakshmi Foundation**: The Foundation is part of GMR Group whose founder pledged US$ 340 million (his entire stake in the company) to create an endowment for the in-house foundation in 2011. The foundation works in the 22 locations in India and abroad where GMR Group operates, and focuses on grant giving and implementation in education, health, livelihood, community development and sanitation. The health component focuses on health awareness, health services capacity development, HIV awareness and sanitation programmes.

- **Rakesh Jhunjhunwala Foundation**: The founder, an investor, has pledged US$ 1 billion of his wealth into his foundation by 2020 with the primary purpose of supporting science.

These are just a few examples from India. There are a host of companies with well-established foundations giving large sums towards health-care initiatives throughout India, but have not been listed here since their corporate focus is largely health-related, creating a potential conflict of interest for the Regional Office to partner and/or receive funds.

**Singapore**

Singapore is increasing its range of tax incentives for philanthropic giving, and hosts the largest percentage of HNWIs in the world. Its giving has more than doubled between 2004 and 2010. A few foundations that warrant further consideration are discussed below.

- **COMO Foundation**: The COMO Foundation is funded from the COMO Group, which owns a number of hotels and other companies. This foundation collaborates with UN and other international organizations. There is no geographic limitation for this foundation and it currently supports relevant work in Indonesia, India, Nepal, Sri Lanka, Thailand and Timor Leste among others. The foundation pursues activities and outreach specifically in Bhutan, Indonesia, the Maldives and Thailand.

- **Temasek Foundation**: One of the key areas of support of this foundation is support to training of health-care workers and nurses across Asia. The foundation has invested US$ 15.1 million in health-care human resources support in Asia.

- **Lien Foundation**: The Foundation uses innovative IT initiatives focusing on improving health-care standards. They have a specific focus on elderly care, water and sanitation, and pre-school.

- **Khoo Foundation**: The Foundation supports the development of health-care in Asia and the Pacific investing US$ 278 million since 2005.

**Hong Kong**

- **Li Ka Shing Foundation**: The Foundation’s founder Li Ka Shing has committed US$ 26.5 billion of his wealth to the foundation, of which US$ 1.6 billion has been invested in health and education. Primarily supports medical research institutes and medical schools around the globe.
• **Fongs Foundation:** The foundation supports a programme called Lifeline Express, which provides mobile cataract surgery services to rural areas across China. The Foundation also supports a range of medical institutes and schools.

**Indonesia**

• **Putera Sampoerna Foundation:** The founder of the Foundation pledged US$ 150 million of his wealth to support a range of education-related initiatives.

**Thailand**

• **Mechai Viravaidya Foundation:** The Foundation supports initiatives on family planning, HIV and youth empowerment.

**Regional philanthropic resources**

• Asian Philanthropy Advisory Network – Asian Philanthropic Forum
• National Volunteer and Philanthropy Centre (Singapore)
• Philanthropy Forum (Singapore)
• Community Foundation of Singapore.

These resources might provide useful starting points for the Regional Office to connect with, by virtue of their understanding and knowledge about philanthropy in the Region as well as their established regional networks.

**High net-worth individuals**

Based on a five year trend forecast of the HNWI population and wealth growth, Asia Pacific is expected to exceed other regions for anticipated wealth, growing 9.8% to US$ 15.9 billion by 2015. From 2007 to 2012 the population and wealth of HNWIs increased at two to three times of the rates around the world. Most wealth growth is in Australia, China, Hong Kong, India, Japan and Singapore. India and Hong Kong witnessed the largest growth in population and wealth of HNWIs in 2012. Indonesia is also growing in wealth creation. The number of HNWIs is predicted to be at 104 000 people by 2015, up from 33 000 in 2010.

Many of these individuals – some self-made and others inheriting their wealth – are exploring ways to not only expand their philanthropic activities but also to ensure that their contributions are producing effective results. Many are starting their own foundations or NGOs that address selected issues. In India alone, over US$ 171 million has been given through philanthropy for health. Connecting with selected individuals and establishing a relationship might yield potential resource support by a significant individual donation, and may encourage an individual to be a champion for a given cause or act as a connector to others.

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Examples of high net-worth individuals in the Region

The Shiv Nadar Foundation (India) is one such example. Shiv Nadar is the co-founder and chairman of HCL. Independent of HCL. He established a foundation through an initial investment of US$ 32 million. Nadar’s personal wealth is estimated at US$ 6.5 billion. In 2010 he pledged to give US$ 1 billion over the next five years towards education, and is also considering support towards public health issues.

The Arghyam Foundation (India) was started by Rohini Nilekani (the wife of Infosys founder Nandan Nilekani). The Foundation started with a US$ 32.5 million endowment provided and has been a public charitable foundation since 2005, giving grants focused on improving access to fresh water and sanitation across India. In August 2013, she added another US$ 27 million to the foundation.

Further examples:

- **Kiran Mazumdar** (India), biotech entrepreneur, has pledged to give away 75% of her wealth towards supporting low-cost quality health-care and cancer care across India.
- **Asit Koticha** (India) has donated over US$ 14 million to date and anticipates donating significant amounts in the future with a focus on health programmes (among others).
- **Ronnie Screwvala** (India), CEO and founder of UTV Group, has contributed US$ 75 million largely to health and other related programmes.
- **Tahir** (Indonesia), the founder and Chairman of Maya Pada Group, pledged US$ 25 million in April 2013 to his foundation, and is making his initial investment in polio eradication partnering with the BMGF.
- **Edwin Soeryadjaya** (Indonesia), Saratoga Investments, has pledged US$ 1.3 billion and is currently supporting the World Food Programme (WFP) and other international organizations working in the region.
- **Michel Ma** (Singapore), founder and owner of IndoChine Group, contributes significantly to the Red Cross and other regional groups assisting migrants and refugees. He is known to be an effective convener of other HNWIs to champion philanthropic causes.
- **Cho Yong Pil** (Korea) is a pop musician who has contributed generously to children’s health and heart disease in Asia.
- **Kree Dej Chai** (Thailand), CEO of SC Asset Corp, has generously supported work on nutrition and aid to new mothers and infants across Thailand.

Multinational corporations

There is an expansive presence of multinational corporations (MNCs) working across Asia, which are also engaged in philanthropic giving. Companies based in the US, for example, are incentivized to reinvest locally generated profits into philanthropic giving in order to avoid high taxation on profits brought back to the US. Many of these companies partner with national and international organizations to provide services or promote social change in the areas in which they operate.
A recent report *Giving in Numbers 2013*\(^{64}\) noted that India and China received charitable gifts from more US-based companies than from any other non-North American country in 2012. Seventy-two per cent of corporate giving was to India and 66% to China. However, only 2% of total giving was to India and 4% to China. Another notable trend in the report was that 71% of companies give internationally, with manufacturing businesses topping the international list followed by energy companies. Business strategic interest is the primary driver for international giving and environmental concern second. Finally, it is worth noting that aggregate corporate giving rose 42% between 2007 and 2012 and is forecast to further increase across Asia.

