Executive Summary

The WHO Regional Office for Africa plays a critical role on the continent with respect to the establishment of health policies, technical guidelines, and norms and standards. It provides technical policy advice, contributes to sustainable capacity building, strengthens management capacity, and provides health leadership by coordinating efforts at regional and national levels.

The rapidly escalating and sustained complexity of the challenges on the continent have generated an increased level of demand for the technical expertise and support provided by WHO. Resource mobilization efforts for the country responses as well as the resource requirements for The Regional Office’s planned activities are of crucial importance to effectively respond to the health challenges in the African region.

However, a significant funding shortfall in all the areas of the Regional Office’s work jeopardizes the ongoing support to Member States and threatens to reverse the modest gains already achieved.

This document considers current trends in donor funding and health priorities and assesses internal structures and challenges on the basis of which a strategy has been developed. The strategy consists of seven major approaches that address a variety of challenges impacting effective resource mobilization. The seven approaches are:

1. Improve communication and information flow;
2. Institute processes, systems and tools;
3. Introduce incentives and empowerment;
4. Enhance skills and capacity;
5. Pursue donor interaction;
6. Strengthen interpersonal relations and
7. Produce results and monitor impact.

It is anticipated that the execution of these strategic approaches and activities will generate adequate resources for the Regional Office to carry out all activities planned for 2009 and facilitate resource mobilization efforts through 2013.
### Abbreviations

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tr>
<td>AC</td>
<td>Assessed Contributions</td>
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<tr>
<td>AfDB</td>
<td>African Development Bank</td>
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<td>AFRO</td>
<td>WHO Regional Office for Africa</td>
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<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
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<td>DAC</td>
<td>Development Assistance Committee</td>
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<td>DAH</td>
<td>Development Assistance for Health</td>
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<tr>
<td>DFID</td>
<td>UK Department For International Development</td>
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<td>DG</td>
<td>WHO Director-General</td>
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<td>EC</td>
<td>European Commission</td>
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<tr>
<td>EDCP</td>
<td>EU Development Co-operation Policy</td>
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<td>EU</td>
<td>European Union</td>
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<tr>
<td>FTE</td>
<td>Full Time Equivalent</td>
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<tr>
<td>DPM</td>
<td>Director of Programme Management</td>
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<tr>
<td>GAVI</td>
<td>Global Alliance for Vaccines and Immunization</td>
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<tr>
<td>GFATM</td>
<td>Global Fund to Fight AIDS, Tuberculosis and Malaria</td>
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<td>HQ</td>
<td>WHO Headquarter</td>
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<td>IDA</td>
<td>International Development Assistance</td>
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<td>IFI</td>
<td>International Finance Institution</td>
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<td>IST</td>
<td>Inter-country Support Team</td>
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<td>JICA</td>
<td>Japan International Cooperation Agency</td>
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<tr>
<td>MDG</td>
<td>Millennium Development Goal</td>
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<td>MIP</td>
<td>Meetings of Interested Parties</td>
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<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
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<tr>
<td>ODA</td>
<td>Official Development Assistance</td>
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<tr>
<td>OECD</td>
<td>Organization for Economic Cooperation and Development</td>
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<tr>
<td>PAHO</td>
<td>Pan American Health Organization</td>
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<tr>
<td>PEPFAR</td>
<td>President’s Emergency Plan for AIDS Relief</td>
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<td>PRM</td>
<td>Partnership and Resource Mobilization unit</td>
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<td>PSC</td>
<td>Programme Support Cost</td>
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<tr>
<td>RD</td>
<td>Regional Director</td>
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<td>RM</td>
<td>Resource Mobilization</td>
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<td>RMT</td>
<td>Resource Mobilization Team</td>
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<tr>
<td>R&amp;D</td>
<td>Research and Development</td>
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<tr>
<td>SEARO</td>
<td>WHO Regional Office for South East Asia</td>
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<tr>
<td>SO</td>
<td>Strategic Objective</td>
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<tr>
<td>SOP</td>
<td>Standard Operating Procedure</td>
</tr>
<tr>
<td>TOR</td>
<td>Terms of Reference</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<tr>
<td>VC</td>
<td>Voluntary Contribution</td>
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<tr>
<td>VFHP</td>
<td>Voluntary Fund for Health Promotion</td>
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<tr>
<td>WB</td>
<td>World Bank</td>
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<tr>
<td>WCO</td>
<td>WHO Country Office</td>
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<tr>
<td>WEU</td>
<td>WHO Office at the European Union</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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<tr>
<td>WR</td>
<td>WHO Representative</td>
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I. Introduction

“Planning is bringing the future into the present so that you can do something about it now.”

Alan Lakein

This Resource Mobilization Strategy has been developed with cognizance of the tremendous health challenges that face countries in the African Region, and with acknowledgement of the necessary role that the World Health Organization’s (WHO) Regional Office for Africa plays in assisting its Member States in overcoming them. The strategy aims to mobilize the funds required to support the Regional Office’s activities in fulfilling WHO’s mandate.

The African Region is WHO’s second-largest region in terms of countries served (46). The challenges of the continent are numerous. The continent bears 66% of the global burden of HIV/AIDS and 60% of the global burden of malaria. The prevalence of TB is 492 cases per 100,000 of the population, average maternal mortality ratio is 1,000 per 100,000 live births, and under-five mortality is about 157 per 1,000 live births. Adding low life expectancy at birth to the already high incidence of road accidents, cardiovascular diseases, and anemia to the already significant burdens represented by malaria, TB and HIV/AIDS, the continent carries one of the highest burdens of disease in the world. WHO’s Member States in the African Region are generally challenged with slow economic growth rates and high levels of poverty; more than 39% of the population lives on less than US$1 a day\(^1\). A considerable number of the countries risk not achieving the Millennium Development Goals (MDGs)\(^2\) targets.

The WHO African Region plays a critical role on the continent with respect to the establishment of health policies, technical guidelines, and norms and standards. It provides technical policy advice, contributes to sustainable capacity building, strengthens management capacity, and provides health leadership by coordinating efforts at regional and national levels.

The rapidly escalating and sustained complexity of the challenges on the continent have generated an increased level of demand for the technical expertise and support provided by WHO. Resource mobilization efforts for country responses as well as the resource requirements for the Regional Office’s planned activities are of crucial importance to effectively respond to the health challenges in the African region. However, a significant funding shortfall in all areas of the WHO African Region’s work threatens to jeopardize its ongoing support to Member States and reverse the modest gains already achieved.

Utilizing detailed information about current donors and funding patterns, this document aims to provide a strategy on how the WHO African Region can mobilize resources for activities planned to support its Member States. The document, furthermore, seeks

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to improve processes for funds flow, provide information about distribution of funds and highlight the importance of improving capacity to deliver and absorb funding at country level, paying attention to under-funded health priorities. This document should be read in conjunction with the Partnerships Strategy Document.

2. Situation Analysis

The burden of disease and health challenges in the African region are many and diverse. Some studies estimate that sub-Saharan Africa carries as much as 90% of the global disease burden, with communicable, maternal, prenatal and nutritional disorders being the leading causes of death. Others associate at least 30% of the disease burden with environment-related diseases such as malaria and respiratory infections. Due to the heavy burden of disease and the significant impact poor health and health systems have on economies and development, health sector development and support is high on most development agendas.

This situation analysis consists of two sections. The first section provides an overview of various trends that influence or inform the strategy. The second section presents a summary of the current organization of WHO’s and the African Regional Office’s resource mobilization activities.

2.1 Trends

The analysis of the external environment and trends presented in this section focuses on the in international development aid for health, the major donors in health, and the most significant leanings in giving.

2.1.1 Trends in Development Aid for Health

Development Assistance for Health (DAH) has grown in recent years from US$2.5 billion in 1990 to almost US$13 billion in 2006. This upward trend has been driven by several factors, including (a) donors’ increasing attention to the challenges presented by the MDGs; (b) strong global mobilization since 1998/99 to address the AIDS pandemic in developing countries, especially in Africa; and (c) donors’ expanding interest in research and development (R&D) in relation to new health technologies to address the major diseases prevalent in poor countries.

The increase in DAH has brought about a noticeable increase in overall health spending in developing countries. Between 1990 and 2003, the total health spending in developing countries increased by more than 100%—from US$170 billion in 1990 to US$410 billion in 2003, or from 4.1% to 5.7% of developing-country GDP.

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2 Economic Commission for Africa.
3 OECD Aid Statistics.
4 See Annex A, B, and C for more detailed information.
The Figure below shows the trends in the geographical distribution of development aid and development aid to the health sector from 2001 to 2006. During this 5-year period development aid to health increased more than 100%.

Table 1: Aid to health and by region

<table>
<thead>
<tr>
<th>Year</th>
<th>Africa</th>
<th>Americas</th>
<th>Asia</th>
<th>Oceania</th>
<th>Europe</th>
<th>Health</th>
</tr>
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<tbody>
<tr>
<td>1997</td>
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In 2008, significant increases were reported as global ODA rose by 10% and reached its higher figure ever recorded. However, the current global financial crisis is having a serious impact on donor countries and the full effects and duration of the crisis are still to be seen. The OECD, the World Bank, IMF, the European Commission and many other organizations have launched new calls for increased aid funding and to create new support initiatives. Aid cuts would place a dangerous additional burden on developing countries and perhaps undo some of the progress already made towards meeting the Millennium Development Goals. There will also be a greater need for aid to safeguard the progress in economic development and to counter the impact of the crisis in developing countries.

2.1.2 Major constraints in Health Funding

Despite the significant increase noted in expenditure on health, it would appear that a great deal of the aid has neither been channeled towards government priorities nor applied towards contributing to developing a holistic approach to strengthening health systems. There are important manifestations of the ineffective application of aid for health at the country level, some which are listed below.

Aid often not being aligned with government priorities. Health aid is often earmarked for specific purposes. Only about 20% of all health aid goes to support governments’ overall programmes. In contrast, an estimated 50% of health aid is provided outside the budget. The remaining 30% indirectly funds country priorities through a variety

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7 OECD Aid Statistics - www.oecd.org/dac/stats
10 i.e. general budget or sector support.
of mechanisms, such as implementing agencies and international organizations. As a result, many countries report difficulties in attracting sustained, flexible funding that can be used to support their health systems, i.e. staff, infrastructure, training, management, etc.

