

# HEALTH AND PHILANTHROPY

## NETFWD POLICY NOTE

Harnessing Novel Approaches  
for Improved Access to  
Quality Healthcare



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Health and Philanthropy

HARNESSING NOVEL APPROACHES FOR IMPROVED ACCESS TO QUALITY HEALTHCARE

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Since 2012, netFWD has been an integral part of the OECD Development Centre, where foundations can gain visibility in the development arena. As the philanthropic sector contributes more ideas and innovation to tackle development challenges, the need for a platform to enable co-operation with and among foundations working for development has never been more pressing.

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## Key findings

This policy note analyses foundations' support for health and reproductive health in developing countries, and further explores how foundations are innovating in the way they partner, fund and implement health programmes on the ground. It builds on the results of the OECD Survey on Private Philanthropy for Development, unpacking giving data from 2013-15 and 2017. It also gathers a selection of case studies to delve into the potential advantages and challenges of two novel approaches: innovative finance and digital health.

Key findings and messages:

- Philanthropy has taken a prominent role in addressing critical health concerns in developing countries. With contributions of USD 12.6 billion between 2013 and 2015, foundations ranked third in the leading sources of funding for health and reproductive health, just after the United States and the Global Fund to Fight AIDS, Tuberculosis and Malaria.
- The Bill & Melinda Gates Foundation (BMGF) provided 72% of health-related funding. Yet even putting aside contributions from BMGF, health remains philanthropy's top supported sector.
- During 2013-15, Africa and Asia attracted most health-related giving, which targeted primarily infectious disease control.
- The sheer scale and complexity of global health challenges are increasingly pushing foundations to explore less conventional ways of partnering, funding and implementing programmes on the ground. Innovative finance and digitalisation are two novel approaches to finance and deliver healthcare in developing countries.
- Some pioneering foundations in innovative finance have demonstrated that through novel financial mechanisms, philanthropists can unlock a significant pool of resources, stimulate research and development for neglected and tropical diseases, optimise resource management and spending on the ground, and remove certain financial barriers to healthcare.
- While some foundations are experimenting with a diversity of new financial tools, this shift of approach has not yet gained strong traction in the overall philanthropic sector. Capacity and entry cost are oft-cited barriers.
- Both large and smaller foundations can engage in different ways to further improve the understanding, design and ultimate performance of innovative financial mechanisms. They can catalyse new instruments, mitigate risk, provide patient capital, facilitate peer learning and support market enablers in developing countries.
- Foundations' experience with digital health reveals that technology can help prevent stock-outs of essential medical supplies and control sales of counterfeit drugs, facilitate collection

of essential data to manage and plan healthcare delivery, expand the reach and capacity of often small numbers of trained healthcare workers and empower patients to manage their own health.

- In digital health, leading foundations are investing their funds following two approaches: “pilot-oriented philanthropy” and “impact-at-scale philanthropy”. Under the first approach, foundations are supporting and often directly developing digital health innovations and collaborating to deploy demonstration pilots. In addition, some foundations are also seeking to change healthcare systems at scale. The two approaches are complementary and often subsequent: the rapid pace of technology innovation opens the door to continually update and improve digital health apps. Yet, the potential of digital innovations to sustainably transform healthcare delivery depends largely on government ownership and adoption within its existing systems and processes.
- Overall, harnessing novel approaches to finance and deliver healthcare requires long-term investments and close collaboration with the private sector. Longer funding cycles would allow foundations to provide patient growth capital in support of promising market-based health solutions. It could also help foundations invest in capacity building for local market enablers, and better support the emergence of a new cadre of tech-savvy leaders and a digitally-literate health workforce. In addition, private companies, including investment firms and mobile network operators, appear as essential partners to grow the pool of additional capital for health, and scale digital health strategies.

## ACKNOWLEDGEMENTS

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## TABLE OF CONTENTS

1. Introduction .....	11
2. Setting the Scene .....	12
2.1 Philanthropic flows for health and reproductive health .....	12
2.2 Regional distribution of giving for health and reproductive health .....	13
2.3 Main health causes targeted .....	14
2.4 Channels and modalities of giving .....	16
2.5 Top foundations in health and reproductive health .....	16
3. Health financing and delivery.....	21
3.1 Innovative finance .....	22
3.2 Novel partnerships to address critical health challenges.....	25
3.3 Expanding innovative finance – priorities for foundations .....	30
3.4 Digital health.....	32
3.5 Case studies in digital health .....	33
3.6 Expanding e-health: recommendations for foundations .....	39
4. Conclusion.....	41
References.....	43
Annex A .....	47

## FIGURES

Figure 2.1 Philanthropic giving by sector 2013-15, USD .....	12
Figure 2.2 Philanthropic giving for health and reproductive health by year 2013-15, USD billion .....	13
Figure 2.3 Philanthropic giving for health and reproductive health by region 2013-15, USD.....	13
Figure 2.4 Philanthropic giving for health and reproductive health by country 2013-15, USD million.....	14
Figure 2.5 Main health and reproductive health causes targeted by region 2013-15, USD million.....	15
Figure 2.6 Leading channels of delivery for health and reproductive health giving, 2013-15, USD million ..	16
Figure 2.7 Top 15 foundations in health and reproductive health by total giving 2013-15, USD million.....	17
Figure 2.8 Top 10 foundations most focused on health in 2013-15, by their share of total giving.....	17
Figure 2.9 ODA commitments for health and reproductive health by country 2013-15, USD billion (constant prices) .....	18
Figure 2.10 Main health and reproductive health causes targeted by ODA 2013-15, commitments, USD billion (constant prices) .....	18
Figure 2.11 Philanthropic giving by sector, commitments, 2017, USD (current prices).....	19
Figure 2.12 Health-related giving by region, 2017, commitments, USD billion (current prices) .....	19
Figure 2.13 Health-related giving, main causes funded, commitments, 2017 (current prices) .....	20
Figure 3.1 Philanthropy’s use of innovative finance and digitalisation to improve healthcare: A selection of examples along the healthcare continuum.....	22