Some examples of MNC giving in the region include the following. Cargill, the food processing and commodity company, has developed two significant long-term partnerships, including in India. In 2012, they awarded a grant of US$ 69.9 million to CARE International to work in 57 countries over five years. They had a specific partnership with WFP in 2001 for US$ 14 million to work in Madhya Pradesh state in central India. Another example is Dell Inc., which is providing up to US$ 500 million in grants to NGOs in India working on education. Procter and Gamble provides another example with their flagship CSR programme Project Shiksha, which partnered with the NGO Child Rights and You to help educate underprivileged children in India. In Thailand, the NIKE Village Development Project is a joint venture in areas where the company worked in collaboration with the Thailand Government and a Thai NGO. The programme provided microfinance for community members as well as opportunities for life skills, job and other relevant training.\(^{65}\)

A fourth example, the IBM Smarter Cities Challenge is a global funding and in-kind capacity building opportunity for those pursuing solutions to social challenges including access to affordable health-care. IBM contributes their core business expertise to collect and analyse critical data, provide solutions and improve complex systems such as health-care. There is a programme in India and possibilities for projects elsewhere in Asia.

There are a host of MNCs that are investing billions of dollars in global health, although many of these may not pass WHO conflict of interest vetting processes. Two examples of health-related companies investing in Asia are Philips and the Abbott Fund. Philips is collaborating with ASEAN to develop the ASEAN health-care consultation to discuss regional health-care challenges, as well as identify and fund innovative solutions. Additionally, they are facilitating an ASEAN NCD network specifically to highlight the need to address NCDs across the region. The Abbott Fund supports programming around two core areas--access to health-care and science education.

\(^{64}\) Published by the Conference Board and the Committee Encouraging Corporate Philanthropy (CECP).

Corporate social responsibility – a growing regional trend

CSR broadly encompasses not only what companies do with their profits but also how they earn them. The term is used interchangeably with corporate citizenship, corporate sustainability, governance and “triple bottom line”. While these terms have different nuanced meanings, in essence CSR is about companies going beyond philanthropy and compliance, towards understanding and addressing how companies impact and influence their environmental, social and economic spheres. In general, however, CSR tends towards philanthropy and sometimes compliance. This is especially the case in Asia where CSR is relatively nascent, especially for non-international operating companies who typically consider CSR to be the building of schools or health clinics or the provision of basic services for the communities where they operate. In Asia and the Pacific, India is arguably the most developed in this respect, but even in India corporate giving is usually driven by the owner or his or her family and support is for “charity” rather for pursuing systemic or social change. Frequently, CSR comprises a company foundation implementing its own projects (as opposed to supporting what others do and/or prioritize). However, this is changing across the Region and slowly there are more and more businesses and wealthy individuals investing for change rather than charity.

CSR in Thailand is in a relatively nascent stage, with little data or studies to document its reach and effectiveness. A recent survey among Thai companies reported that 42% engage in some sort of CSR activities and 71% indicate they primarily engage in the communities where they operate. Health is a priority CSR focus for Thai corporations and emphasis is placed on supporting disease awareness and prevention. A similar study conducted in Indonesia found that among 226 of the largest companies in 10 major cities across the country 57% stated that they engaged in CSR activities. Companies with regional or international presence are more likely to have a strategy for CSR than their smaller national counterparts.

A UNDP study tried to capture similar information among companies located in the Maldives. The results indicate that only 23% of companies engage in CSR activities, mostly associated with the tourist industry and with international links. Myanmar is another country that is now being monitored for CSR engagement since sanctions were largely lifted last year allowing the US and other companies an incentive to start operations in the country. It is too soon to assess what type of impact CSR will potentially have in Myanmar but this new opening presents an opportunity.

A few additional examples of CSR, which have potential but are limited in scope, include the Four Seasons Hotels, which operate throughout Asia. The hotel and resort chain provides local support to programmes where it operates. For example, Four Seasons in the Maldives offers youth apprenticeships. Banyan Tree Holdings is based in Singapore with hotels and resorts across the region. The head of the company, Claire Chiang, is a noted philanthropist who supports a range of international organizations including UN Women and supports
programmes on health and education. Hilton Worldwide also supports global efforts to end child trafficking and related programmes.

**Venture philanthropy**

Venture philanthropy is the newest model of giving. It adapts the tools and approaches of venture capital and private equity and applies them to philanthropic giving. This funding mechanism is relatively new and is a very recent trend in Asia. In many respects, it is quite similar to established philanthropic models. While traditional foundations provide grants, venture philanthropists provide “investments” accompanied by a due diligence process.

There are many variants of venture philanthropy, although generally the model differs from traditional approaches in that it involves more time invested up front identifying just a few potential organizations in which to invest, extensive due diligence and in-depth analysis examining the model of work. Once an investment is made, it typically comprises long-term core funding accompanied by ongoing infusion of capacity building from the investor. Additionally, venture philanthropy tends to support for-profit initiatives designed for social change and to a lesser extent non-profit initiatives.

There are variations on the venture philanthropy models. Some focus on a specific social issue and the investment process is rooted in the venture capital model. For example, the Medtronic Foundation is investing US$ 6 million in tackling NCDs in India, in order to accelerate programmes and expand access to quality care and management. The investment focuses on human resource development and health system development. The Foundation brings in experts to support the identification, review and investment processes, as well as the essential financial and knowledge resources. Alternative models are used by financial service providers such as ADM Capital, a Hong Kong-based investment funds adviser. ADM provides what they refer to as a “shared vehicle”, in which their investors are offered an opportunity to invest funds towards philanthropic activities while ADM funds the core needs of the organization. Significant time and resources are invested in identifying and vetting organizations prior to support. ADM currently supports initiatives across Asia with a focus on health-care, children and youth at risk. Other examples include private banks such as the LGT Group, which also invests in health-care but is limited to India.

Finally, some initiatives raise philanthropic capital from social investors to invest in innovative initiatives across India. For example, the Acumen Fund targets investments for US$ 1 million (with a range from US$ 250 000 to US$ 2.5 million) per investee, for a horizon of 7 to 10 years. The investees benefit from hands-on engagement of Acumen employees for skills development in areas such as strategy and change management, executive coaching and recruitment.
Social impact investing

Impact investing is similar to venture philanthropy but more limited in scope as it only invests in ventures that will yield financial returns, whereas venture philanthropy does not necessarily expect financial returns. Impact investing is the deployment of capital with the expectation of financial returns alongside measurable social and environmental impact.

According to an ADB survey among potential investors, while there is interest in investing across Asia, there is still considerable reluctance. Investors expressed an interest to see greater access to information and liquidity, demonstrated track record for financial, social and environmental impact, and yield options among impact investment funds with assets of over US$ 100 million. This approach is becoming popular in Asia and is predicted to continue. At the moment, Singapore and Hong Kong are driving exploration and capital sourcing. India remains the primary recipient of impact investing to date with some selected examples in China.