Aid being unpredictable, short-term, and volatile. In addition to being heavily earmarked, health aid can often be very short-term and volatile. The volatility in the frequency and timing of the aid that a country receives restricts the ability of ministries of health and finance to make long-term plans—such as employing more doctors or nurses, widening access to HIV/AIDS treatment, or scaling up health service provision—without incurring major risks with respect to the sustainability of financing for these services.

**Aid being poorly harmonized, increasing transaction costs for governments.** The high number of donors present in health sector, the large number of separate health programs, and large volume of resources may carry unpredictable risks and transaction costs unless they are well coordinated, both with each other and with governments. Governments in the African Region are rarely in a position to impose harmonization, coordination and/or alignments. A related issue is that the presence of multiple health partners may inadvertently undermine the governments’ broader efforts in the health sector.

### 2.1.3 Trends in Giving

There are discernable trends in international financing for health, of which the following five points are particularly noteworthy for the African Region.

**Donors favor Africa.** The African Region continues to receive significant donor attention. With the Region being host to some of the countries in the world with the weakest health infrastructure, the WHO Regional Office for Africa is centrally placed for the execution and support of bilateral and regional initiatives.

**Donors earmark their support.** Many donors choose to earmark their contributions to align with their national priorities for development aid and/or facilitate accountability. Donors are decentralizing their support. Analyses of donor funding trends clearly indicate that there is a distinct shift towards decentralization, bypassing global and in most cases also regional structures.

**Donors demand accountability.** The increased level of interaction at country level has also engendered a demand for increased accountability and more onerous requirements on reporting on outcomes.

**Donors demand results.** Donor agencies are increasingly under scrutiny from their own constituencies and have to justify international development strategies with taxpayers, internal pressure groups and civil society organizations. As a result there has been a significant increase in hands-on involvement and an emphasis on results and impact.
2.1.4 Major Contributors to Health Efforts

National governments, notably the Ministries of Health, are naturally among the major contributors to health development efforts. However, beyond the national governments there are other major contributors, including the following:

**Government donors.** The 10 largest government contributors of Official Development Assistance (ODA)\(^{11}\) in order of magnitude are United States (0.20% of GNI), Japan (0.27 % of GNI), France (0.47 % of GNI), United Kingdom (0.49 % of GNI), Germany (0.36 % of GNI), Netherlands (0.81% of GNI), Sweden (0.99 % of GNI), Canada (0.31 % of GNI), Italy (0.24 % of GNI) and Spain (0.29 %).\(^{12}\) Most of the governments on the list have upheld their position as top-ten contributors for the past decade or more—a testimony to the commitment that most of the major governments have to international development. However, only a fraction of them are honoring their G8 commitment of 0.7 % of GDP in foreign aid.\(^{13}\) There are also several new and emerging governments on the donor scene that are expected to play a significant role in the development arena, such as Russia, Korea, Brazil and the new European Union Member States.

**International Finance Institutions (IFI) and National Governments.** Both the former and notably the latter are significant contributors to health initiatives and health sector development. The Abuja Commitment of Heads of State in 2001 included the intent of all countries in the African Region to allocate 15% or more of their national budgets to health. The major international IFIs—the World Bank, the International Monetary Fund and the International Finance Corporation—as well as the African Development Bank are major lenders to governments to finance health projects.

**Foundations.** US foundations represent by far the largest contributors to international public health, with the Bill & Melinda Gates Foundation being the largest benefactor. International giving by all US foundations reached US$3.8 billion in 2005.\(^{14}\) The single largest share of international grants goes towards international development in general (22%) followed by health (12.2%), environment (10.4%), education (10.2%) and the arts (9%). Within the health sector support is mainly provided towards public health, medical research, and disease-prevention programs aimed at stemming the global AIDS crisis and other pandemics.

**Private sector.** The private sector plays a significant and growing role. Collaboration with WHO ranges from consultative processes over research and development to drug donations (to combat river blindness, polio, vitamin A deficiency, etc.) and logistics. A growing number of business coalitions on the continent have focused on HIV/AIDS, TB and malaria, as well as more general wellness programmes.\(^{15,16}\)

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\(^{11}\) www.oecd.org/dac/stats/daclist as at January, 2006


\(^{13}\) www.globalissues.org/TradeRelated/Debt/USAid.asp.


\(^{15}\) The state of business coalitions in Sub-Saharan Africa, Global Business Coalition.

\(^{16}\) Guidelines on working with the private sector to achieve health outcomes, EB 107/20, 2000.
Non-governmental organizations (NGOs) and civil society organizations (CSOs). Both are increasingly playing a prominent role in the design, planning, and execution of health projects. A recently published report concluded that approximately 40% of health care in poor countries was provided by private faith-based organizations (FBOs). Encouraged by initiatives such as the GFATM and the President's Emergency Plan for AIDS Relief (PEPFAR), an increasing number of indigenous organizations are now leading in-country health projects on behalf of international donor agencies.

Academia. The capacity of academic institutions, both in the West as well as in the African Region, to access international funding and implement health projects has resulted in a significant elevation of the roles and influence they exercise in prioritizing health projects and advising host government agencies. Due to the scientific nature of interventions and services, academic institutions represent growing competition for donor funding.

2.2 Institutional Arrangements

The analysis of the institutional environment consists of four sections. The first section provides a snapshot of WHO Headquarters efforts, which underpins the framework and reference for the Regional Office's strategy. The second section presents the current status of the Regional Office’s efforts, the platform on which this strategy is founded. The third, fourth and fifth sections outline the outcomes of an Internal Needs Assessment, SWOT (Strengths, Weaknesses, Opportunities and Threats) analysis, and WHO’s comparative advantage respectively. The last section identifies the current shortfall that this strategy seeks to meet in the short term.

2.2.1 Global level arrangements

WHO is currently moving towards a new strategic direction to address health issues in broader, cross-cutting areas of work that will facilitate collaboration and coordination both across and outside the organization. A six-year Medium-term Strategic Plan (MTSP) was developed within the overall context of the 11th General Programme of Work (GPW) in recognition of the need to adopt a more strategic planning and programming tool. The GPW is arranged in 13 Strategic Objectives (SOs) with each SO sub-divided into Organization-wide Expected Results (OWERs).

Historically, WHO relies on funding from Member States. Contributions are either given as Assessed Contributions (AC) or Voluntary Contributions (VC); more than 72% of WHO’s funding is received via VC. However less than 10% of these funds are un-earmarked, which has led WHO to take steps to encourage its main Partners to provide more un-earmarked funding for the MTSP. WHO has framework agreements with 16 of the major donor agencies, 11 agreements with agencies and foundations and 16 agreements with other UN Agencies and International Governmental agencies.

17 Faith in Action; Examining the role of faith-based organizations in addressing HIV/AIDS, Catholic Medical Mission Board and Global Health Council, 2005
18 FY05 Annual Program Results Partner Count (All Countries), PEPFAR, 2006
19 In comparison, the Strategic Plan for 2006-2007 had 36 Areas of Work.
20 WHO’s processing of voluntary contributions is guided by The Voluntary Fund for Health Promotion Standard Financial Processing Procedures SFP8/VFHP Rev. 5.
21 The majority of VC contributions derive from the governments of Canada, Netherlands, Norway, Sweden, the UK and USA.
23 This includes six framework agreements with directorates or departments within the EC.
24 This includes African Development Bank, Inter-American Development Bank, Organization for Economic Cooperation and Development and the World Bank Group.
WHO’s overall resource mobilization efforts are guided by the Resource Mobilization framework finalized in December 2005.25 WHO Headquarters recognizes the importance of positioning its fundraising efforts centrally in the changing global health architecture and prioritizes resource mobilization efforts to the MTSP. The major objective is to ensure full financing of the MTSP, with a larger proportion of funds being either totally un-earmarked or very broadly earmarked to the level of Strategic Objective (SO).26

WHO Headquarters remains largely responsible for mobilizing resources for the Regional Office for Africa, as well as for other regional offices. Each Cluster in Headquarters has at least one, and in most cases several individuals dedicated to resource mobilization. The Planning, Resource Coordination and Performance Monitoring Unit (PRP) coordinates WHO’s efforts and facilitates donor relationships with governments and development agencies. Each PRP team member serves as desk officer for major or emerging donors to WHO.

### 2.2.2 WHO Regional Office for Africa Resource Mobilization Efforts

Resource Mobilization efforts at WHO African Region are guided by the global framework (referred to above), as well as its five strategic orientations.27 (see box 1).

**Improving internal capacity.** Regional resource mobilization efforts are largely initiated by divisions or country offices with support from the Partnership and Resource Mobilization Unit (PRM), which has two primary objectives: (1) Advocate for and promote effective collaboration and partnerships between WHO and partners, and coordinate the implementation, monitoring and evaluation of programmes and activities developed in collaboration with partners in the African Region; and (2) Provide support to divisions and country offices, including Member States, upon request, for resource mobilization and management of external relations, partnership and mobilized resources.28 The Regional Office has also put in place three regional Inter-country Support Teams (IST) to improve the quality and cost-effectiveness of support, response times, cross-fertilization, collaboration, engagement at the sub-regional level, implementation, and success rates for resource mobilization. The IST teams are based in Ouagadougou, Libreville and Harare. Significant emphasis is placed on training and capacity building, e.g. to improve presentation and negotiation skills. Most recently, the PRM concluded the first of a series of trainings on resource mobilization issues for country and sub-regional staff to help build capacity at regional and country office levels and provide information, tools and mechanisms to facilitate and support national resource mobilization efforts.

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25 Developed with input from more than 200 self-nominated staff with the objective to secure extra-budgetary resources and the desire to strengthen resource mobilization efforts across the organization.
28 Terms of Reference (TOR) of the Partnership and Resource Mobilization Unit (PRM).
**Organizing donor meetings.** Staff members of the Regional Office/PRM have played an important role in facilitating and organizing meetings with donors. One such example was the visit to the AfDB Headquarters in Tunis from 10–11 April 2006 to discuss funding of neglected tropical diseases (lymphatic filariasis, schistosomiasis and soil transmitted helminth infections and dracunculiasis), inspired by a similar coordinated effort by SEARO.

### 2.2.3 Internal Needs Assessment

In recognition of the importance of taking country office needs into consideration in the design of this strategy, a survey was designed and administered electronically to all 46 country offices in the region. Forty-one responses were collected. The respondents represented all staff categories as following: WR (29%), programme managers (34%), technical Staff (24%) and IST staff (17%). The remaining 4% represented other staff categories (not specified).