## BOXES

BOX 1. OFFICIAL DEVELOPMENT ASSISTANCE FOR HEALTH AND REPRODUCTIVE HEALTH.....	18
BOX 2. PHILANTHROPIC GIVING FOR HEALTH IN 2017 .....	19
BOX 3 DEFINITIONS OF INNOVATIVE FINANCE FOR DEVELOPMENT .....	23
BOX 4. INNOVATIVE FINANCE INSTRUMENTS USED BY FOUNDATIONS IN HEALTH A NON-EXHAUSTIVE GLOSSARY .....	24
BOX 5 FIGHTING CHAGAS DISEASE THROUGH INNOVATIVE FINANCE.....	26
BOX 6. SUPPORTING INNOVATIVE SOCIAL ENTERPRISES.....	28
BOX 7. INNOVATIVE FINANCIAL PRODUCTS TO EXPAND ACCESS TO HEALTH .....	30
BOX 8. EXAMPLES OF DIGITAL HEALTH.....	32
BOX 9. EMPOWERING HEATHCARE PROVIDERS THROUGH E-LEARNING .....	35
BOX 10. SCALING TELEMEDICINE PROGRAMMES.....	36
BOX 11. PROMOTING BETTER AND TIMELIER DATA .....	37
BOX 12. DIGITAL FINANCIAL SERVICES TO DEMOCRATISE ACCESS TO CARE .....	37
BOX 13. DIGITAL TOOLS TO EMPOWER PATIENTS AND HEALTH PERSONNEL .....	38

## ABBREVIATIONS AND ACRONYMS

<b>AKDN</b>	Aga Khan Development Network
<b>BMGF</b>	Bill & Melinda Gates Foundation
<b>CIFF</b>	Children’s Investment Fund Foundation
<b>DAC</b>	Development Assistance Committee
<b>DCD</b>	Development Co-operation Directorate
<b>DIBs</b>	Development Impact Bonds
<b>ICT</b>	Information and communication technology
<b>LDC</b>	Least developed country
<b>LIC</b>	Low-income country
<b>LMIC</b>	Lower-middle income country
<b>M&amp;E</b>	Monitoring and evaluation
<b>NDCs</b>	Non-communicable diseases
<b>netFWD</b>	Network of Foundations Working for Development
<b>NGO</b>	Non-governmental organisation
<b>Norad</b>	Norwegian Agency for Development Cooperation
<b>ODA</b>	Official development assistance
<b>OECD</b>	Organisation for Economic Co-operation and Development
<b>PDP</b>	Product Development Partnership
<b>PPP</b>	Public-private partnership
<b>R&amp;D</b>	Research and development
<b>SDG</b>	Sustainable Development Goal
<b>SIDA</b>	Swedish International Development Cooperation Agency
<b>SII</b>	Social impact investment
<b>UMIC</b>	Upper-middle income country
<b>USAID</b>	United States Agency for International Development



## 1. INTRODUCTION

### ***Philanthropic foundations support the health and reproductive sector above all else***

An unprecedented OECD survey of more than 140 foundations working for development revealed that philanthropies targeted the health and reproductive sector above all else. Between 2013-15, the sector attracted USD 12.6 billion from philanthropies (OECD, 2018b).

Yet even when put together, philanthropic funds and official development assistance (ODA) still fall far short of the trillions needed to achieve the Sustainable Development Goals (SDGs) (OECD, 2018b, 2018c). SDG 3, for example, aims to “ensure healthy lives and promote well-being for all at all ages” by 2030. According to the World Health Organization, low- and middle-income countries will need an additional USD 3.9 trillion in funding over 15 years to achieve this goal (Stenberg et al., 2017).

### ***Larger foundations are using innovative finance to raise new funds for health and optimise traditional sources***

Innovative finance for health is increasingly attracting investors of all types, and philanthropic foundations are no exception. Through financial vehicles such as loans, guarantees and performance-based grants, larger foundations and their partners are mobilising new funds for health. In harnessing such innovative practices, they are also optimising traditional funding sources (OECD, 2014). However, smaller foundations with less capacity or budget struggle to embrace these new approaches.

Over the last two decades, developing countries have made great strides against several of the leading causes of disease and death. These efforts have led to a decline in infant and maternal mortality, and a lower incidence of neglected tropical diseases, HIV/AIDS and tuberculosis (United Nations, 2018). However, progress has been uneven, with stark disparities both between and within countries. There is a 36-year gap between countries with the shortest and longest life expectancy. Furthermore, children from poor households are nearly twice as likely to die under the age of five as children from urban and wealthier families (WHO, 2011).

### ***Foundations are deploying many strategies, including technology, to address health gaps***

Information and communication technologies (ICTs) are developing rapidly. In particular, with the swift penetration of mobile phones in isolated and deprived areas, digital health is going mainstream. Based on evidence to date, foundations and global health practitioners believe technology could improve the reach of proven health interventions to healthcare management, coverage and quality. Strategies range from training frontline health workers and empowering patients with information, to improving national health data collection.

To learn more about these novel trends and explore other ways in which philanthropy supports health, the OECD Network of Foundations Working for Development (netFWD) launched its Health Working Group. This policy note draws on insights from the first meeting of the working group in June 2017, additional interviews and material from leading foundations working on health issues and the results of the OECD Survey on Private Philanthropy for Development in 2013-15 and 2017. It dives deeper into the landscape of philanthropic giving for health (Chapter 2), and further explores how some foundations have used innovative finance and digital health (Chapter 3).

## 2. SETTING THE SCENE

This chapter provides an overview of philanthropic giving for health and reproductive health in developing countries (OECD, 2018a).<sup>1</sup> Specifically, it unpacks quantitative data from the OECD Survey on Private Philanthropy for Development (OECD, 2018b, 2019), and further elaborates the analysis of the OECD Report on Private Philanthropy for Development (2018a). To that end, it describes philanthropic flows by funder, volume, causes targeted, modality of giving and recipients. It also describes how foundations are supporting health in humanitarian settings.