The four primary main areas ripe for impact investing in the region are education, alternative energy, sustainable agriculture and health-care. In terms of health-related impact investing, studies show that the relevant areas that would benefit significantly from this approach are likely to be water and sanitation, and rural and elderly health-care.

There are a handful of organizations and resources in the Region working to catalyse impact investing including:

- Asia Community Ventures (Hong Kong)
- Lok Capital (India)
- Shujog (Singapore)
- Artha (India)
- SOW Asia Foundation (Hong Kong)
- Impact Investment Exchange for Social Enterprise in Asia (Singapore).

There are a range of companies now supporting social impact investing globally. Relevant examples to demonstrate work in this area are given below.

- JP Morgan has invested over US$ 50 million in social impact investing including innovative health-care programmes.
- Schwab Foundation for Asian Social Entrepreneurs awards social entrepreneurs who are change-makers for social causes including health-care. One relevant example is Asher Hasan, Founder and CEO of Naya Jeevan, which founded a way to provide low-income families with affordable and high quality health-care in Pakistan.
- Global Partnerships is a US based non-profit impact investor with global health as a priority impact area. Their work is currently focused on the US, as well as Central and Latin America.
- Global Impact Investing Network (US) manages the Center for Health Market Innovations. The Center features programmes that help make quality health-care delivery by private organizations affordable and accessible to the world’s poor.
- Endeavor Global (US) and Social Finance (UK) are two organizations that help social entrepreneurs to gain access to global capital markets. Both have sections dedicated to health-care.
Partnership models

There are various ways in which WHO Regional Office for South-East Asia can develop partnerships. The following highlights a some models that can be further explored.

Public–private partnerships

PPPs are defined as arrangements or contractual agreements between a public agency and a private sector entity, built on the expertise of each partner and meets a public need through the appropriate allocation of resources, risks and results.

In the global health landscape, there are a number of PPPs that WHO is part of and/or collaborates with, and are well known, including the Roll Back Malaria Partnership, Safe Injection Global Network, Stop TB, GAVI Alliance and the Global Fund. However, beyond these well-known global collaborations, there are numerous examples of PPPs at all levels employed to address a range of health-care challenges, and the Asia region is no exception.

The use of PPPs for health-care in Asia is rising and is utilized for attracting investment, greater value generation and attempting to reduce the burden on already limited public finances. India, for example, decided to invest 30% of the Department of Biotechnology’s budget in PPPs. Singapore is in a PPP with its scientific and research institutes and Roche for US$ 103 million to create a transnational medicine hub to advance the drug discovery timeline. Indonesia engages in PPPs to construct or upgrade facilities across the care network, adding critically needed capacity and improving quality and efficiency.66

The challenges with these particular PPPs is that many Asian countries still need to build sound regulatory frameworks in which to operate, and have fair and transparent bidding processes as well as a certain basic level of human resource capacity to ensure such investments yield the necessary results.

Multi-partner trust funds and joint partnerships

The multi-partner or multi-donor trust funds (MDTFs) are partnerships whereby the UN system, national authorities and funding partners establish a joint fund that uses the “pass through fund management model”. These funds can be established in a variety of ways and can have a thematic or geographic focus. Despite the range of possibilities, the shared fund has common guiding strategies:67

- involve a broad range of stakeholders in the decision-making process
- build on existing structures (rather than creating parallel ones)
- strengthen aid effectiveness through coordinated and harmonized interventions
- full transparency and accountability in funding, management and implementation
- focus on effective and efficient delivery of results.

MDTFs are generally established to support a country and/or global strategic priorities that are defined in national or strategic plans of the UN Development Assistance Frameworks (UNDAFs), Delivering as One (DaO) and similar strategic frameworks.

WHO, as a UN agency, participates in the development of UNDAFs at the country level and can apply for funds as relevant where MDTFs exist in country programmes. In total, WHO globally received over US$ 315 million from MDTFs and Joint Programmes (JPs).68 Across the South-East Asia Region, this funding model does not appear to be a significant avenue of resources for WHO country offices, but it is something that can be tapped where available. For example, WHO has an approved budget of over US$ 14 million in the MDG Achievement Fund, some of which is applied in the Region. In the Maldives, WHO country office will receive two years of funding for health-related programming through the Maldives One UN Fund. There is also a small Bhutan UN Country Fund which has a health component that the country office may access.

Outside of the UN system, there are isolated examples of similar multi-donor trust funds or joint funding arrangements for health. One example in the Region is the Bhutan Health Trust Fund established by the government, which also matched seed funding from donors. The administration of the fund is not proving to be effective, but it is an existing mechanism that has potential for funding future health programming in Bhutan.

The World Bank also administers MDTFs and manages one that is health-related. The Health Results Innovation Trust Fund (HRITF) was created in 2007 to support results-based financing approaches in the health sector for achievement of the health-related MDGs, in particular target 1c, and goals 4 and 5. Current donors include Norway and the UK with commitments totalling US$ 550 million until 2022. The bulk of the funds programmes are in Africa. Support to countries in Asia is limited to Thailand and India, and special “knowledge and learning grants” to Bangladesh, Bhutan, Nepal, Sri Lanka and Timor Leste. The World Bank recently announced an additional US$ 700 million funding until end-2015

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67 Drawn from the Multi-partner Trust Fund Office Gateway (see www.mptf.undp.org for details).

68 See GATEWAY factsheet for details of WHO portfolio of MDTFs and JPs.
for women’s and children’s health. This additional funding will support programming in the poorest countries and enable scaling up of programmes underway through the HRITF.

Another example is the World Bank and Bangladesh MDTF for the health sector. In September 2012, the World Bank, relevant donors and the Government of Bangladesh made an agreement for the fund in which US$ 280 million from Australia, Sweden, the UK and the US will go to the Bangladesh Health Sector Development Programme. The Government will fund 75% and the World Bank will provide US$ 359 million credit through its IDA.

Health councils

Health councils are collaborations or alliances formed with health experts, leaders, and stakeholders across a given geographic area. They typically include government, non-for-profit organizations, private and other relevant experts that gather and disseminate information on complex health issues, connect or build networks, and provide advice or guidance for health-related challenges.

Following are three different types of health councils. The Global Health Council is a membership alliance with over 4500 members and 325 different organizations represented from 39 different countries. The organization is dedicated to improving the health of the billions of people living on less than US$ 2 per day. The organization endeavours to speak with a collaborative voice, convene key stakeholders around global health priorities and engage decision-makers to influence global health policy.