The major findings were that:

- 30% did not know if their country programme had a budget shortfall
- 33% estimated that they had a shortfall of between US$1–10 million
- More than 90% were of the opinion that it was the responsibility of the WR solely to (a) identify funding opportunities, (b) pursue funding opportunities, (c) meet and negotiate with funders and (d) promote the Regional Office with external partners
- 53% stated that they did not have or were unsure about whether they had the skill set or capacity needed for resource mobilization.

The respondents provided the following suggestions on how to enhance the Regional Office’s ability to mobilize resources:

- Delegate RMB responsibility and fund administration to country level.
- Develop capacity at country level.
- Work to consolidate WHO’s leadership in health.
- Re-assess the level of Programme Support Costs.
- Coordinate efforts with Headquarters.
- Become more flexible in working with the private sector.
- Simplify general and operating procedures.
- Develop comprehensive resource mobilization strategies.
- Introduce more transparency in the allocation of funding.
- Introduce incentives for resource mobilization, and punishment for mismanaging resources.
- Better share information and best practices.
- Introduce marketing and communication strategies.
- Focus on adding value to other efforts carried out.
- Improve reporting abilities.

A more complete summary of the survey results is presented in Annex D.
2.2.4 SWOT Analysis

The results of a SWOT analysis conducted on the ability of the WHO Regional Office for Africa to mobilize resources are shown in the table below.

<table>
<thead>
<tr>
<th>STRENGTHS</th>
<th>WEAKNESSES</th>
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<tbody>
<tr>
<td>• Sub-Saharan's lead organization in health.</td>
<td>• Inadequate absorptive capacity in Country Offices.</td>
</tr>
<tr>
<td>• Prominent normative and regulatory role.</td>
<td>• Inefficiencies in receiving, tracking and monitoring funding.</td>
</tr>
<tr>
<td>• Presence in all Member States.</td>
<td>• Few incentives for staff to engage in RMB activities.</td>
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<tr>
<td></td>
<td>• Inadequate knowledge, skills and/or experience.</td>
</tr>
<tr>
<td></td>
<td>• Inequitable distribution of funds/PSC.</td>
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<td></td>
<td>• Lack of coordinated efforts between HQ, Regional and Country levels.</td>
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<tr>
<td></td>
<td>• Proposals developed at HQ level may not reflect the Regional Office’s priorities.</td>
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<thead>
<tr>
<th>OPPORTUNITIES</th>
<th>THREATS</th>
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<tr>
<td>• Aid for the health sector is increasing.</td>
<td>• Significant and increasing competition from other organizations in health.</td>
</tr>
<tr>
<td>• New emerging donors and wealthy foundations.</td>
<td>• Global financial crisis.</td>
</tr>
<tr>
<td>• Range of partners at all levels increasing.</td>
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<tr>
<td>• Strong platform for support to health priorities in the MDGs and the Paris Declaration.</td>
<td></td>
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<tr>
<td>• Major new funding initiatives: GAVI, GAIN, GFATM, PEPFAR, PMI.</td>
<td></td>
</tr>
<tr>
<td>• Increase in harmonization efforts.</td>
<td></td>
</tr>
</tbody>
</table>

2.2.5 Comparative Advantage

WHO is in a unique position, due to the leadership mandate its Members States in the field of health have accorded it.

WHO’s single most important competitive advantage is that occupies a niche in the marketplace that no other organization can currently claim. It is this strategic leadership advantage on which this strategy is built and on the basis of which WHO can continue to add value both through assisting countries manage the influx of new or earmarked funding as well as by assisting them in determining health policies and setting priorities.

2.2.6 Funding Shortfall

The current biennium budget for 2008–2009 estimates that there is a need for a minimum of US$478 million for the Regional Office, ISTs activities and human resources, of which the bulk (US$405 million) is expected to be generated as extra budgetary funding.

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20 Based on interviews with staff at Headquarters, regional and country levels.
The graph below provides information on the trends in the sources of financing of the Regional Office’s programme budget in recent years.

It illustrates that the organization relies increasingly on voluntary contributions to fund its activities.

Table 2:
Sources of finance for the WHO Regional Office for Africa Programme Budget, 2000–2009

Table 3:
Balance between planned and received voluntary contributions (USD), 2000–2007

This graph illustrates the balance between the voluntary contributions planned in the Programme-budget and the funds actually mobilized and received by each division at the end of each biennium.
The two graphs above clearly highlight the importance of mobilizing resources from voluntary contributors in order for the Regional Office to carry out its activities according to its mandate. It is equally important to highlight that the majority of planned activities currently remain largely under-funded.

3. Challenges

A number of challenges need to be overcome for the Regional Office to be successful in its resource mobilization efforts. These appear to cluster around seven categories.

1. Lack of information. It appears that not enough strategic and relevant information related to resource mobilization flows within and beyond the Regional Office. A prime example was generated by the Internal Needs Assessment survey, where 30% of the individuals responding did not know the shortfall in their country office budgets. Information relating to definitions, donor profiles, processes, application of PSC, funding opportunities, predictability of funding etc. needs to be readily available or easy to access.

It is equally important to improve internal communication at the Regional Office level, from the Regional Office to and from countries, between countries, and between the Regional Office and Headquarters and other regional entities. Preliminary discussions between the Regional Office and Headquarters early in proposal development process are strongly encouraged.

2. Lack of processes and standard operating procedures. It is imperative that the Regional Office standardizes processes and operation procedures with respect to the mobilization of resources. The organization requires a solid complement of basic processes that will facilitate rather than hamper initiative and enhance efforts.

3. Lack of incentives and empowerment. Staff members require incentives to identify opportunities, design projects and articulate activities to donor audiences. They need to do so in a conducive environment that encourages both individual and team efforts.

4. Insufficient skills or capacity. Individuals need relevant skills and capacity to capture and optimize opportunities as they are presented to them. However, training is not in itself an objective. It needs to be accompanied by support for applying newly acquired skills and capacity at the country level.

5. Lack of donor and partner interaction opportunities. Mobilizing resources is intimately linked with two factors: (1) knowing about an opportunity that exists, and (2) getting the donor's attention. The latter requires in most cases getting in front of the donor. Annexes F and G present examples of donor opportunities as well as resources for “donor intelligence”.

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30 See page section 2.2.3 above.
6. **Little emphasis on existing and interpersonal relations.** The value of existing relations and networks cannot be overemphasized. Studies have shown that a major motivation in the decision to commit funding is the relationship between the donor and the recipient. Efforts should be undertaken not only to build new relationships, but to nurture existing ones.

7. **Emphasis on producing results and monitoring impact.** Donors are placing increasing importance on implementation, delivery, monitoring and evaluation of programmes, as well as documentation of impact. The Regional Office should in its proposals, reports and through inter-personal communication highlight the mechanisms and systems it has in place to ensure accountability, transparency and cost-effectiveness.

4. **Objective**

Competition for donor funding for health has increased significantly, and the WHO African Region has to be prepared to position itself prominently, not only in comparison to its peer agencies, but also increasingly, to highlight its comparative advantages and complementary offerings vis-à-vis academia, research oriented private institutions, fund management institutions and the civil society, all important partner organizations.

The overall objective with this strategy document is two-fold, namely:

To mobilize adequate resources for the WHO African Region to carry out all the activities planned, and to put in place an enabling environment for resource mobilization efforts through 2013.

5. **Guiding Principles**

The strategy is predicated and has been developed on the following set of guiding principles:

**Embracing One WHO.** The recognition that WHO needs one corporate approach in its interaction and relations with its donors and partners. Embracing one WHO ensures that donors and partners get a consistent message regardless of the source within WHO.

**Meeting country needs.** Governing the Regional Office’s interaction with donors and partners is the inviolable principle that the Regional Office maintains its core mandate and role—supporting its Member States.

**Creating an enabling environment for fundraising.** An enabling environment includes adequate support and other factors that directly or indirectly influence an individual’s or the organization’s ability to identify, mobilize, track, spend, monitor and report back on funding received. All these activities are to be undertaken within the parameters provided by the World Health Assembly (WHA) and Executive Board (EB), the Regional Committee (RC) and other Regional Managerial Organs.

31 These includes organizational structures; human resources; effective operational and managerial systems, tools, guidelines and practices.
Building the capacity of internal human resources first. A noticeable and sustainable increase in the current levels of funding can only be achieved by building the capacity within the WHO African Region at both the regional and country levels, and strengthening the skills needed to generate additional funding.

Results-based programming and implementation. The significant increase in the number of players in the international public health arena has resulted in high competition for resources. To remain relevant in this increasingly competitive landscape, it is imperative that the Regional Office delivers high quality services and assistance in a timely and appropriate manner. It is equally important to deliver on promises made and to be accountable for results and impact through rigorous monitoring and evaluation of efforts.

6. Strategic Approaches

The strategy is intended to be a practical document. During the preparation and consultation process, there were several challenges that were recurrently identified as major impediments to resource mobilization efforts. Addressing those challenges would greatly improve the chances of the WHO African Region mobilizing the resources required to achieve its objectives.

The approach to resource mobilization in the WHO African Region is based on causal relations. By addressing or removing challenges to resource mobilization, dramatic impact could occur, which, combined with some essential enablers, could result in a significant increase in funding.

The following sections present the objectives with the proposed set of activities that will address the top seven challenges identified in the section above.

6.1 Improve Communication and Information Flow

Develop a basic information package. There appears to be some confusion about terminologies, definitions and understandings, notably when it comes to definitions of a donor, a sponsor, a funding shortfall, a budgeting gap and PSC issues. It is recommended that PRM, with input from other colleagues, develop a basic information package to help address some of the misunderstandings, to improve the management of voluntary contributions.

Share existing information. It seems like a worthwhile exercise would be to compile all existing information related to resource mobilization and strategic planning, and disseminate it widely. Such information should include organizational charts, focal points for donors at Headquarters, contact details for resource mobilization personnel, information about the Regional Office’s budget shortfalls, priorities and current donor profiles. During this strategic planning process the PRM unit has collected a number of documents from other parts of the organizations; these could serve a starting point, or be directly applied to the work of the Regional Office.

Proactively solicit information. It is recommended that a biannual working session is organized between PRM staff members and representatives of the various units
at the Regional Office, with the purpose of determining the exact divisional and programmatic needs and discussing concrete opportunities for mobilizing resources and/or strategies for accessing funding.

**Enhance the use of technology for information sharing.** The existing Intranet is a valuable platform for posting donor profiles, providing guidance on proposal and report writing, providing information about application of PSC’s, etc. Because some countries do not have access to the Intranet, other technologies for information sharing, such as SharePoint software, should be explored as an alternative.