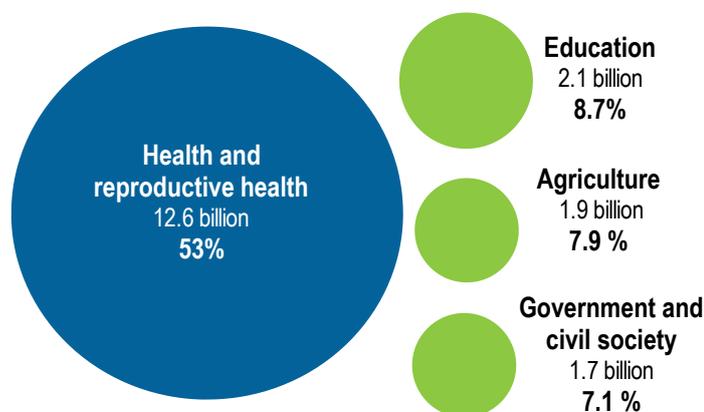
### 2.1 PHILANTHROPIC FLOWS FOR HEALTH AND REPRODUCTIVE HEALTH

#### *Philanthropies target health and reproductive health, allocating USD 12.6 billion over 2013-15*

Health and reproductive health were by far the main sectors targeted by foundations working in developing countries. Foundations gave USD 12.6 billion from 2013 to 2015 to support health and reproductive health. Nearly three-quarters (72%) came from the Bill & Melinda Gates Foundation (BMGF).

Even after putting aside funds from BMGF, health remains philanthropy's top supported sector. The sector represents 53% of total philanthropic flows for development (Figure 2.1). Funding for health and reproductive health steadily increased during 2013-15 – from USD 3.3 billion to USD 5.8 billion (Figure 2.2). Higher funding for infectious disease<sup>2</sup> – from USD 2 billion to USD 3.5 billion – was the main driver behind this increase.

Figure 2.1 Philanthropic giving by sector 2013-15, USD

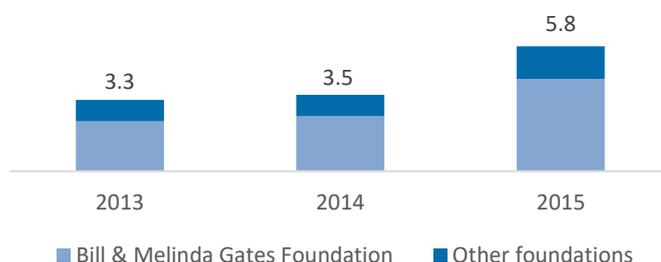


Source: OECD (2018b), *Survey on Private Philanthropy for Development 2013-15: Data Questionnaire*, [www.oecd.org/dac/financing-sustainable-development/development-finance-standards/beyond-oda-foundations.htm](http://www.oecd.org/dac/financing-sustainable-development/development-finance-standards/beyond-oda-foundations.htm)

<sup>1</sup> The terms “developing countries” and “developing economies” refer to all countries and territories on the OECD Development Assistance Committee List of Official Development Assistance (ODA) recipients. The list comprises all low- and middle-income countries based on gross national income per capita as published by the World Bank, with the exception of G8 members, European Union (EU) members and countries with a firm date for entry into the EU. It also includes all of the least developed countries as defined by the United Nations (OECD, 2018a).

<sup>2</sup> For this publication, infectious disease control refers to activities under the health sector (immunisation; prevention and control of infectious and parasite diseases, malaria, and tuberculosis) and population policies/programmes and reproductive health (sexually transmitted diseases, including HIV/AIDS).

Figure 2.2 Philanthropic giving for health and reproductive health by year 2013-15, USD billion



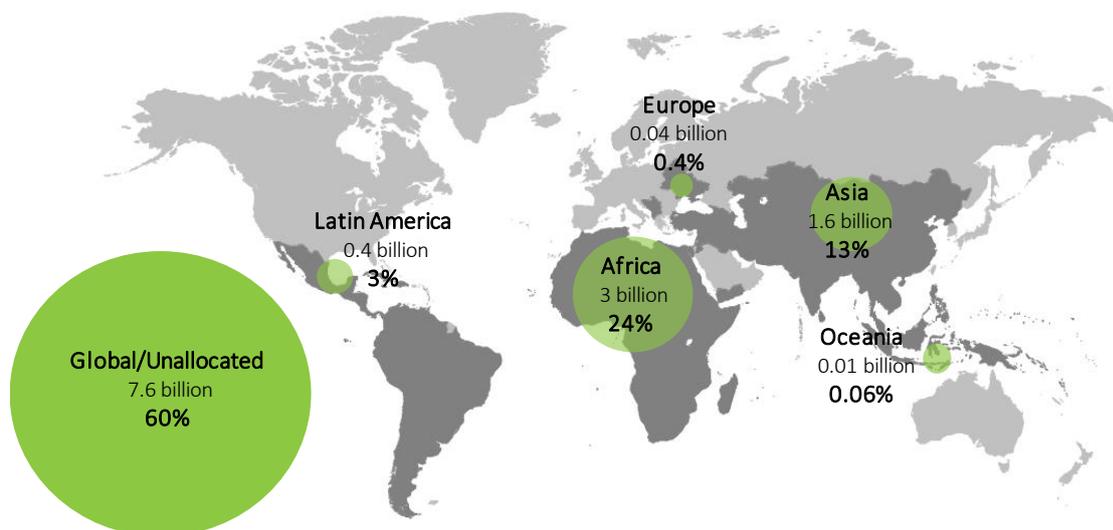
Source: OECD (2018b), *Survey on Private Philanthropy for Development 2013-15: Data Questionnaire*, [www.oecd.org/dac/financing-sustainable-development/development-finance-standards/beyond-oda-foundations.htm](http://www.oecd.org/dac/financing-sustainable-development/development-finance-standards/beyond-oda-foundations.htm)

## 2.2 REGIONAL DISTRIBUTION OF GIVING FOR HEALTH AND REPRODUCTIVE HEALTH

### *Philanthropic giving for health is concentrated in Africa and Asia*

Between 2013 and 2015, Africa received 24% of philanthropic funds for health and reproductive health, and Asia 13% (Figure 2.3). All told, 60% of giving was unallocated to a specific region. Most global/unallocated giving for health was channelled through Gavi, the Vaccine Alliance (USD 1.8 billion, or 24% of total unallocated funding for health).