Brazil’s health councils illustrate a different council model. There are health councils across all of the country’s 5000 plus municipalities. They are empowered by law to inspect public accounts and demand accountability, and some strongly influence how resources are spent for health-care. Initial evaluations of these health councils indicate that they are inclusive, effective and have created a culture of health-care prioritizing in Brazil. The following explains more about how they function:

Brazil’s Sistema Unico de Saúde (SUS), is a universal, publicly-funded, rights-based health system: a rarity in Latin America. Middle-class Brazilians may continue to use private health services, but the government has an obligation to serve everyone. The Brazilian “Citizens’ Constitution” of 1988 established health as the right of all, defined its provision as the duty of the state and guaranteed the right to participate in the governance of health. It laid the groundwork for the establishment of institutionalised mechanisms for citizen engagement at municipal, state and national levels. Designed and put into place during an era in which neo-liberal health reforms elsewhere in the world – and especially in Latin America – have driven the marketisation of health, Brazil’s SUS holds a number of important lessons for anyone interested in making public services more effective, responsive
and accountable. Ordinary Brazilian citizens and the health workers who serve them understand a great deal about the health problems of their communities and how these might be addressed. Brazil’s system of health councils and conferences illustrates the value of this knowledge. Each month tens of thousands of Brazilian citizens representing a spectrum of civic associations – churches, women, black, disabled and lesbian, gay, bisexual and transsexual movements, NGOs, unions, neighbourhood associations and more – meet with those who run their health services and provide their health-care. They come together with a broader body of citizens, health managers and health workers every two or four years in municipal health conferences, from which delegates are put forward for conferences at the state and national levels. Hundreds of thousands of citizens took part in shaping proposals that were then debated amongst 3,500 participants at one National Health Conference in 2008. At such events, proposed amendments collated from days of group work are blazoned across giant screens, the kind used at rock concerts, while members of the crowd wave placards or chant when their desired amendment comes up for a vote. Through this process of debate, contestation, refinement and reformulation, good ideas from citizens often survive to find a place in state and national policies. And when they do not, citizens who recognise the value of their ideas often continue to fight for them; some as health user representatives elected to represent their communities at the councils; others through their civic associations or political parties. Amid all the debate, one important consensus has emerged around the value of maintaining the national health services itself.\(^69\)

A third example is the Health Council of Canada, which engages with federal, provincial and territorial governments, national and regional organizations, researchers, providers, patients and citizens by creating opportunities for dialogue, support and engagement through conferences, presentations and sharing of practices on health-care. The US has a range of health councils as well, with most operating at the state or city level rather than nationally. There does not appear to be anything comparable in place in Asia.

**South–South partnerships**

South–South cooperation is a broad framework of collaboration among countries of the global south. The partnership is between at least two countries for the promotion of technical and economic cooperation for political, economic, social, cultural, environmental or technical domains. The countries share knowledge, skills, expertise and/or resources to meet development goals. Collaboration in which “traditional” donors and multilaterals

facilitate South–South initiatives through the provision of funding, training and technology systems as well as other forms of support is referred to as “triangular” cooperation.

Health is an area of growing importance for South–South cooperation, especially for emerging economies. In March 2011, Research and Information Systems for Developing Countries (RIS) published a discussion paper entitled *South–South cooperation in health and pharmaceuticals: Emerging trends in India–Brazil collaborations*. The report suggests that the India–Brazil partnership in the health sector is an area in which the two countries have increasingly cooperated bilaterally as well as in several international forums. The exchanges have included joint research and development, developing joint agendas in multilateral forums such as WHO, establishing new fellowships for research and study, as well as initiatives around trade in the pharmaceutical sector and entrepreneurial linkages.

There are many examples of South–South cooperation in health with a growing number specifically between the BRICS countries, with some including WHO as a partner. RIS has also documented emerging trends in BRICS research and entrepreneurial collaboration in the health field. The report indicates that collaboration is generally of mutual benefit for participating countries. It is often aimed at shared health needs and does not necessarily consist of donor recipient relationships, but rather reflects capacity building in health biotechnology research and development.

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70 Available at: http://www.ris.org.in/images/RIS_images/pdf/dp172_pap.pdf
CHAPTER 6
Strategic considerations

In November 2013, WHO held a second Financing Dialogue meeting in Geneva to review its funding outlook for the biennium 2014–15, and to identify solutions to address funding challenges. Two hundred and sixty-six representatives from 92 Member States and 14 non-Member State partners participated. At the time, according to WHO Secretariat, 61% of the US$ 4 billion required for the 2014–15 Programme Budget was available. For the first time, Member States and other contributors provided funding projections to enhance the understanding of the organization's financial situation, and to better plan for delivery of results, in advance of the biennium. These projections totalled US$ 935 million, bringing to 85% the proportion of Programme Budget funding that was available or projected.

Resource mobilization was included as an essential piece in this Financing Dialogue, as well as the need for coordinated and targeted organization-wide resource mobilization.

According to available reports, WHO still needs to:

- mobilize funds for underfunded areas within the Programme Budget
- identify means to ensure coordination and clarification of roles and responsibilities in resource mobilization and partnership building
- develop specific strategies to attract non-traditional donors
- link resource mobilization and partnership building plans across WHO planning and strategic processes.

The aim of this analysis and the strategic considerations that follow is to capture and align with these points for The Regional Office moving forward in 2014–15 and beyond. The Regional Office must consider and address certain constraints and opportunities in order that the partnerships, interagency coordination and resource mobilization (PIR) team can progress with new and innovative work arrangements. Current resource mobilization opportunities are well developed and the Regional Office should capitalize on these openings. The final section of this chapter is divided into two sets of recommendations: short-term inputs, which will build the foundation, and the longer-term interventions.

Constraints

The following highlights critical impediments that may limit WHO Regional Office for South-East Asia in cultivating new and innovative arrangements for resource mobilization and partnerships.
• The limited human resources of the PIR team will constrain its ability to implement a new resource mobilization strategy. Given its short staffing, there will be a limited amount the team can achieve, considering the scale and scope of work required to bring a new strategy to life.

• Limited financial resources will also be an obstacle for creating some foundational work products.

• There are limited skill sets at various levels for resource mobilization and partnerships building. Based on the skills audit undertaken as part of a broader survey, there is a clear absence of expertise on building partnerships, minimal understanding of resource mobilization approaches beyond traditional proposal writing, and a general weakness to think strategically and beyond specific areas of work.

• Partnership building and resource mobilization are generally not considered a priority, which makes implementing any strategic plan difficult and may render action plans ineffective. While management may state in surveys that this is a priority, it often does not translate into action. There is an apparent disconnect between what is seen as the essential goal and what is collectively delivered. However, the lack of commitment to mobilizing resources seems largely attributable to a lack of time and capacity, rather than a lack of interest.

• Thematic regional programmes and country programmes need to clearly articulate answers to the following critical questions: Why fund WHO? (i.e. as opposed to the government or a NGO) what is WHO added value and what is its impact? Answering these questions is the cornerstone to an effective donor “pitch”. Based on discussions with staff, these questions remain largely unanswered.