**Establish a Regional Office Resource Mobilization and Partnership team.** For the purposes of facilitating the development of this strategy each division was asked to designate a resource mobilization and partnership focal point. It is strongly recommended that the team established through this nomination be formalized and its Terms of Reference be developed. The team should meet frequently, and one of its major objectives should be information dissemination and sharing. It is recommended that the focal points for resource mobilization and partnerships also assume the role of focal points for communication within their units.

**Strengthen communication linkages at all levels.** Headquarters colleagues need to be better informed about the work and activities in the Region, and should be encouraged to consult with the Regional Office and engage in joint planning processes. Increased communication will allow colleagues at Headquarters to better represent the needs and priorities of the Regional Office. A communication loop should be established that will allow countries, as well as the Regional Office, to convey important information to communication focal points at Headquarters and beyond. The recent DPM meeting clearly identified the need for consistent messages from WHO to donors at country, regional and Headquarters levels, and emphasized the need for consistency at all levels.\(^{32}\)

**Strengthen communication with external audiences.** It is recommended that a comprehensive package of information is compiled and adapted to donor audiences. It is proposed that this work is carried out in close collaboration with the public information and communication programme (INF) at the Regional Office and Headquarters levels.

**Increased use of the Regional Office’s website.** The Regional Office’s website is a premier vehicle for communicating to external audiences, including potential donors. Certain parts of the website could cater to the specific information needs of the various donor audiences, provide services and tools that would facilitate donor decision-making, and include contact details for regional spokespeople, who would be properly trained and briefed to communicate effectively with external audiences. It is recommended that more rigor is applied to implementing the existing standard operating procedure (SOP) for updating, posting and renewing information on the website.

**Include resource mobilization updates in all all-staff meetings.** The Regional Office already holds regular all-staff meetings, which could serve to further enhance

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information sharing and open communication on resource mobilization. The staff meetings should also be used to underscore the importance of resource mobilization and create a culture of shared responsibility and pride in mobilizing the funds needed, on the basis of good work and strong capabilities.

**Develop an Advocacy and Communication Strategy.** It is recommended that a formal advocacy and communication strategy be developed by a small working group of experts from within and outside the region. The strategy could potentially be developed in the RMT forum with input from the ISTs and country offices.

### 6.2 Institute processes, networks, systems and tools

**Clarify roles and responsibilities.** It is first and foremost essential to clearly articulate and describe the role and responsibilities for resource mobilization at various levels—the Regional Office level, the IST office level, and the country-office level.

**Establish Task Force on facilitation of funds flow.** A very large number of factors were cited as obstructing resource mobilization efforts. Issues ranged from thresholds for signatory powers of WCO’s, through to level and allocation of PSC, and unreasonable delays in clearing of agreements and contracts. It is strongly encouraged that a task force is formed to immediately seek to come up with appropriate solutions to these and other challenges identified.

**Further standardize donor agreements.** Following the new delegation of authority, directors, IST’s coordinators and WRs are authorized to sign donor agreements of up to US$500,000. This delegation only applies when standard donor agreements are used. The Regional Office and Headquarters already have a set of standard donor clauses in agreements. However, it is recommended that these standards agreements are made more widely available, and with proper instructions, so that WHO may advocate for their use with donors. It is also recommended that more and better-tailored agreement standards to cover different arrangements between WHO and governments, NGOs and other non-commercial enterprises are developed.

**Simplify notification procedure.** In the past, many problems occurred in the tracking and monitoring of funding, and there were several instances where recipients were not aware of commitments and/or obligations. A new management system (GSM) has been launched in 2008, which should facilitate the management of voluntary contributions with online notifications. However, end-users of the GSM will need to be trained and be able to get assistance to understand the new procedure and requirements.

**Develop resource mobilization manual.** There is already a lot of information available related to standard procedures and best practices from Headquarter and regional levels that can be compiled, used directly or amended to serve the needs at the Regional Office level. A comprehensive resource mobilization manual should be developed, including standard operating procedures and processes. The manual could ideally be made available as a CD-ROM, after the one produced by colleagues in SEARO or on-line, as is the case in UNDP.

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33 On July 1st for Headquarters and November 1st for the Regional Office.
6.3 Introduce Incentives and Empowerment

Incorporate resource mobilization targets in appraisals. Another recommendation is the introduction of performance objectives related to mobilization of resources in the terms of reference of all WRs, senior management staff and a substantial number of other key positions. These individuals’ appraisals should reflect their ability to mobilize resources and highlight the personal and individual responsibilities for creating an enabling environment within their divisions and units through enforcing high quality programming, timely and appropriate donor reporting and proactive engagements in mobilizing resources.

Introduce incentive-based rewards. The Regional Office should consider providing incentives for all its staff to take responsibility for and help in mobilizing resources. It is proposed that one or a combination of the following economic incentives immediately be put in place:

- **Challenge rewards.** Favorably consider allocating “top-up” funding for support raised from external donors for a given project.
- **Innovation rewards.** Entertain and fund innovative proposals from staff throughout the region through a competitive process.
- **Performance rewards.** Reward projects, units or divisions with extra allocation of funding on the basis of outstanding performance.

**E-news on grants and awards.** It is recommended that a monthly e-newsletter that lists all significant grants, awards or funding commitments secured, giving recognition to the staff or divisions responsible for securing the funding, is developed and circulated. In the case of major or significant donor contributions to the Regional Office’s work, the Regional Director could circulate a separate e-mail.

6.4 Enhance Skills and Capacity

**Build the resource mobilization case internally.** First and foremost it is important to educate staff about the premise for mobilizing resources for the Regional Office. Getting key individuals to understand and fully embrace the concept and the roles and responsibilities associated is a critical first step.

**Secure Senior Management buy-in.** Top-level management buy-in is required to facilitate and support the execution of this strategy. Senior Management includes not only that of the Regional Office, but also country office, sub-regional and Headquarters staff. Sensitization is needed to determine why and how the Regional Office anticipates to mobilize resources, and ideally if and how efforts can be supported and expanded across departments and in the field. Finally, it is essential that the Regional Office’s senior management understands how funding will be allocated and which priorities and guidelines will be pursued or followed as unspecified funding becomes available.

**Build regional and sub-regional and country capacity.** It is important that staff members are equipped with essential skills that will enable them to be successful. Initial skill-building sessions should focus on building the individuals’ ability to identify and assess opportunities, to assess and determine the interests of external audiences.
through conversation, and to make conversation with the objective of sourcing information or soliciting advice. Proper skill-building sessions with emphasis on improving negotiation skills, proposal writing skills and presentation skills should be organized through trainings, workshops and working sessions using a variety of media, including the Internet and video-conferencing.

6.5 Pursue Donor Interaction

Encourage interpersonal relationships. The need for strong interpersonal relationships should not be underestimated. It is critical that opportunities for interacting with and ideally meeting with donor audiences throughout the year are tracked and seized. Senior management and technical staff from the Regional Office attend meetings throughout the year, on the continent and abroad. Consideration should be given to tracking fund solicitation meetings or courtesy visits to potential or new donors. A system will be put in place to track these interactions and follow up on any leads they generate.

Establish a RM taskforce for the Regional Office. A resource mobilization taskforce for the Regional Office comprised of representatives of the donor community, the international development community, academia, civil society and the private sector should be established. The taskforce will help to direct resource mobilization efforts and serve as ambassadors for the Regional Office and the countries it represents. The taskforce should ideally meet a couple of times a year with a set agenda. Its meetings could be convened in conjunction with major stakeholder gatherings such as the World Health Assembly or Regional Committee meetings.

Identify opportunities. It is important to proactively identify funding opportunities, as soon as or ideally before they become public knowledge. There are many sources and resources available summarizing tender opportunities or cataloging donors with a particular interest or focus. Constantly scanning the horizon, networking and soliciting intelligence is the responsibility not only of the PRM but also of every staff member at the Regional Office, regardless of position. It is important to take note of individual donor countries’ financial year; often there are opportunities for accessing unspent year-end funds a couple of months before they expire.

Donor intelligence gathering. It is recommended that donor intelligence be collected and made widely available to facilitate and encourage interaction. This work will be guided by and jointly executed with the PRM. Intelligence should include donor profiles (policies, preferences, geographical focus), but also include a mapping of donor hubs on the continent and pooling of like-minded donors around thematic areas of attention. The Diaspora represents a growing and increasing donor potential and such information should be included in the donor intelligence gathering process.

Capitalize on international meetings and events. It is recommended that a calendar be developed to map all major donor and/or partner meetings and events on the continent and beyond. The maintenance and distribution of the calendar could be the responsibility of the PRM. With proper mapping and preparation, it is possible to
turn a variety of events into communication, advocacy and/or resource mobilization platforms. Such opportunities include the annual meetings of the Regional Committee, World Economic Forum, Bellagio meetings, African governments’ finance ministers meetings, and the G8 Summit.

**Organize an annual donor forum.** For many years WHO Headquarters convened the so-called Meetings of Interested Parties (MIP), which provided donors an opportunity to get technical updates on topical areas, network with WHO staff and their peers, and consider future funding decisions. With the increasing presence of donors on the African continent as well as the increased funding for the continent, the time seems ripe for the Regional Office to introduce a similar annual meeting concept.

**Organize donor round tables.** It appears that donors have a particular interest in focused and targeted efforts. The Regional Office is already convening a variety of donor and partner roundtables. It is suggested that these opportunities for engaging funding organizations be organized more frequently, according to donor preferences. Thematic or geographic donor roundtables would ideally be co-hosted with in-country donor representatives. Consideration should be given to organizing roundtables of same-language countries, including for emerging and new donor audiences such as Portugal and Brazil.

**Organize annual meetings in donor capitals.** Organize meetings in capital cities of development donor agencies and developing country governments. For the latter group, separate meetings with the Ministry of Finance or Department of Treasury are recommended. Visiting a donor agency at its own premises allows ample opportunity to meet or convene meetings with a larger number of decision makers, organize briefings for the entire agency, and gather intelligence and information on-site that would otherwise not be readily available. The meetings could ideally be combined with already scheduled travel, meetings, workshops and/or events, or be planned to include other donor audiences in the locality, e.g. foundations, private individuals, academic institutions or non-profit organizations. It is essential that such meetings are coordinated and organized with the support of colleagues at Headquarters.