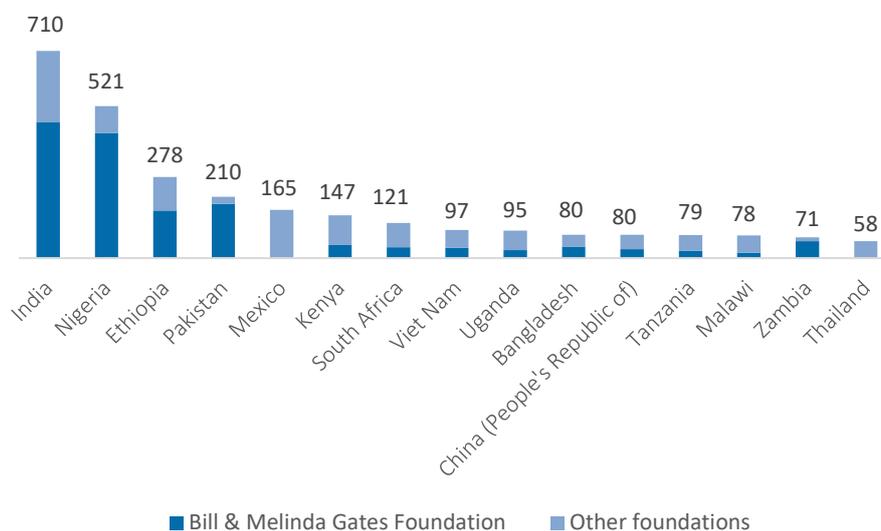
Figure 2.3 Philanthropic giving for health and reproductive health by region 2013-15, USD



Source: OECD (2018b), *Survey on Private Philanthropy for Development 2013-15: Data Questionnaire*, [www.oecd.org/dac/financing-sustainable-development/development-finance-standards/beyond-oda-foundations.htm](http://www.oecd.org/dac/financing-sustainable-development/development-finance-standards/beyond-oda-foundations.htm)

In line with the regional distribution of philanthropic funds, 14 of the 15 top recipient countries were in Africa and Asia. India was by far the main country targeted by foundations, receiving USD 710 million in 2013-15, with 66% of these funds coming from BMGF (Figure 2.4).

Figure 2.4 Philanthropic giving for health and reproductive health by country 2013-15, USD million



Source: OECD (2018b), *Survey on Private Philanthropy for Development 2013-15: Data Questionnaire*, [www.oecd.org/dac/financing-sustainable-development/development-finance-standards/beyond-oda-foundations.htm](http://www.oecd.org/dac/financing-sustainable-development/development-finance-standards/beyond-oda-foundations.htm)

### 2.3 MAIN HEALTH CAUSES TARGETED

#### *Foundations primarily target infectious disease control*

Infectious disease control was the main cause targeted by foundations globally. In Africa and Asia, most giving for health-related causes targeted infectious disease control. In Latin America, foundations targeted reproductive health as the leading cause for their support.

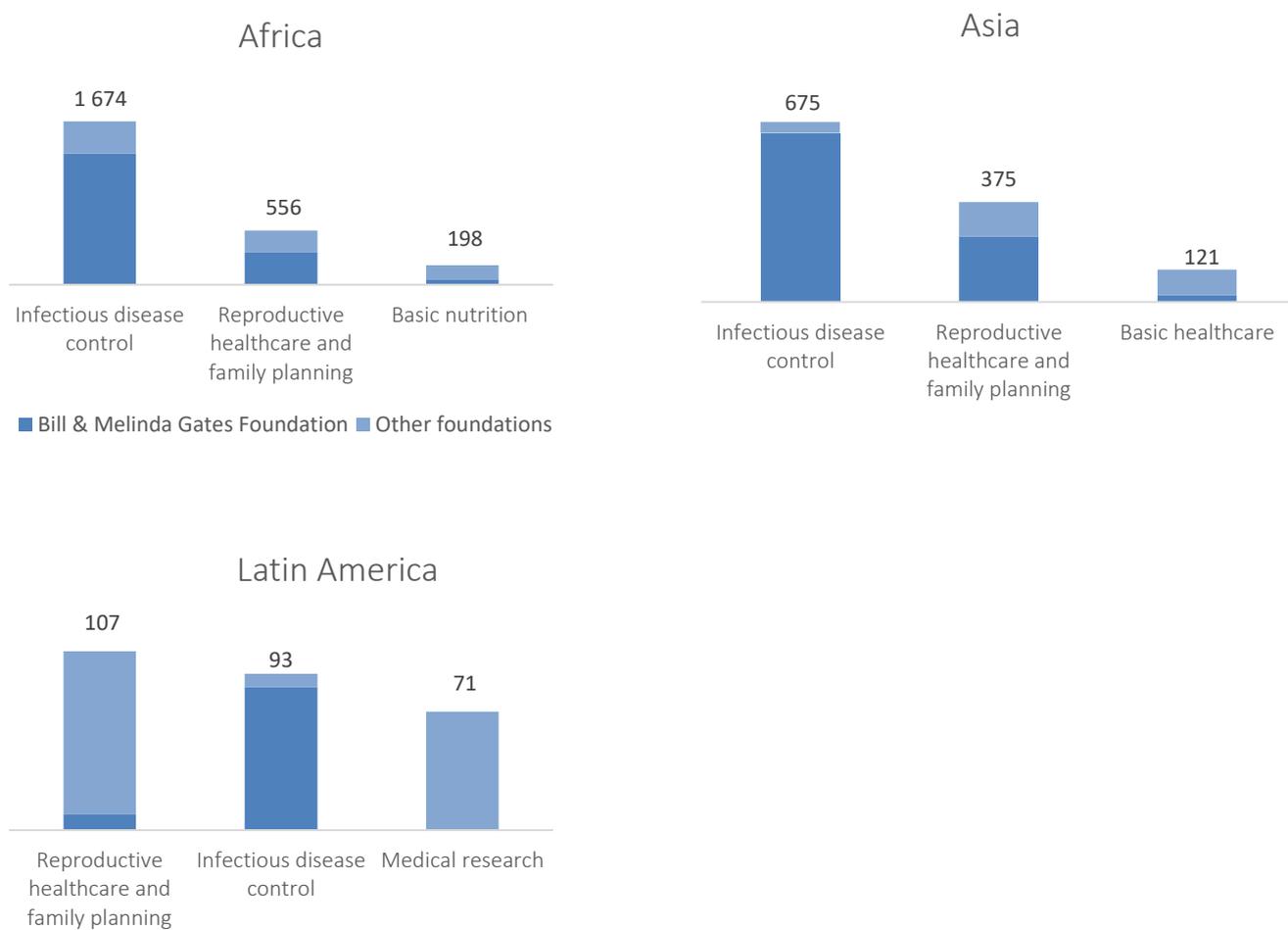
On average, 61% of total giving for health and reproductive health targeted infectious disease control<sup>3</sup> (USD 7.7 billion), followed by reproductive health and family planning (16%) and basic nutrition (5%). In Africa, foundations provided USD 1.7 billion to infectious disease control, followed by reproductive healthcare and family planning with USD 556 million and basic nutrition with USD 198 million. In Asia, foundations provided 675 million for infectious disease control, followed by reproductive healthcare and family planning (USD 375 million) and basic healthcare (USD 121 million). The giving pattern was different in Latin America, where reproductive healthcare and family planning ranked on top (Figure 2.5).