• Lack of clear operational linkages between the Communications and PIR teams. The two departments require integrated strategies and commonly developed

• Bureaucratic hurdles in relation to private sector partnerships and lack of clear corresponding guidelines creates a lack of incentive for relevant staff to pursue potential partnerships in this sector. This includes the lack of a streamlined process for vetting potential private sector partners.

• Lack of clear guidance on resource mobilization and partnerships from WHO headquarters. This will limit any future engagement of the team at regional or at country level.

• Lack of clear guidelines from WHO headquarters on funding modalities available for the Regional Office to engage with partners. For example, how can the Regional Office accept individual contributions through the UN Foundation? How can it establish a MDTF?

• Lack of integrated global communications and resource mobilization strategy.

• There are no traditional donors located within the South-East Asia Region.

Opportunities

There is equally a set of opportunities upon which WHO Regional Office for South-East Asia can capitalize for developing new partnership arrangements and funding opportunities.

• WHO reform process is creating a window of opportunity by allowing space to reflect on critical questions and opening the space for potentially new and innovative ideas.
• WHO policy deliberations on partnerships with non-state actors will hopefully streamline and simplify the vetting process.
• Despite the global economic slowdown, most traditional DAC donors remain committed to global health.
• There is increasing wealth being continuously created across Asia and it is forecasted to continue.
• Philanthropy is a growing field in the Region but the donor base is largely uninformed, which creates an opportunity for WHO to educate a growing potential donor base about regional health priorities and opportunities for impact.
• Regional potential for new and innovate partnerships arrangements such as ASEAN, SAARC, etc.
• There are increasing examples and case studies of good practices that can be harnessed and refined for the Regional Office programmes.
• National and international corporations across South-East Asia have a growing interest in supporting health-related initiatives as part of CSR and philanthropic giving.
• There are nascent donor countries in the Region that have the potential to grow such as India, Indonesia and Thailand.

**Strategic interventions**

This section presents two sets of recommendations for the Regional Office that can be adopted according to available human and financial resources. The first set of recommendations focus on short-term interventions that either require minimal additional inputs to accomplish or are suggested as “foundation building” recommendations, that is smaller initial steps the team can undertake in order to establish the necessary relations, work products and procedures necessary before longer-term strategies can be pursued. Implementing this first set would be the essence of a workplan for PIR and its said objectives. The second series of recommendations are focused on longer-term undertakings and are contingent upon having the necessary human and financial resources as well as political commitment from WHO leadership.

**Building the foundation**

1. **Demonstrated leadership commitment for new partnerships:** The Regional Director and Directors must prioritize and articulate the importance of developing new partnerships in order for any strategy to come to light. This is true to a large extent for WHO Representatives at the country level as well. Leadership must articulate its commitment, and provide time and space for this to develop. As part of this process, it would be helpful for a senior management retreat to be organized specifically for the Regional Office and country programme leadership as they are often the first face of WHO with potential donors. It is essential that this group of leaders be able to answer the following three critical questions: Why fund WHO? What is WHO added value? What is WHO’s impact?

2. **Increased linkages between communications and PIR:** Collaborate with the Communications Department (or hire a shared specialist) to develop core communication
products/materials that can be used to pitch to donors about the importance of supporting health in the Region, and why they should support WHO.

3. **Establish links with regional philanthropy networks:** There is a growing array of regional networks dedicated to cultivating and improving philanthropic giving across Asia. It is of value for the PIR team to cultivate and establish relations with some of these networks, both to learn from their experiences and to be linked into such networks. The Asian Philanthropy Advisory Network is one such example, which also hosts an annual Asia Philanthropy Forum. These venues provide consolidated opportunities for WHO to learn and explore new possible donor opportunities. Another organization worth meeting is Dasra, which is only focused on India, but has filled a philanthropic niche in India – that of the interlocutor between donors and recipient organizations. Their approach and experiences might benefit WHO, especially that of the India office, as it attempts to cultivate funds and new partners.

4. **Cultivate new donor relations:** Establish relations with a select group of potential new donors. Regional studies on cultivating philanthropy in Asia recommend that generally speaking it is the personal connections and understanding that initiates giving. In the Asian context, friend raising precedes fund raising. It is important to build face-to-face, personal relationships that help potential donors to come to know and trust the organization. This is a time-consuming and ongoing process, and given Asia’s growing wealth it makes sense for PIR staff to start developing these networks as soon as possible.

5. **Engage anew with existing WHO donors:** Introduce an innovative idea to WHO donors that they might contribute towards seed funding or a pilot effort. As outlined in the previous section, Rockefeller (health systems), Bloomberg (NCDs) and Skoll Global Threats Fund (surveillance) are working regionally and/or in selected countries. The country offices should reach out to foundations in their respective locales. Government donors, such as the Republic of Korea and Japan are also two potential donors in the Region that should also be approached at the respective country levels. Finally, in light of the recent World Bank announcement of an additional US$ 700 million to its MDG fund, it is worth exploring further how WHO can access those resources, as well as other pre-existing UN managed MDTFs.

6. **Publish “technical notes” for funding health:** In collaboration with communications and technical experts, develop two products that can be utilized for resource mobilization and partnerships building. First, a simple guidebook for potential donors on how they can support the Regional Office on specific global health issues and priorities for the Region. Second, a core selection of innovative concept notes that can be used to encourage funding around a particular priority area.
7. **Partnerships policy endorsed by headquarters:** Negotiate an interim arrangement whereby the Regional Office can move ahead and speak with potential private sector partners. As part of this dialogue, it is important to identify the means for streamlining the vetting process for potential donors, in order to avoid delays. Ideally, these issues will be effectively addressed in the forthcoming non-state actor policy from WHO headquarters.

8. **Identify new or reconfigure existing funding modalities:** Research and identify the means for the Regional Office to receive funding within the Region. For example, can the Regional Office receive a donation from an individual through the UN Foundation? What are other funding modalities that the Regional Office can employ to receive funds? Presumably, these answers are known to WHO headquarters but this information needs to be effectively distilled and conveyed to the Regional offices so that they have some latitude to act.

9. **Country level engagement with new donors:** Engage country offices to research in their respective partnerships resources including reaching out to national foundations, connecting with HNWIs, and researching CSR possibilities with national and multinational corporations in the country. The regional office can tackle the other locales relevant for the Regional Office (e.g. such as Hong Kong and Singapore) where many foundations, networks and other regional hubs exist for philanthropy as well as health-care.

10. **Resource mobilization and partnerships integrated into WHO’s biennial strategic planning process:** PIR should actively engage in the biennial strategic planning process for 2016–2017 from the outset in order to determine the implications for resource mobilization (RM) and partnerships. Since this opportunity has passed for 2014–2015, the PIR team should work in the interim with the new plans and the country team to proactively develop action plans.