**Capitalize on Regional Committee meetings.** These meetings appear to be an ideal forum for fundraising and advocacy activities. Outside the formal agenda set for the meetings, there are ample opportunities for side meetings with donor audiences.

**Optimize the strategic position of ISTs.** Inter-country Support Teams (ISTs) represent unique opportunities for identifying opportunities at sub-regional and country levels, and for facilitating face-to-face meetings with donors.

**Embark on non-DAC country and emerging markets outreach.** It is expected that aid from non-DAC OECD countries and emerging economies in Europe such as the Czech Republic, Hungary, Poland, Slovakia, Iceland, Turkey, South Korea and Mexico, will increase significantly over the coming 5- to 10-year period (see Annex B). This presents an unprecedented opportunity to sensitize these donors about supporting cost-effective health interventions, advocate for their support, and assist them in their transition from emerging market economy to international development donor. Special emphasis should be placed on reaching out to government officials in these countries, ideally through WHO Representatives, and ideally in their own languages.
6.6 Strengthen Interpersonal Relations

**Break down internal barriers.** Establishing cross-divisional working groups for, e.g., joint proposal development or reporting will facilitate not only a mutual understanding of other parts of the organization's work, but also the later division of funds raised. Working groups around the achievement of the MDGs and/or other thematic approaches are encouraged. Staff loans, in which a staff member supports another division's work for a period of time, are another strategy; such an arrangement is already practiced with great success between the Division of AIDS/HIV, Tuberculosis & Malaria (ATM) and PRM.

6.7 Produce Results and Monitor Impact

**Improve donor reporting systems.** Donors are under increasing pressure to justify programmes and projects with their stakeholders and constituencies. The Regional Office should develop and deliver donor reports that assist donor agencies in justifying investments in international public health in general, and the Regional Office in particular, by providing compelling results and evidence from the investments.

**Provide additional implementation support.** It is acknowledged that there often are complexities and challenges associated with project start up and/or implementation. It is recommended that an initial “kick off” meeting be organized prior to the commencement of any new initiative. The purpose of the meeting would be to bring representatives of relevant units and divisions together to make sure everyone understands the project and the type of support that colleagues may be able to provide.

7. Critical Success factors

Several critical success factors need to be recognized prior to commencing the execution of this strategy. The three key ones are:

- Country plans developed and resource mobilization targets identified for each country and division to focus efforts, make tailored pitches and strategic decisions.
- Roles and responsibility of the WR, programme, technical and IST staff vis-à-vis resource mobilization and representation defined.
- Time, money and resources dedicated for resource mobilization staff and other key individuals to organize, attend, solicit and participate in face-to-face meetings with donors and funding agencies on the continent and abroad.

8. Budget

The execution of this plan requires the commitment of human and financial resources. However, given the current financial position of the Regional Office, it is not an option to simply recruit additional staff.
In addition to the PRM staff capacity and expertise, it is proposed that the requisite human resource commitments be met the following manner:

- Following the trend of decentralization of donor support, strategic donor hubs have appeared in West, East and Southern Africa which concentrate representations of all the key development partners. At least one Regional Office staff member should be positioned in each hub to strengthen efforts in partnership and resource mobilization, organize and participate in events, gather information, identify opportunities, advocate and communicate with main partners.

- The Regional Office needs to explore secondments, staff-loan arrangements or Junior Professional Officers (JPOs) to increase the number of staff engaged in raising and managing voluntary contributions in key areas.

- Each division allocates 0.15 FTE towards regional business development and partnership efforts.

- Each country office allocates 0.10 FTE towards regional business development and partnership efforts.

The budget required as detailed in the table below:

<table>
<thead>
<tr>
<th>Strategic Approaches</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
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</thead>
<tbody>
<tr>
<td>6.1: Improve information flow and internal/external comm.</td>
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<tr>
<td>Develop and disseminate Information Package (incl. revisions)</td>
<td>106 000</td>
<td>39 400</td>
<td>28 100</td>
<td>15 890</td>
<td>30 410</td>
</tr>
<tr>
<td>Improve and update website content</td>
<td>10 000</td>
<td>7 000</td>
<td>5 000</td>
<td></td>
<td></td>
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<tr>
<td><strong>SUB-TOTAL</strong></td>
<td><strong>116 000</strong></td>
<td><strong>46 400</strong></td>
<td><strong>33 100</strong></td>
<td><strong>15 890</strong></td>
<td><strong>30 410</strong></td>
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</table>

| 6.2: Institute processes, systems and tools                |          |          |          |          |          |
| Develop resource mobilization manual and CD-ROM resource   | 45 113   | 25 611   | 41 424   | 18 172   | 40 067   |

| 6.3: Introduce incentives and empowerment                  |          |          |          |          |          |
| Develop and institutionalize incentive awards              | 25 000   | 30 000   | 30 000   | 30 000   | 25 000   |

| 6.4: Enhance skills and capacity                           |          |          |          |          |          |
| Trainings and workshops                                    | 280 803  | 193 283  | 274 392  | 207 971  | 293 676  |

| 6.5+6: Pursue donor interaction and strengthen interpersonal relations |          |          |          |          |          |
| Missions to visit donors                                   | 27 500   | 29 500   | 29 500   | 32 500   | 32 500   |
| Missions to support countries/IST for resource mobilization | 38 000   | 28 000   | 10 000   | 5 000    | 5 000    |
| Annual donor meeting                                       | 205 000  | 146 000  | 205 000  | 186 000  | 195 000  |
| **SUB-TOTAL**                                              | **270 500** | **203 500** | **244 500** | **223 500** | **232 500** |

| 6.7: Produce results and monitor impact                    |          |          |          |          |          |
| Monitoring and Evaluation (incl. reporting)                 | 39 000   | 20 000   | 21 000   | 20 000   | 21 000   |
| Any other related activity                                 |          |          |          |          |          |
| **TOTAL**                                                  | **776 416** | **518 794** | **644 416** | **515 533** | **642 653** |

*The budget, in US$, is illustrative only and does not consider inflation or cost increase.*
9. Monitoring and Evaluation

Monitoring and evaluation of the impact of this resource mobilization strategy is of paramount importance. The single most important measure of success will be the Regional Office’s ability to mobilize adequate resources to carry out all its planned activities in 2008-2009 and beyond, through to 2013.

The PRM unit already evaluates and reports regularly on the implementation of strategies to the Regional Office’s executive management. PRM will refine its evaluation tool to include monitoring of progress in the implementation of this strategy. Additional milestone and indicators will be introduced.

The table below provides a summary of milestones and indicators of progress towards the resource mobilization goal.

<table>
<thead>
<tr>
<th>Milestone (M) or Indicator (I)</th>
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<tbody>
<tr>
<td>Overcoming the information challenge</td>
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<tr>
<td>Overcoming the communication challenge</td>
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<tr>
<td>Overcoming the lack of processes challenge</td>
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<tr>
<td>Overcoming the challenge of providing incentives and empowerment</td>
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<tr>
<td>Overcoming the challenges related to capacity building and skills building</td>
</tr>
<tr>
<td>Overcoming the challenge of improving interaction with donors and partners</td>
</tr>
<tr>
<td>Overcoming the challenges posed by human nature</td>
</tr>
<tr>
<td>Produce results and monitor impact</td>
</tr>
</tbody>
</table>
Annex A - Trends in Official Development Assistance

General ODA from DAC Donors
With the end of exceptionally high debt relief, total official development assistance (ODA) from members of the Development Assistance Committee (DAC) fell by 8.4% in real terms in 2007 to US$103.7 billion, according to provisional data reported by members. This represents a drop from 0.31% of members’ combined gross national income in 2006 to 0.28% in 2007.

The fall was expected. ODA had been exceptionally high in 2005 (US$107.1 billion) and 2006 (US$104.4 billion), due to large Paris Club debt relief operations for Iraq and Nigeria. Debt relief grants diminished in 2007 to US$8.7 billion as the Paris Club operations tapered off.

Excluding debt relief grants, DAC members’ net ODA rose by 2.4%.

Bilateral aid to sub-Saharan Africa, excluding debt relief, increased by 10% in real terms. This represents an improvement on the recent rate of increase. But it is clear that donors still face a real challenge to meet the Gleneagles G-8 summit projection to double aid to Africa by 2010.35

OECD/DAC country members are implementing significant increases in their bilateral programmes. Bilateral aid is usually between 60-80% of total ODA (see annexed graph). Most donors now have grant-only programmes, with Japan being the primary exception.

Bilateral Aid: Percentage of total ODA for 2004
(OECD / DAC countries)

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35 OECD/DAC website. Information released April, 2008.
Sub-Saharan Africa gets nearly a third of all aid, and aid to Africa is set to double by 2010 (see ODA for Africa).

The top ten recipients vary from year to year. Large countries feature regularly, but emergency and reconstruction in Iraq now put it on top, with debt relief to DRC putting it second. Ghana was the only other African country in the top ten for 2003-2004.

ODA is the main source of external financing for low-income countries, nearly double their export earnings (except for oil).

General budget support (approximately 5% of ODA) – a new aid instrument in the past ten years – has become a significant form of resource transfer in a few aid-dependent countries and a focus for coordinated donor support of local priorities.

ODA provided by governments to and through NGOs has been on the rise, reaching nearly US$5 billion in 2004.

DAC members allocate approximately 30% of their total ODA to multilateral organizations (includes the banks). Donors are putting a larger share of their country funding through multilateral channels for specific projects or programmes.

Over the last 15 years, education and health have received a steady 15% of all aid (see ODA for health). In 2003-2004, 53% of aid went to education, health, government infrastructure and production. Debt relief accounted for 17% of aid.

The Future

Aid to the world's poorest countries is expected to reach about US$130 billion by 2010, an increase of US$50 billion from 2004 and twice the amount spent in 2000. But the aid 'boom' in 2005-06 is primarily due to debt relief for Iraq and Nigeria and emergency aid to the Indian Ocean Tsunami hit countries.

A number of donors have announced clear deadlines for reaching the target ODA budgets of 0.7% of GNI. Denmark, Norway, Luxembourg, the Netherlands and Sweden already meet that target (see table).