According to data on country-level giving for the top five recipients, most funding for India and Ethiopia targeted reproductive healthcare and family planning. India received USD 292 million for reproductive

<sup>3</sup> For this publication, infectious disease control refers to activities under the health sector (immunisation; prevention and control of infectious and parasite diseases, malaria, and tuberculosis) and population policies/programmes and reproductive health (sexually transmitted diseases, including HIV/AIDS).

healthcare and family planning (41% of total health-related giving for the country) and Ethiopia received USD 89 million (32% of total). In Nigeria and Pakistan, most funding went to infectious disease control, with an estimated USD 310 million in Nigeria (60% of total) and USD 170 million in Pakistan (81%). In Mexico, medical research was the leading cause financed, representing 40% of philanthropic funds for health and reproductive health.

Figure 2.5 Main health and reproductive health causes targeted by region 2013-15, USD million



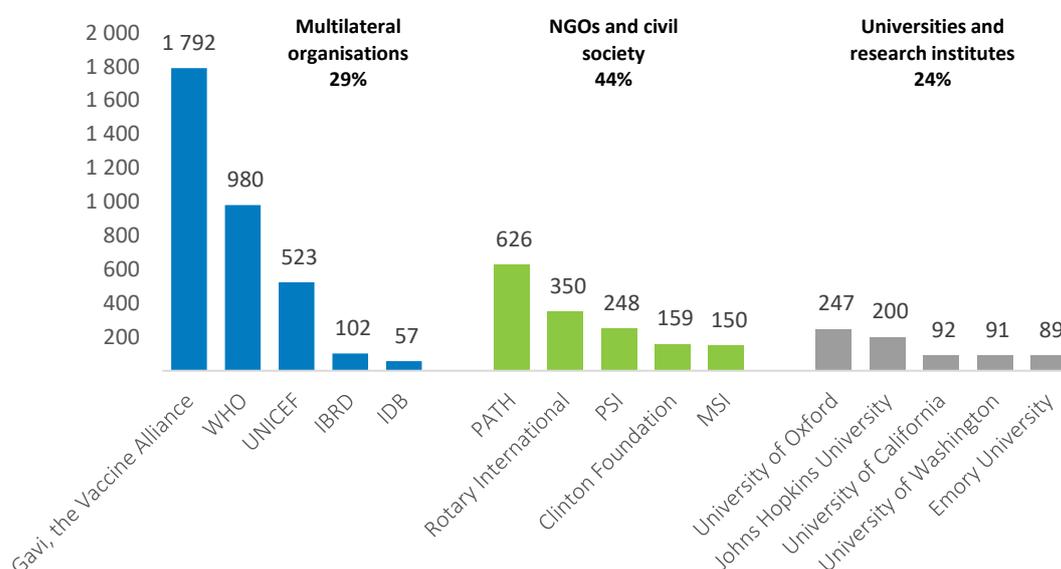
Source: OECD (2018b), *Survey on Private Philanthropy for Development 2013-15: Data Questionnaire*, [www.oecd.org/dac/financing-sustainable-development/development-finance-standards/beyond-oda-foundations.htm](http://www.oecd.org/dac/financing-sustainable-development/development-finance-standards/beyond-oda-foundations.htm)

## 2.4 CHANNELS AND MODALITIES OF GIVING

### *Most foundations use intermediaries to channel their funds for health and reproductive health*

Most foundations channelled their funds for health and reproductive health through intermediary organisations. Intermediaries comprised non-governmental organisations (NGOs) and civil society (44%); multilateral organisations (29%); and universities, research institutes and think tanks (24%) (Figure 2.6). They most often provided giving for health-related causes through earmarked contributions and project funding (USD 10.6 billion, or 84% of total giving for health), followed by core support (15%).

Figure 2.6 Leading channels of delivery for health and reproductive health giving, 2013-15, USD million



Note: Acronyms stand for World Health Organization (WHO), United Nations Children’s Fund (UNICEF), International Bank for Reconstruction and Development (IBRD), Islamic Development Bank (IDB), Population Services International (PSI) and Marie Stopes International (MSI).

Source: OECD (2018b), *Survey on Private Philanthropy for Development 2013-15: Data Questionnaire*,

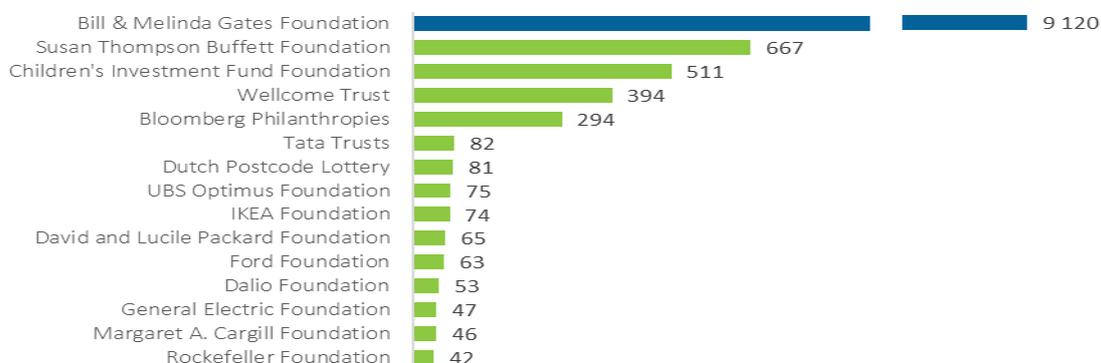
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## 2.5 TOP FOUNDATIONS IN HEALTH AND REPRODUCTIVE HEALTH

### *Five foundations provide 87% of funding in health and reproductive health sector*

The main funders in health and reproductive health include BMGF (72%), the Susan Thompson Foundation (5%), the Children’s Investment Fund Foundation (4%), Wellcome Trust (3%), and Bloomberg Philanthropies (2%) (Figure 2.7). Consistent with the geographical allocation of giving, the top 25 foundations targeted India (USD 679 million), Nigeria (USD 511 million), Ethiopia (USD 268 million), Pakistan (USD 208 million) and Mexico (USD 144 million).