11. **Corporate social responsibility for health workshop:** Consider hiring an external CSR for health expert to undertake basic training for country office staff on what is/how to approach CSR in general. Such a workshop will create opportunities to discuss how to package ideas and concepts, highlight what are appropriate roles and responsibilities for WHO, and other actors to be engaged. This could be particularly useful for smaller programmes such as Bhutan, the Maldives and Sri Lanka, where there is also a sizeable hotel and tourism industry.

12. **Building internal capacities:** Based on the skills audit and review of training needs in country offices and among regional staff, there is a critical need for communications and PIR training. As there is no dedicated PIR staff in the country or regional programmes, it is essential for programme staff to develop a foundational understanding of how to conceptualize and pitch concepts to potential donors. Additionally, staff should be in a position to articulate the three questions outlined for leadership above. Alternatively, the Regional Office management can explore how dedicated staff can be hired in the country offices to take forward the work on partnerships and resource mobilization (or explore hiring a number of staff to cover select countries).
Medium- to long-term strategic initiatives

1. **Integrate resource mobilization into country cooperation strategy planning (CCS exercises):** Resource mobilization and partnerships staff, as well as those from communication departments, should be actively involved in the CCS planning and strategizing at all levels. When the country office undertakes strategic planning, PIR/communications should be part of the process.

2. **Regional MDTF for health:** The two most underfunded programme areas – and two that the majority of the country offices have articulated as a critical need – are NCDs and health systems development. The resource mobilization team can organize an exploratory dialogue with the technical leads in the Regional Office and selected country office staff about establishing a special fund/MDTF to support these two areas of work across the the Regional Office. For example, NCDs is one programme area that is underfunded regionally and globally and constitutes the highest disease burden for the Region. Moreover, initial research demonstrates that it is not a resource-intensive area, but requires a range of partnerships to start tackling NCD prevention. The PIR team could work with the technical lead for NCDs to determine what type of support is needed, what a joint programme might look like and how results can be demonstrated.

   Possible donors to engage in this discussion might include Bloomberg, Rockefeller, Russia, ADB and ASEAN as a possible starting point. Bloomberg supports NCD-related work, supports WHO and maybe interested in such an initiative. Russia is a small but steady, and increasingly interested, global health donor and is committed to NCDs. ASEAN is working with Philips to promote programming around NCDs, and ADB is a regional actor that has prioritized global health in its regional portfolio. Country offices might be able to engage their respective ministries for support as well.

3. **WHO guidebook on CSR for health:** Research further and explore the idea of a WHO-published guidebook for educating corporations for undertaking CSR work such as workplace health and wellness programmes. An example of such a publication is one developed by the Entrepreneurs Foundation of the Silicon Valley Community Foundation (SVCF). They launched a global health initiative that included a guidebook for corporations providing instruction for investing in global health. It provides guidance to help raise awareness and inspire action on global health issues. The guide aims to provide a context for engaging in global health challenges and impacts, as well as how to engage your workforce, customer base and corporate philanthropy to make an impact. The publication can be reviewed and, if found useful, a discussion started with this organization to see if they might be interested to do something for the Asia region on a pro bono basis.

4. **Cultivate HNWIs as health champions:** Identify and start to establish relations with HNWIs in relevant countries. Before initiating this process, it is important to have suitable communication products developed, understand how a potential contribution can be channelled, and explore appropriate regional priorities that might be profiled to such individuals. Three possibilities that can be explored in working with a core
group of HNWIs are: individual donations; leveraging their networks and engage them as a “champion” on a given health issue and bringing a small group together to create a “giving circle”, in which a group of donors contribute significantly into a programme area over a number of years.

5. **Explore possible partners and donors focused on the Asia diaspora:** Asians residing in the US and elsewhere are a quickly growing funding group with most of their philanthropy focused back in Asia. This potential resource can be explored at two levels. First, there are organizations which help advise this group in giving. One such group is Kordant Advisors, which provides philanthropic advice to Asian Americans interested in investing in Asia. Another is Give2Asia, which created a funding platform from which individuals can give grants to organizations pre-vetted by the organization, or work with the organization to identify possible funding arrangements. Second, there are HNWIs who are contributing portions of their wealth in grants or social investments across Asia.

6. **Regional health campaign:** Meet with technical teams to explore the idea of establishing a regional thematic campaign in line with global health priorities. For example, WHO Regional Office for South-East Asia could potentially spearhead a regional campaign on women’s health and catalyse work, resources and partnerships to improve social outcomes for women. Regional bodies such as SAARC, ASEAN, etc. might be useful to link with such an effort to generate political momentum. This type of arrangement can lend itself to partnerships with other UN agencies (e.g. UN Women) and foundations or NGOs that support women, such as the Global Fund for Women.

7. **Asian health councils:** Further explore the idea of facilitating the creation of regional health councils. Two relevant examples are in India where the new Companies Bill incorporated CSR requirements. WHO might facilitate a health council that works between the Ministry of Corporate Affairs and Ministry of Health, for example, to bring together the relevant stakeholders and leverage the opportunity for part of the corporate 2% going towards effective health programming. Another example is the Global Health Council, which has offices in the US, Europe and Africa and perhaps could be encouraged through other partners to open an Asian affiliation either in New Delhi or Bangkok.

8. **Advancing South–South cooperation:** This partnership model can be leveraged further within the Region and across the global south. UHC could be a thematic area of focus as there have been successes in other countries on UHC and it is an issue most country offices are grappling with. Beyond a regional issue such as UHC, there are many examples among the country offices demonstrating current engagement in South–South cooperation, at least at a regional level. These can be researched and leveraged as most seem to be quite limited or nascent in their development.

9. **Facilitate an experts health group:** Owing to the Regional Office’s long standing and expansive presence across the Region, WHO would be an appropriate actor to catalyse an experts group focused nationally or regionally by thematic issue. WHO would be in a position to bring together the range of relevant actors in the nongovernment community, government, academics and donors that work on a given issue to begin dialogue, either
on addressing a shared challenge or as a means to test a new model of intervention. This is not meant as a technical experts discussion but as a strategic discussion on how to work more effectively, cultivate partnerships and identify new resources, not focused on scientific solutions but moving beyond to intersectoral dialogue.

Convening an experts group would allow WHO to address some of the gaps identified above such as providing a platform for exchanging information, capturing experiences of and lessons learned by different actors working on the same social challenge, creating a network of connections between potential donors and grantees, linking technical experts with implementers and funders, and creating opportunities for funds to be leveraged.
Annex I: Country Profiles
## COUNTRY PROGRAMME PROFILE: BANGLADESH

<table>
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<th>Programme areas</th>
<th>High priorities</th>
<th>Current donors (not including AC funds or regional other)</th>
<th>Funding levels</th>
<th>Two priority areas for funding</th>
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<tr>
<td>CDs</td>
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<td>Norway, Germany, Japan</td>
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### 2014–15 funding forecast compared to that of 2012-13 biennium

**Funding challenges**

- Donor priorities are often different from country priorities.
- There is competition for resources owing to high donor presence.
- There are many actors with which to coordinate.
- Government of Bangladesh is slow to disburse funds and implement.