The 2005 OECD Report warns that as of 2007, when these large debt relief operations are complete, donors will have to increase other forms of aid by around 10% per year, double the rate of recent annual increases, to reach ODA targets.
**ODA for health**
In June 2005, the OECD Development Center released a study on aid allocations for health. It reached three conclusions:

a. While the share of health in total ODA has increased over the last decade, it is HIV/AIDS that accounts for this increase. If HIV/AIDS is excluded from the calculation, health has actually declined, with only infectious disease control increasing its share.

b. Resource allocations towards HIV/AIDS and reproductive health are much higher than those that would have been expected had the “burden of disease criterion” been used to set priorities, i.e. pro-poor health interventions (basic health infrastructure or nutrition) have actually seen their share of health assistance drop.

c. There is no clear relationship between the health-care priorities of poor-countries, as expressed in PSRPs, and health-related ODA. This demonstrates that improving the alignment between health assistance and recipient-country priorities remains an important challenge.

d. According to OECD/DAC statistics, bilateral ODA for health in 2006, out of all sectors, averaged 4.7% from DAC donors, ranging between 15.9% (Ireland) and 1.7% (Austria).

Source: OECD/DAC

While there has been an increase in aid between 2000-2004, only 25% (or $6.9 billion) of the US$27 billion were available for poverty reduction or Millennium Development Goal programs after deducting new aid resources due to aid to Afghanistan and Iraq, debt cancellation, and support for refugees in donor countries.

**ODA for Africa**
Total DAC aid to the region fell substantially during the 1990s, as the G7 donors drastically reduced their aid budgets, and only began to recover in 2000. In 2004, only 21% of DAC bilateral-country aid (excluding debt relief and multilateral assistance) was directed to Sub-Saharan Africa, well below the 24% reached in 1990, and only somewhat above the 18% low in 1999. From 1999-2004, DAC donors have provided US$20.4 billion in new country-directed aid to Africa, with debt cancellation accounting for almost half of this amount.
Since 2000, most DAC donors and many of the non-DAC donors (e.g. new EU Member States, China, and oil-rich states) have made renewed pledges and commitments to Africa, particularly for sub-Saharan Africa. At the Gleneagles Summit in 2005, the G8 committed to doubling aid to Africa by 2010. If the G8 and other donors deliver on their commitment to Africa, it will lead to an increase of ODA to Africa of US$25 billion a year by 2010, out of an estimated US$50 billion globally. For 2005 and 2006, much of that will be achieved through major debt relief, most notably for Nigeria. A majority of donors have concluded regional strategy papers, outlining priority areas of cooperation, often accompanied by individual country strategy papers. Bilateral aid remains the largest pot of money and with commitments to increase ODA will most likely continue to grow.

While increased ODA is needed in Africa, OECD/DAC estimates that if ODA increases as indicated, many African countries will be experiencing historically high levels of aid dependence by 2010; with several experiencing unproductive aid/GNI ratios. The DAC and the World Bank are currently conducting an exercise to access what DAC donors and the multilaterals are planning over the next years to see if a productive allocation of aid funds can be encouraged, e.g. the establishment of a “Development Fund for Africa” within the UN system.
Annex B - Changes in Aid Architecture: Non-DAC Donors

1. **Non-DAC OECD countries** (Czech, Hungary, Poland, Slovakia, Iceland, Turkey, South Korea and Mexico) – Most have ambitious plans to scale up their aid. South Korea is aiming to reach a programme of US$1 billion by 2010, including tripling its ODA to Africa to US$100 million by 2008. It is predicted that non-DAC OECD countries combined will at least double their current ODA to approximately US$1 billion by 2010.

2. **Non-OECD New EU Member States** (Cyprus, Estonia, Latvia, Lithuania, Malta, Slovenia) – All have commitments under the EU decisions last May to make their best endeavors to reach 0.17% of GNI by 2010 and 0.33% by 2015. The absolute amounts from this group will be small given the size of their economies.

3. **Middle East and OPEC countries and funds** – They are a cohesive group of donors who primarily limit their assistance to project finance in loan (or Islamic banking) form. For example, the Arab Bank for Economic Development in Africa, an institution funded by the member states of the Arab League, only provides assistance to non-Arab countries of Africa. While the present oil market has allowed this group enhanced possibilities in providing development assistance, it is unlikely that the current preference of bilateral aid versus multilateral aid will change. There is a slow shift towards smaller scale community-oriented projects within the context of government poverty reduction programs. Past contributions are between US$2–3 billion per year, mainly from Saudi Arabia. Additional resources in debt relief stand to be delivered through the HIPC mechanism. The Muslim world and Africa, along with the Balkans and Central Asia, will continue to be a priority. (Note: There is significant Arab presence at the Africa Union, as well as NEPAD, and the African Development Bank.)

4. **China and India** – These are the two donors currently under much discussion. Both have long been donors as well as aid recipients. What is to be noted is that aid from India and China will have a much less significant impact for the developing world than the impact of their policies of trade and investment.

**China** – The development of China’s future relations with Africa is set out in a comprehensive government paper, published in January 2006, including political cooperation, economic development, education, health and environment issues, and peace and security. During the November 2006 China-Africa Cooperation Forum, China committed to doubling its aid to Africa by 2009, including pledges to build 30 hospitals, train medical staff and provide US$37.5 million for anti-malaria drugs. This follows, China’s announcement in September 2005 to give US$10 billion in loans and other aid for developing countries over the next three years, with Africa as a priority. China sat on the Commission for Africa and Premier Wen Jiabao recently completed a tour of seven African countries. Discussions with China to contribute to the International Finance Facility for Immunization (IFFIm) are still ongoing. (Note: China provided a US$1.72 million extrabudgetary contribution to WHO in 2006).

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36 The first China-Africa Cooperation Forum took place in Beijing in 2000, establishing a mechanism for promoting diplomatic relations, trade and investment between China and African countries. A second China-Africa Cooperation Forum was held in December 2003 in Addis Ababa. Follow-up meetings of senior officials were held in October 2004 and August 2005. During the next ministers’ forum scheduled for late 2006 in China.
India - India will most likely continue to have a select number of bilateral ODA recipients in comparison with China. India plans to move beyond just providing training and technical assistance and highly concessional aid. The Indian Development Initiative, a new lending instrument aimed for sub-Saharan Africa, has been proposed to Cabinet. Under its Techno-Economic Approach for Africa-Indian Movement, India has offered US$200 million for regional programmes under NEPAD.

Others
Chile has a bilateral aid programme and has shown serious interest innovative sources of finance (e.g. airline tax).

Brazil is both a bilateral and multilateral donor, including within the Lusophone Commonwealth and is also interested in innovative sources of finance (e.g. IFFIm).

South Africa has a modest bilateral programme, but its economic weight in the region gives it considerable influence in the development of its neighbours.

Russia continues to be the primary source of assistance to Commonwealth of Independent States, and is considering a more formal structure for delivering aid.

Malaysia and Thailand are beginning to develop bilateral programmes beyond just providing training and technical assistance.
Annex C - Changes in Aid Architecture: European Union (EU) Aid

In 2000, the European Commission (EC) launched a reform programme to speed up the implementation of the EC’s external assistance and to improve the quality of aid. It resulted in the creation of EuropeAid, who is responsible for implementation of assistance through a decentralized system. There are 80 EC delegations globally responsible for EC aid.

In May 2005, the EC and all EU Member States agreed to increase their ODA progressively in order to achieve the MDGs by 2015. The EC will double its aid between 2004-2010, and allocate half of it to Africa. This commitment should result in an estimated Euros 20 billion in ODA per year. In addition, the EU will increase its financial assistance for sub-Saharan Africa and will provide collectively at least 50% of the agreed increase of ODA resources to the continent while fully respecting individual Member States priorities in development assistance.

In October 2005, the EC issued a communication on Africa “EU Strategy for Africa”. The Strategy sets out the steps the EU will take with Africa between now and 2015. Its primary aims are the achievement of the MDGs and the promotion of sustainable development. It addresses development assistance and increased financing for Africa. It also highlights that the EU is developing a coherent and coordinated response to the crisis in human resources for health, which will support the needs as identified in the NEPAD health strategy.

In December 2005, the EU launched its new development-policy statement “European Consensus on Development”. It is the common framework for EU action (including Member States and the Commission). The first part sets out common objectives and principles for development cooperation in order to guide Community and Member State activities. The second part sets out EC development policy, which is to be complementary with Member State policies.

In March 2006, in order to meet its 2005 commitments to substantially scale up aid, the EC approved three communications to improve the efficiency, coherence and impact of EU development aid: (a) “EU aid: delivering more, faster and better” presents a concrete action plan with 9 time-bound deliverables; (b) “Joint multi-annual programming” proposes a joint EU framework for programming development aid; and (c) “Financing for Development and Aid Effectiveness” monitors the EU’s performance against its commitments in terms of volume of aid and effectiveness of delivery. In support of this, the EU Donor Atlas, which globally maps European development assistance, has been updated.

The “EU Strategy for Africa” is a platform for both Community aid (financed from the EU budget and the European Development Fund) and the bilateral aid programmes financed and implemented by the each EU Member States. As far as the European Commission is concerned, in addition to the specific instruments with a continental dimension, the strategy will be implemented via the aid channelled coming from the European Development Fund. The EU is currently negotiating specific strategies, including funding for health, with each partner country and region for the period 2008 – 2013.
Annex D – Survey results

Of the 45 country offices included in the survey, responses were received from 41 individuals, giving a fair representation of almost all the countries and all the sub-regions. The respondents were distributed amongst the various staff categories as follows: WR (29%), Programme Managers (34%), Technical Staff (24%) and IST Staff (17%). The remaining 4% represented other staff categories (not specified).

The major findings from the survey were as follows:

Knowledge about size of funding shortfalls. 8% of the respondents indicated that they did not expect a funding shortfall in the biennium 2008-2009. 27% estimated that the shortfall would be under US$1 million. 33% estimated it to somewhere between US$1 and 10 million and 3% expected that it would exceed US$10 million. The most noteworthy discovery was that almost every third responded did not know if they would experience a funding shortfall or not.