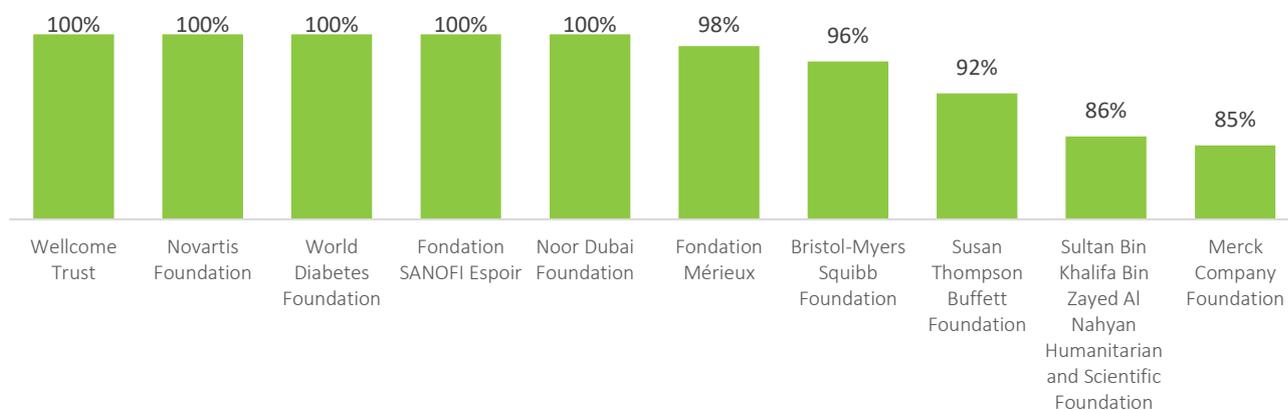
Figure 2.7 Top 15 foundations in health and reproductive health by total giving 2013-15, USD million



Source: OECD (2018b), *Survey on Private Philanthropy for Development 2013-15: Data Questionnaire*, [www.oecd.org/dac/financing-sustainable-development/development-finance-standards/beyond-oda-foundations.htm](http://www.oecd.org/dac/financing-sustainable-development/development-finance-standards/beyond-oda-foundations.htm)

Five foundations were entirely specialised on health and reproductive health, giving all of their support to this sector (Figure 2.8).

Figure 2.8 Top 10 foundations most focused on health in 2013-15, by their share of total giving

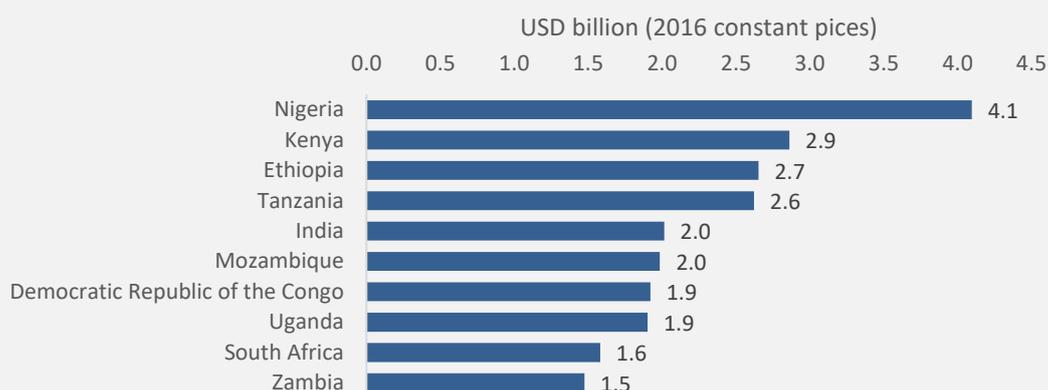


Source: OECD (2018b), *Survey on Private Philanthropy for Development 2013-15: Data Questionnaire*, [www.oecd.org/dac/financing-sustainable-development/development-finance-standards/beyond-oda-foundations.htm](http://www.oecd.org/dac/financing-sustainable-development/development-finance-standards/beyond-oda-foundations.htm)

## BOX 1. OFFICIAL DEVELOPMENT ASSISTANCE FOR HEALTH AND REPRODUCTIVE HEALTH

Between 2013-15, official development assistance (ODA) flows for health and reproductive health amounted to USD 66.6 billion (13% of total ODA).<sup>4</sup> Contrary to philanthropic giving, health and reproductive health were not the main sectors targeted by ODA. As with philanthropic flows, ODA for health and reproductive health targeted primarily African countries. Nigeria (USD 4.1 billion), Kenya (USD 2.9 billion) Ethiopia (USD 2.7 billion), and Tanzania (USD 2.6) were the top recipients.

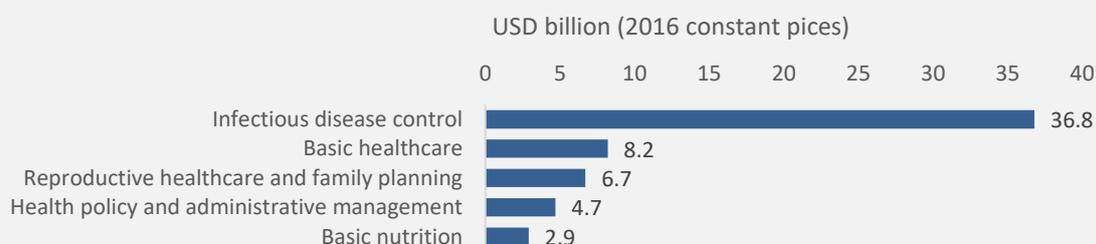
**Figure 2.9 ODA commitments for health and reproductive health by country 2013-15**



Source: OECD (2018c), *OECD International Development Statistics: Creditor Reporting System* (database), [www.oecd.org/dac/stats/idsonline.htm](http://www.oecd.org/dac/stats/idsonline.htm)

Similar to philanthropic giving, ODA flows for health and reproductive health targeted infectious disease control<sup>5</sup> (USD 36.8 billion), followed by basic healthcare (USD 8.2 billion).