**Resource mobilization and partnership possibilities**

- Learn more about WHO-Government memorandum of understanding (MoU), where the government pays WHO for some of its services; learn why process worked, obstacles, and how it could be replicated.
- Explore the possibility of leveraging regional and South–South cooperation.
**Programme areas** | **High priorities** | **Current donors (not including AC funds or regional other)** | **Funding levels** | **Two priority areas for funding**
---|---|---|---|---
CDs | | OK | | 
NCDs | NCDs | Under | X | 
Health through life course | Australia, OPEC, UNEP, GEF | OK | | 
Health systems | Funding UHC and human resource development | Under | X | 
Preparedness, surveillance and response | ECHO | OK | | 

2014–15 funding forecast compared to that of 2012–13 biennium same level of resources

**Funding challenges**

- Considered lower middle-income country and thus will graduate from GAVI. Other traditional donors have withdrawn.
- Bhutan is a low priority for global initiatives.
- Bhutan is a small landlocked country of little interest to the international donor set.
- The government does not want WHO to fundraise in competition with them, and since there is minimal donor interest both parties might pursue the same funders.
- There are no donors present in Bhutan with the exception of the Government of India.
- There are minimal private sector companies present and they are not yet in a position to support health programmes through CSR or philanthropy.

**Resource mobilization and partnerships possibilities**

- There is a corpus funded US$ 24 million in the Bhutan Health Trust Fund (BHTF) and the Prime Minister is now prioritizing this fund so that interest from it can fund vaccines.
- Explore how WHO can identify the expertise to support the improved management of the BHTF.
- Explore regional funding options for support to work on NCDs and other underfunded issues.
- Explore possible South–South cooperation on providing health-care in small isolated countries; research other countries that have successes in providing health-care in similar contexts and invite them for a knowledge exchange and lessons learned.
- Explore CSR possibilities in hotel and any other existing industry or facilitate for government.
- Explore South–South arrangements to see how WHO work can be funded by government resources, i.e. how have other country programmes managed to secure financial commitments from the government to fund WHO technical support.
### COUNTRY PROGRAMME PROFILE

<table>
<thead>
<tr>
<th>Programme areas</th>
<th>High priorities</th>
<th>Current donors (not including AC funds or regional other)</th>
<th>Funding levels</th>
<th>Two priority areas for funding</th>
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<td>UNCERF</td>
<td>Insufficient</td>
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2014–15 funding forecast compared to that of 2012–13 biennium same level of resources

#### Funding challenges

- Funding are mostly emergency based, humanitarian and short term.
- No donors are present in the country due to lack of interest, political challenges and sanctions.
- There is no WHO presence in Seoul where donors from the Democratic People’s Republic of Korea are present (Although there is presence of the Regional Office for the Western Pacific in Seoul, the Democratic People’s Republic of Korea is part of the South-East Asia Region).
- Sanctions on the country prevent proper engagement on supporting health activities.

#### Resource mobilization and partnerships possibilities

- Explore how the Democratic People’s Republic of Korea can increase support to programme.
- Explore the possibility of support from Australia, Japan and OPEC countries.
- Explore the possibility of support from Skoll Foundation and US Centers for Disease Control and Prevention (CDC) for surveillance needs.
- Research WHO convening a “health summit” or donor meeting in Seoul, Beijing and/or Delhi as well as in Geneva to garner possible support.
COUNTRY PROGRAMME PROFILE

INDIA

<table>
<thead>
<tr>
<th>Programme Areas</th>
<th>High priorities</th>
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<td>Rotary, DFID, BMGF, USAID</td>
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<td></td>
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</table>

2014–15 funding forecast compared to that of 2012–13 biennium same level of resources

Funding challenges

- Government has resources and donors providing support directly, so there is no support for WHO.
- The environment is not sufficiently responsive or transparent for donors.
- There is a lack of support for developing strategic partnerships.

Resource mobilization and partnerships possibilities

- Explore leveraging South–South arrangements between India and Brazil to address UHC.
- Explore an exchange for India to learn from Brazil how it finances WHO work (this would be equally useful for Bhutan, the Maldives and Thailand).
- Research and identify a core group of Indian companies to work with on CSR for health.
- Explore possibility of working with Ministry of Corporate Affairs to promote effective health programming in CSR.
- Explore the facilitating an “experts group” with relevant ministries, the private sector and other health-related partners to tackle specific health-related challenge(s).
- Research the possibility of establishing a health council in India.
- Research and explore possible relationships with select HNWIs.
- Advocate with government about creating tax incentives for health-related philanthropy.
## Country Programme Profile: Indonesia

<table>
<thead>
<tr>
<th>Programme areas</th>
<th>High priorities</th>
<th>Current donors (not including AC funds or regional other)</th>
<th>Funding levels</th>
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<td>USAID, Australia</td>
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</table>

**2014–15 funding forecast compared to that of 2012–13 biennium** unknown

### Funding challenges

- There is some competition between WHO and NGOs for some funding sources.
- Obstacles at WHO headquarters level have prevented any successful PPPs.
- WHO is unable to access some philanthropic opportunities.
- CSR is an increasing avenue for resource mobilization, but WHO has been unable to access the same to date.

### Resource mobilization and partnerships possibilities

- Explore how to support Government of Indonesia in leveraging its current leadership role in global health.
- Identify possible HNWIs to ascertain interest their in supporting health.
- Research CSR possibilities and what WHO’s role can be in facilitating CSR for health.
## COUNTRY PROGRAMME PROFILE MALDIVES

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</table>

**2014–15 funding forecast compared to that of 2012–13 biennium** slight increase

### Funding challenges

- The Maldives is considered to be a middle-income country.
- There are no donors present.

### Resource mobilization and partnerships possibilities

- Explore regional funding options (if there is a regional fund created).
- Explore possible South–South cooperation on providing health-care in small isolated countries.
- Research and explore the possibility for CSR starting with tourism industry and hotels (specifically Hilton Worldwide, COMO group and Banyan Tree).
- Explore the possibility of engaging Japan as a donor and/or knowledge resource.
- Regional or South–South exchange on MDTF administration.
COUNTRY PROGRAMME PROFILE MYANMAR

<table>
<thead>
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<th>Programme areas</th>
<th>High priorities</th>
<th>Current donors (not including AC funds or regional other)</th>
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<td>X</td>
</tr>
<tr>
<td>Preparedness, surveillance and response</td>
<td>Weak systems in place</td>
<td>USAID, Australia</td>
<td>Low</td>
<td></td>
</tr>
</tbody>
</table>

2014–15 funding forecast compared to that of 2012–13 biennium potentially higher

**Funding challenges**

- There are too many donors present with conflicting/different priorities.
- There is a lack of sustained WHO leadership in the country.
- Donors are not interested in supporting WHO or Ministry of Health directly.
- Insufficient budget ceiling (and difficulty increasing it) has slowed down implementation and demotivates the country office from mobilizing additional resources.
- New donors are not well coordinated and this results in donor-driven projects.
- There is a perception that agencies other than WHO are more efficient in providing technical assistance.
- Donors tend to support projects at decentralized (peripheral) levels, minimizing the specific functions of a central/intermediate level where WHO’s involvement is most required.
- WHO support to the country is perceived as being spread too thinly across many areas.