Table D1. Proposed roles and responsibilities for WHO staff members at country levels

<table>
<thead>
<tr>
<th>Role of individuals in the country or sub regional offices</th>
<th>Identify partnering or funding opportunities</th>
<th>Follow up on funding or partnering opportunities</th>
<th>Write Proposals</th>
<th>Meet and/or negotiate with donors and partners</th>
<th>Monitor funding</th>
<th>Write donor reports</th>
<th>Market WHO/AFRO to partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>WR</td>
<td>93.8%</td>
<td>93.8%</td>
<td>28.1%</td>
<td>96.9%</td>
<td>65.6%</td>
<td>31.3%</td>
<td>93.8%</td>
</tr>
<tr>
<td>Program Manager</td>
<td>75.9%</td>
<td>69.0%</td>
<td>86.2%</td>
<td>65.5%</td>
<td>79.3%</td>
<td>89.7%</td>
<td>44.8%</td>
</tr>
<tr>
<td>Technical Staff</td>
<td>66.7%</td>
<td>60.0%</td>
<td>93.3%</td>
<td>26.7%</td>
<td>66.7%</td>
<td>80.0%</td>
<td>30.0%</td>
</tr>
<tr>
<td>Administrative Officer</td>
<td>43.5%</td>
<td>43.5%</td>
<td>39.1%</td>
<td>30.4%</td>
<td>100%</td>
<td>82.6%</td>
<td>21.7%</td>
</tr>
<tr>
<td>IST Staff</td>
<td>84.2%</td>
<td>73.7%</td>
<td>68.4%</td>
<td>63.2%</td>
<td>73.7%</td>
<td>73.7%</td>
<td>84.2%</td>
</tr>
</tbody>
</table>

Role of individuals in the country or sub regional offices. The respondents were asked which roles and responsibilities various staff members should have. The table below summarizes the findings, which clearly suggests that the WRs have a central and proactive role to play in identification and pursuit of funding opportunity while playing a significant role in representing WHO with donor and partner audiences.

Personal assessment of capacity and skills. When asked if the respondents felt they themselves had the capacity and/or skills to be effective in engaging new partner including non-traditional partners or mobilizing resources at country or sub-regional level, almost half (47%) felt that they had that capacity, 15% said that they definitely did not have it and 38% indicated that they were not sure.

Recommended role of the Regional Office. The respondents were asked what role they would recommend that the Regional Office should or could play in mobilizing resources and developing partnerships for country and sub-regional activities. The chart below summarizes the responses.
Major areas of improvement. Finally the respondents were asked to provide feedback on and suggestions to what should be done to enhance the Regional Office’s ability to mobilize resources. The most common answers are listed below:

- Delegate RMB responsibility and fund administrations to country level.
- Develop capacity at country level.
- Work to consolidate WHO’s leadership in health.
- Re-assess the level of Program Support Costs.
- Coordinate efforts with HQ.
- Become more flexible in working with the private sector.
- Simplify procedures and operating procedures.
- Develop comprehensive RMB strategies.
- Introduce more transparency in allocation of funding.
- Introduce incentives for RMB and punishment for mismanaging them.
- Better sharing of information and best practices.
- Introduce marketing and communication strategies.
- Focus on adding value to other efforts carried out.
- Improve reporting abilities.
Annex E - Funds flow analysis

The following tables provide information about the allocation of funding between WHO Headquarters and its regional offices, as well as within the African region.

This table provides the distribution of funds in the previous biennium (2006/2007) as well as the anticipated breakdown of funding for the current biennium (2008/2009) during which the African Region is to receive approx. US$986.7 million - a 28.3% increase from the last biennium.

<table>
<thead>
<tr>
<th>Budget distribution Between WHO HQ and Regions in US$ million</th>
<th>Approved 2006-2007</th>
<th>% of total</th>
<th>Proposed for 2008-2009</th>
<th>% of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Africa</td>
<td>768.9</td>
<td>26.5</td>
<td>986.7</td>
<td>26</td>
</tr>
<tr>
<td>Americas</td>
<td>181.6</td>
<td>6.3</td>
<td>258.1</td>
<td>6.8</td>
</tr>
<tr>
<td>South East Asia</td>
<td>290.7</td>
<td>10</td>
<td>432</td>
<td>11.4</td>
</tr>
<tr>
<td>Europe</td>
<td>188.2</td>
<td>6.5</td>
<td>250.9</td>
<td>6.6</td>
</tr>
<tr>
<td>Mediterranean</td>
<td>287.6</td>
<td>9.9</td>
<td>402.7</td>
<td>10.6</td>
</tr>
<tr>
<td>Western Pacific</td>
<td>222.7</td>
<td>7.7</td>
<td>327.2</td>
<td>8.6</td>
</tr>
<tr>
<td>WHO HQ</td>
<td>962.7</td>
<td>33.2</td>
<td>1132.5</td>
<td>29.9</td>
</tr>
<tr>
<td>Total</td>
<td>2902.4</td>
<td>100</td>
<td>3790.1</td>
<td>100</td>
</tr>
</tbody>
</table>

The table below provides information about the distribution of approved, available and already disbursed funding to the regional office and the country offices in the biennium 2004/2005 and for the year 2006.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2004/2005</td>
<td>406,940,000</td>
<td>428,091,000</td>
<td>368,264,000</td>
<td>337,795,000</td>
<td>318,120,851</td>
<td>179,867,201</td>
<td>447,901,000</td>
<td>458,787,000</td>
<td>393,016,000</td>
</tr>
<tr>
<td></td>
<td>55%</td>
<td>48%</td>
<td>48%</td>
<td>45%</td>
<td>49%</td>
<td>48%</td>
<td>47%</td>
<td>52%</td>
<td>52%</td>
</tr>
<tr>
<td>2006</td>
<td>501,552,000</td>
<td>328,718,480</td>
<td>179,867,201</td>
<td>447,901,000</td>
<td>318,120,851</td>
<td>191,056,063</td>
<td>318,120,851</td>
<td>318,120,851</td>
<td>191,056,063</td>
</tr>
<tr>
<td></td>
<td>53%</td>
<td>51%</td>
<td>48%</td>
<td>47%</td>
<td>49%</td>
<td>52%</td>
<td>49%</td>
<td>52%</td>
<td>52%</td>
</tr>
<tr>
<td>Total</td>
<td>908,492,000</td>
<td>756,809,480</td>
<td>548,131,201</td>
<td>785,696,000</td>
<td>776,907,851</td>
<td>584,072,063</td>
<td>546,801,251</td>
<td>546,801,251</td>
<td>546,801,251</td>
</tr>
<tr>
<td></td>
<td>54%</td>
<td>49%</td>
<td>48%</td>
<td>46%</td>
<td>51%</td>
<td>52%</td>
<td>51%</td>
<td>52%</td>
<td>52%</td>
</tr>
</tbody>
</table>

The last table provides an indication of how assessed and voluntary contributions are allocated across departments and activities. Judging from the distribution of voluntary contributions the donors seem to have a preference for communicable disease programmes (indicated by support to IVD, HIV, CPC and MAL) as well as emergency responses (represented by EHA).
<table>
<thead>
<tr>
<th>Assessed Contributions</th>
<th>Voluntary Contributions</th>
</tr>
</thead>
<tbody>
<tr>
<td>The five best funded activities</td>
<td>2004-2006 (millions)</td>
</tr>
<tr>
<td>SCC</td>
<td>115</td>
</tr>
<tr>
<td>OSD</td>
<td>28</td>
</tr>
<tr>
<td>IIS</td>
<td>22</td>
</tr>
<tr>
<td>CSR</td>
<td>21</td>
</tr>
<tr>
<td>HRH</td>
<td>11</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Assessed Contributions</th>
<th>Voluntary Contributions</th>
</tr>
</thead>
<tbody>
<tr>
<td>The five best funded activities</td>
<td>2004-2006 (millions)</td>
</tr>
<tr>
<td>HFS</td>
<td>0.755</td>
</tr>
<tr>
<td>BMR</td>
<td>0.801</td>
</tr>
<tr>
<td>IER</td>
<td>0.864</td>
</tr>
<tr>
<td>RPC</td>
<td>0.915</td>
</tr>
<tr>
<td>TOB</td>
<td>0.949</td>
</tr>
</tbody>
</table>
Annex F - Donor Mapping

**Paris Declaration on Aid Effectiveness**

In March 2005, donors and developing countries agreed to landmark reforms in the way they do business. These reforms, enshrined in the Paris Declaration on Aid Effectiveness, are aimed in helping countries meet the MDGs by 2015. Increased aid flows will not reduce poverty if donors do not change the way they provide aid, and if developing countries do not change the way they manage it. Developing and donor countries, as well as the multilateral banks (and GAVI), are adopting harmonization/alignment agendas. Progress is currently monitored at country-level and a second monitoring round will take place in 2008 ahead of the High-Level Forum on Aid Effectiveness in Ghana. The importance of the Paris Declaration lies in the fact that donors are undertaking support of national development priorities.

**OPPORTUNITY**

The key roles of the WHO Regional Offices and WRs are to assist governments in prioritizing health (and immunization) in national development planning. WHO intends to hold a high level forum on global health architecture and the Regional Office for Africa will be establishing a mechanism called “Program Assistance for Facilitation in Health (PAF-H)” to provide support to countries to address barriers to scaling up in order to meet the health-related MDGs.

**G8**

Since 2002, the G8 (all of whom except Russia are OECD/DAC members) have made several commitments to both Africa and health (fighting infectious diseases). In 2005, the G8 provided 75% of ODA from DAC members. The G8 collectively increased aid to Sub-Saharan Africa totaling approximately US$18.6 billion, while non-G8 DAC donors actually decreased their aid to the region. With regard to immunization, polio eradication through the Global Polio Eradication Initiative has been the priority for the G8. At the 2006 G8 Summit in St Petersburg, support for measles through the Global Measles Partnership, was added. Fifteen African countries have benefited from the G8 proposal to cancel debt through the “Multilateral Debt Relief Initiative”. The G8 is committed to implementing the Paris Declaration. At the 33rd G8 summit in Germany in June 2007 (which also included Brazil, India, Mexico, China and South Africa), emphasis was placed on fighting HIV/AIDS, TB and malaria; establishing effective health systems; and achieving peace and security, while emphasizing African ownership as essential preconditions for social and economic development. An additional US$60 million was committed to programs addressing these three diseases, while renewed commitments were made for assistance to African countries for achieving the MDGs and optimizing opportunities to convert debt relief into development.

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37 The five key principles of the Paris Declaration are ownership, alignment, harmonisation, managing for results and mutual accountability.
38 OECD/DAC is currently undertaking a survey to establish baselines for the 12 indicators; and the World Bank is conducting an Aid Effectiveness Review to complement the OECD/DAC survey.
39 Resolution WHA 58/25, adopted on 22 May 2005, requests the Director-General inter alia to ensure that WHO continues to implement country level activities in accordance with member states’ priorities, as agreed by the governing bodies, and that WHO staff and programmes at all levels adhere to the international harmonization and alignment agenda as reflected in the Paris Declaration. Guidance has been sent out to all WRs/LOs in August 2005 and an email set up specifically to answer questions (harmonization@who.int).
40 The African Development Bank, UNICEF, WHO and the World Bank have together developed a proposal for regionally-based technical support, the PAF-H, which was endorsed by the 56th Regional Committee of WHO/AFRO in September 2006.
41 Organization for Economic Cooperation and Development/Development Assistance Committee (OECD/DAC).
OPPORTUNITY
The G8 have increasingly been occupied with challenges on the African continent and the forum itself is a unique platform for advocacy and raising awareness. A separate but coordinated effort must be made to place immunization in the context of the MDGs and health systems development at upcoming G8 agendas.