**Figure 2.10 Main health and reproductive health causes targeted 2013-15, commitments**



Source: OECD (2018c), *OECD International Development Statistics: Creditor Reporting System* (database), [www.oecd.org/dac/stats/idsonline.htm](http://www.oecd.org/dac/stats/idsonline.htm)

<sup>4</sup> Official development assistance (ODA) is defined as those flows to countries and territories on the DAC List of ODA Recipients and to multilateral development institutions which are: i. provided by official agencies, including state and local governments, or by their executing agencies; and ii. Each transaction of which: a) is administered with the promotion of the economic development and welfare of developing countries as its main objective; and b) is concessional in character and conveys a grant element of at least 25% (calculated at a discount rate of 10 per cent). The figures presented here include flows from DAC countries, from multilateral organizations and from non-DAC countries.

<sup>5</sup> For this publication, infectious disease control refers to activities under the health sector (immunisation; prevention and control of infectious and parasite diseases, malaria, and tuberculosis) and population policies/programmes and reproductive health (sexually transmitted diseases, including HIV/AIDS).

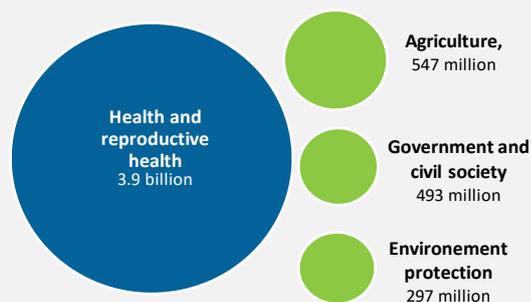
## BOX 2. PHILANTHROPIC GIVING FOR HEALTH IN 2017

Following the encouraging results of the survey covering the 2013-15 period, the OECD DCD is reaching out to the largest philanthropic foundations working for development to establish regular data-sharing partnerships. As a result, the OECD DAC statistics on development finance include 26 foundations that are reporting on their grant-making and programme-related investments on a regular basis.

The most recent round of data on 26 foundations in 2017 confirmed major trends unveiled by the 2013-15 data (OECD, 2019). Funding for development from participating foundations targeted primarily health and reproductive health, followed by agriculture, government and civil society, and environment protection. Health and reproductive health received USD 3.9 billion, or 55% of total giving by these foundations in all sectors (Figure 2.11).

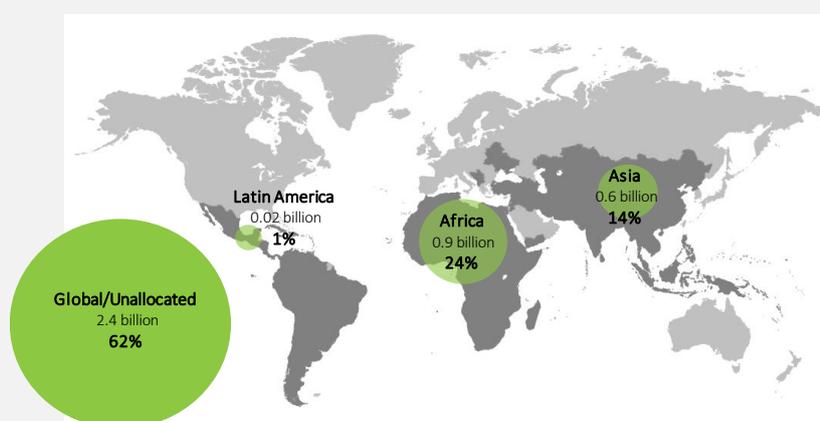
As with the 2013-15 data, the main receiving region of health-related giving was Africa. It received USD 0.9 billion, followed by Asia with USD 0.6 billion. The largest share of health-related giving (2.4 billion, or 62% of total) was allocated globally rather than to a specific region (Figure 2.12).

Figure 2.11 Philanthropic giving by sector, commitments, 2017, USD (current prices)



Source: OECD (2019), "Private philanthropy for development", *OECD International Development Statistics: Creditor Reporting System* (database), [www.oecd.org/dac/stats/idsonline.htm](http://www.oecd.org/dac/stats/idsonline.htm)

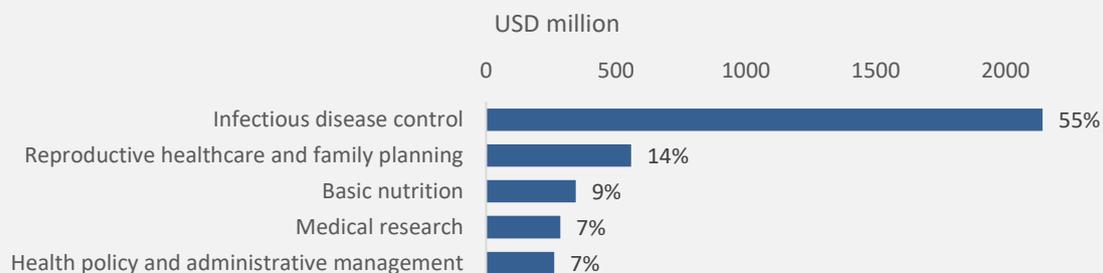
Figure 2.12 Health-related giving by region, 2017, commitments, USD (current prices)



Source: OECD (2019), "Private philanthropy for development", *OECD International Development Statistics: Creditor Reporting System* (database), [www.oecd.org/dac/stats/idsonline.htm](http://www.oecd.org/dac/stats/idsonline.htm)

In 2017, as in 2013-15, infectious disease control<sup>6</sup> was the leading cause targeted by health-related giving (USD 2.1 billion), followed by reproductive healthcare and family planning (USD 558 million) (Figure 2.13).