**Resource mobilization and partnerships possibilities**

- Prioritize for strategic planning exercise/action plan development that integrates communications and partnerships building (such an exercise might help start the process of changing perceptions about WHO as a partner).
- Learn more about CSR opportunities as the country opens up to new markets and partners.
- Explore possible joint partnerships with other multilateral organizations owing to their large presence.
COUNTRY PROGRAMME PROFILE  NEPAL

<table>
<thead>
<tr>
<th>Programme areas</th>
<th>High priorities</th>
<th>Current donors (not including AC funds or regional other)</th>
<th>Funding levels</th>
<th>Two priority areas for funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDs</td>
<td>CDs</td>
<td>GAVI, GF</td>
<td>OK</td>
<td></td>
</tr>
<tr>
<td>NCDs</td>
<td>NCDs</td>
<td>Russia</td>
<td>Under X</td>
<td></td>
</tr>
<tr>
<td>Health through the life course</td>
<td>Health environment and MDGs</td>
<td>COIA</td>
<td>OK</td>
<td></td>
</tr>
<tr>
<td>Health systems</td>
<td>Human resource development</td>
<td>GHW and COIA</td>
<td>Under X</td>
<td></td>
</tr>
<tr>
<td>Preparedness, surveillance and response</td>
<td>High priority across</td>
<td>EU, USAID</td>
<td>OK</td>
<td></td>
</tr>
</tbody>
</table>

2014–15 funding forecast compared to that of 2012–13 biennium reduction

Funding challenges

- Competition between actors exists for resources.
- Donors interests do not always match government priorities.
- WHO bureaucracy can make fundraising challenging.
- Health is not regarded as a priority in UNDAF, and RM through this modality is limited.

Resource mobilization and partnerships possibilities

- Leverage Regional and South–South exchanges.
- Further explore the possibility of accessing joint programme and MDTFs.
- Explore PPPs, especially in establishing standards for hospitals and clinics under development.
<table>
<thead>
<tr>
<th>Programme areas</th>
<th>High priorities</th>
<th>Current donors (not including AC funds or regional other)</th>
<th>Funding levels</th>
<th>Two priority areas for funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDs</td>
<td>Sasakawa, GAVI, GF</td>
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<td></td>
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<tr>
<td>NCDs</td>
<td>NCDs</td>
<td>Russia</td>
<td>Under</td>
<td>X</td>
</tr>
<tr>
<td>Health through the life course</td>
<td>Health environment and MDGs</td>
<td>Under</td>
<td>Under</td>
<td>X</td>
</tr>
<tr>
<td>Health systems</td>
<td>UHC and human resource development</td>
<td>OK</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preparedness, surveillance and response</td>
<td>UNCERF</td>
<td>Under</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2014–15 funding forecast compared to that of 2012–13 biennium reduction

**Funding challenges**

- Sri Lanka is classified as a lower middle-income country moving to upper middle-income status.
- There are not many donors at present. However, World Bank has given a large loan to the health sector for a 5–7 year period.
- Human rights situation is an impediment for donor support (especially from Multilateral Organisation Performance Assessment Network countries).
- Sri Lanka Government is more interested in technical support from donors rather than financial assistance, as it is looking for sustainability and self-reliance.

**Resource mobilization and partnerships possibilities**

- Leverage South–South and regional exchanges.
- Explore PPPs.
- Explore designating more centres of excellence and WHO Collaborating Centres.
<table>
<thead>
<tr>
<th>Programme areas</th>
<th>High priorities</th>
<th>Current donors (not including AC funds or regional other)</th>
<th>Funding levels</th>
<th>Two priority areas for funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDs</td>
<td>TB, drug-resistant malaria</td>
<td>GF, UNAIDS, USAID, BMGF</td>
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<tr>
<td>NCDs</td>
<td>NCDs</td>
<td>Bloomberg (tobacco and road safety)</td>
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<td>X</td>
</tr>
<tr>
<td>Health through the life course</td>
<td></td>
<td></td>
<td>Under</td>
<td></td>
</tr>
<tr>
<td>Health systems</td>
<td>Tackling migrant health challenges</td>
<td>EU</td>
<td>OK</td>
<td>X</td>
</tr>
<tr>
<td>Preparedness, surveillance a response</td>
<td></td>
<td>USAID, CDC, Australia</td>
<td>OK</td>
<td></td>
</tr>
</tbody>
</table>

**2014–15 funding forecast compared to that of 2012–13 biennium reduction**

**Funding challenges**

- Thailand is considered to be a middle-income country.
- Government is self-financing so there is no need for external resources.

**Resource mobilization and partnerships possibilities**

- Explore how to leverage Thailand’s role as an exporter of knowledge.
- Research how to identify and network with high-level expertise as needed in the country.
- Reflect and articulate an answer to what is WHO added value in Thailand?
- Explore possible links with MacArthur Foundation to ascertain interest in a programme or hosting an exchange on funding health for migrants.
- Explore possibilities for CSR for health among national companies and investments from MNCs present in Thailand.
## COUNTRY PROGRAMME PROFILE TIMOR LESTE

<table>
<thead>
<tr>
<th>Programme areas</th>
<th>High priorities</th>
<th>Current donors (not including AC funds or regional other)</th>
<th>Funding levels</th>
<th>Two priority areas for funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDs</td>
<td>TB, vaccine preventable diseases</td>
<td>GF, Australia, GAVI</td>
<td>OK</td>
<td></td>
</tr>
<tr>
<td>NCDs</td>
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<td>Under X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Health through the life course</td>
<td>Health related MDGs</td>
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</tr>
<tr>
<td>Health systems</td>
<td>Human resource development</td>
<td>EU, GAVI</td>
<td>Under X</td>
<td></td>
</tr>
<tr>
<td>Preparedness, surveillance and response</td>
<td>Weak systems across</td>
<td></td>
<td>OK</td>
<td></td>
</tr>
</tbody>
</table>

2014–15 funding forecast compared to that of 2012–13 biennium same level.

### Funding challenges

- Timor Leste is considered to be a middle-income country.
- No donors present.

### Resource mobilization and partnerships possibilities

- Explore how to access existing MDTFs.
- Research possibilities for establishing joint programme or MDTF on health in the country.
- Explore possible regional and South–South exchanges.