Non-DAC Donors
When discussing ODA, most, if not all, of the attention is focused on the 22 DAC member countries. During the 1990s and the first part of this century, aid from DAC countries represented 95% of all international aid. But the landscape is changing as non-DAC donors (e.g. new EU Member States such as Turkey, Bulgaria, and Poland; as well as the Gulf States, China, India and South Korea) start to assume or re-assume a much larger share of aid financing, with a particular focus on Africa (see Annex C). The consequence is an increased range of aid options that developing countries can access to finance their development activities. Non-DAC countries generally have very little experience and expertise in the field of international development aid, let alone with some of the challenges the African continent is experiencing. As such, DAC donors are in dialogue with non-DAC donors to address concerns about the latter conforming to the standards put forth in the Paris Declaration.

OPPORTUNITY
New Non-DAC members represent significant new funds that could be released for AFRO initiatives with a targeted and tailored strategy.

European Union (EU) Aid
In the last 5 years, aid from the EU has undergone significant changes. In 2000, aid from the European Commission (EC) was decentralized to its 80 delegations at country-level. In 2005, the EC issued a communication on Africa, the “EU Strategy for Africa”, which sets out its relationship with Africa to achieve the MDGs. This communication supports the earlier agreement of the EC and all EU Member States to increase their ODA, half of which will be allocated to Africa. In March 2006, the EC approved three communications to improve the efficiency, coherence and impact of EU development aid. The strategy will be implemented via the aid channelled from the European Development Fund (EDF). The EU is currently negotiating specific strategies, including funding for health, with each partner country and region for the period 2008–2013. This clearly supports the trend towards more direct country support and suggests many future opportunities for tapping into country level funding.

OPPORTUNITY
As EU aid represents ODA of 25 Member States and the Commission, i.e. the aid of “26 donors”, it will be important for VPD to work with ERG and the WHO Office at the European Union (WEU) to develop a country-level plan of action to work with countries, the EC delegations and EU Member States.

42 The Russian G8 Presidency held a special meeting in April 2006 with DAC and non-DAC donors to discuss issues of common concern.
43 The EC has launched a dedicated website on the EU Strategy for Africa (www.europe-cares.org/africa).
The Bill and Melinda Gates Foundation

Over the past few years, the Foundation has undergone several organizational improvements. As of 1 May 2006, the Foundation has been reorganized into three program groups (U.S. Program, Global Development Program and Global Health Program) — each of which is led by a president. The Global Health Program continues to focus on 1) access to existing vaccines, drugs and other tools to fight diseases common in developing countries and 2) research to develop health solutions that are effective, affordable and practical. A strategic review of health funding priorities is in its final stages taken into consideration the recent endowment of more than US$35 billion from Warren Buffet. WHO has strategic relations with the Foundation and receives grant funding from them. Majority of funding currently supports the Global Polio Eradication Initiative (GPEI) but some is also provided to vaccine research and development initiatives. The Foundation has since the inception of GAVI been its very strong financial supporter and has committed in excess of US$1.5 billion to the partnership.

OPPORTUNITY
WHO has a long-standing relationship with the Gates foundation at multiple levels. Given the recent increase at the Foundation as well as the hiring of more high-level health expertise at the Foundation, it is strongly recommended to pursue AFRO-specific funding in coordination with HQ.

Debt Relief - “Multilateral Debt Reduction Initiative” (MDRI)

At the G8 Summit in 2005, leaders agreed to a proposal to cancel 100% of outstanding debts of eligible Heavily Indebted Poor Countries (HIPC’s) to the International Monetary Fund (IMF), the World Bank’s International Development Association (IDA) and the African Development Fund, and to provide additional resources to ensure that the financing capacity of these institutions is not reduced. In December 2005, the IMF’s debt relief package to 19 countries (13 from Africa) was agreed. In March 2006, IDA announced the cancellation of debt to 17 countries (the same as the IMF, but excluding Cambodia and Tajikistan). The African Development Fund approved $8.5 billion in debt relief in April 2006. The ultimate goal of the MDRI is to assist beneficiary countries to achieve the MDGs. Both the Global Fund and GAVI are exploring options to work with countries to convert debt relief into resources for HIV, TB, malaria and immunization.

OPPORTUNITY
Provide information about debt relief opportunities and explore opportunities for countries to work with host governments to convert debt and channel debt relief funding towards health objectives.

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44 The Global Health portfolios will include HIV, Tuberculosis, Reproductive Health, and Avahan (the HIV program in India); Global Health Strategies (which includes vaccine-preventable diseases); Infectious Diseases; Global Health Technologies; Global Health Advocacy; and Special Initiatives.

45 The Global Health Program will be led by President Tachi Yamada, a physician, scientist, and business leader, former chairman of research and development for GlaxoSmithKline. He joined the Foundation on 1 June 2006.

46 Benin, Bolivia, Burkina Faso, Cambodia, Ethiopia, Ghana, Guyana, Honduras, Madagascar, Mali, Mozambique, Nicaragua, Niger, Rwanda, Senegal, Tajikistan, Tanzania, Uganda and Zambia.
US Presidential Malaria Initiative
In June 2005, President Bush launched the President’s Malaria Initiative (PMI). He pledged to increase U.S. malaria funding by more than $1.2 billion over five years to reduce deaths due to malaria by 50 percent in 15 African countries and challenged other donor governments, private foundations, and corporations to help reduce the suffering and death caused by this disease. PMI is a collaborative U.S. Government effort led by the U.S. Agency for International Development (USAID), in conjunction with the Department of Health and Human Services (Centers for Disease Control and Prevention), the Department of State, the White House, and others. The PMI goal will be achieved by reaching 85 percent of the most vulnerable groups – children under 5 years of age and pregnant women – with proven and effective prevention and treatment measures. PMI uses a comprehensive approach to prevent and treat malaria, supporting four key areas – indoor residual spraying of homes with insecticides, insecticide-treated bed nets, lifesaving antimalarial drugs, and treatment to prevent malaria in pregnant women.

In the first three focus countries – Uganda, Tanzania, and Angola – PMI distributed more than 1 million mosquito nets to protect pregnant women and children under age 5; conducted indoor residual spraying campaigns to shield over 2 million people; and procured over one million treatments of highly effective artemisinin-based combination therapies (ACTs) and other antimalarial drugs to treat the disease. This year, an additional 30 million people are expected to benefit from lifesaving treatment and prevention measures as PMI expands to four additional countries.

OPPORTUNITY
To tap into and/or create synergies with the PMI and PMI implementing partners to create opportunities and create synergies.

The President’s Emergency Plan for AIDS Relief (PEPFAR)
PEPFAR is a five-year, US$15 billion initiative to combat the global AIDS epidemic. Launched in 2003, PEPFAR has set the goals of providing treatment for 2.5 million people, prevent more that 12 million new infections and to support care for 12 million people, including more than 5 million orphans and vulnerable children. The funding is distributed amongst 15 priority countries with some of the world’s highest infection rates. The 15 countries eligible for funding are: Botswana, Côte d’Ivoire, Ethiopia, Guyana, Haiti, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, Vietnam and Zambia.

The injection of funding in the focus countries has allowed for a significant scale up of initiative, efforts and introduction of innovative approaches and new – local – partners. In FY 2006 more than 83% of the total number of implementing partners were indigenous. As of September 2007 more than 1.3 million individuals in the focus countries were on ART treatment.

OPPORTUNITY
Although the majority of PEPAR funding is allocated to HIV/AIDS specific interventions that are executed by international and/or implementing partners in country there appears to be valuable synergies as well as valid opportunities for WHO to play a role in PEPAR funded projects.
Millennium Challenge Corporation (MCC)

The Millennium Challenge Corporation is a US Government corporation focused on enhancing development in some of the poorest countries in the world. MCC, which was only established in 2004, is founded on the principle that aid is most effective when it reinforces good governance, economic freedom and investments in people. Its vision is to reduce global poverty through the promotion of sustainable economic growth. MCC bases its evaluation of a country’s eligibility to receive assistance on independent and transparent indicators. The MCC recognizes the importance of investing in health to foster successful human and economic development and two of the indicators focus on a country’s effort to provide adequate health care to its citizens. The first measures the total public expenditure on health and the second – referred to as the immunization rate indicator – measures a government’s commitment to providing essential public health services and reducing child mortality.

OPPORTUNITY
Countries applying for MCC funding may need support to meet the health criteria. WHO’s country offices are uniquely positioned to work with its hosting governments to design, plan and help execute efforts to improve global health objectives e.g. immunization rates.
Annex G - “Donor Intelligence” Resources

Bilateral (country-specific and regional) and Multilateral ODA

1. EU Donor Atlas, 2008 - The EU has published a new version of the EU Donor Atlas, which shows the scale and geographic spread of EU member states aid, the focus of each Member’s aid programme and the countries and sectors assisted.

2. OECD/DAC Development Cooperation Report – The annual report provides information on the foreign aid policies and programmes of donor countries, including detailed statistics and analysis, and reviews the most importance issues of the previous year.

3. EU Country Strategy Papers (CSPs) – As part of the EU’s commitment to joint multi-annual programming, it is revising the framework for the 2000 CSPs. The new CSPs are currently under preparation and will include (a) information on the programmes of other donors in the country, and (b) a retrospective and prospective (2006-2013) financial matrix of donors.

4. World Bank Aid Effectiveness Review, 2006 Country Profiles – The country profiles are a common evaluation of progress toward the Paris Declaration and review, e.g., aid alignment and harmonization at country-level.

5. Country Health Focus Fact Sheets – These fact sheets, produced exclusively for WHO by OECD/DAC, present three categories of information for each aid recipient country or territory for the period (2002-2004): (a) overall ODA (2003-2004), broken down by major donor and by recipient sector; (b) health-specific ODA (2002-2004), broken down by major donors and in comparison to aid for all sectors; and (c) sub-sectoral breakdown of health aid for a country, compared to the sub-sectoral breakdown for health aid to all countries.
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