**Figure 2.13 Health-related giving, main causes funded, commitments, 2017 (current prices)**



Source: OECD (2019), "Private philanthropy for development", *OECD International Development Statistics: Creditor Reporting System* (database), [www.oecd.org/dac/stats/idsonline.htm](http://www.oecd.org/dac/stats/idsonline.htm)

<sup>6</sup> For this publication, infectious disease control refers to activities under the health sector (immunisation; prevention and control of infectious and parasite diseases, malaria, and tuberculosis) and population policies/programmes and reproductive health (sexually transmitted diseases, including HIV/AIDS).

### 3. HEALTH FINANCING AND DELIVERY

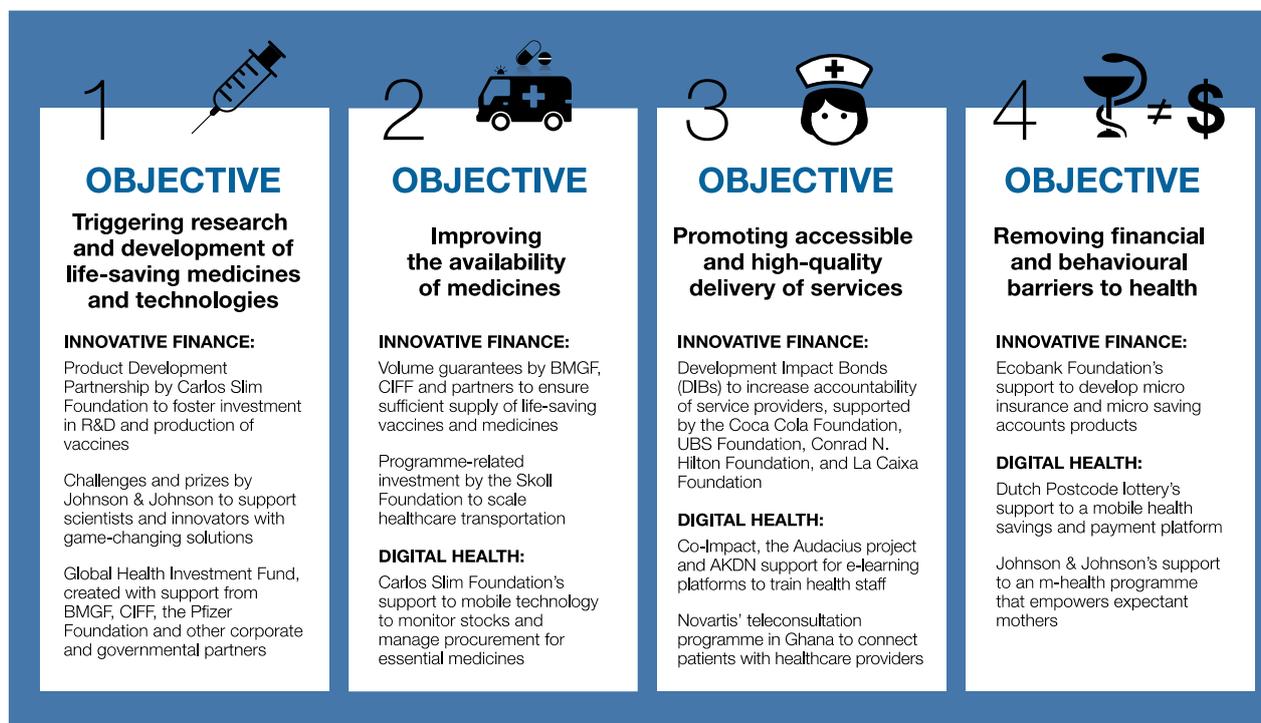
Philanthropy has taken a prominent role in addressing critical health concerns in developing countries. With contributions of USD 12.6 billion between 2013 and 2015, foundations ranked third in the leading sources of funding for health and reproductive health, just after the United States and the Global Fund to Fight AIDS, Tuberculosis and Malaria (OECD, 2018b).

However, the sheer scale and complexity of global health challenges are increasingly pushing foundations to explore less conventional ways of partnering, funding and implementing programmes on the ground. Innovative finance and digitalisation have steered philanthropy's experimentation in health, offering the promise to transform healthcare financing and delivery.

This chapter illustrates how foundations are using innovative finance and digital health to address critical deficiencies in healthcare coverage and quality in developing countries. Through a selection of case studies, it explores the potential advantages and challenges of these strategies. Specifically, it analyses how financial (the "how") and digital (the "what") innovations can help address four major challenges facing the entire sector along the health continuum:

1. *Underinvestment in research and development (R&D) for life-saving drugs and technology:* There is much need for additional funding for medical research on neglected tropical diseases, and other life-saving technologies. However, incentives for the private sector to do so are weak, as foreseen profits in low-income markets often do not offset costs.
2. *Lack or unreliable supply of medicines and health products:* Shortages and stock-outs of essential drugs and medical supplies are recurrent in developing countries, and counterfeit or substandard medicines frequently reach the shelves.
3. *Inaccessible and low-quality services:* Developing countries still face an acute shortage of qualified health workers and equipped healthcare facilities.
4. *Financial and behavioural barriers to health:* With limited or non-existent social protection schemes, many families still cannot afford the financial costs of essential care, or lack the information to adopt preventive and health-enhancing behaviours.

**Figure 3.1** Philanthropy’s use of innovative finance and digitalisation to improve healthcare: A selection of examples along the healthcare continuum



Source: Author.

### 3.1 INNOVATIVE FINANCE

#### *Innovative finance is multi-faceted*

There is no single definition of innovative finance (Box 3). In general terms, it comprises mechanisms to raise funds that supplement conventional philanthropic grants and ODA, that channel funds to recipient countries and that optimise use of those funds on the ground (Le Gargasson and Salomé, 2010; OECD, 2014; World Bank, n.d.).

Such mechanisms are not necessarily new. What makes them innovative is their deployment in a different context or with a different purpose. In this case, they aim to improve coverage and quality of healthcare in developing countries (Mundle and Davis Pluess, 2017).

#### *Innovative finance for health has evolved over decades*

Innovative finance for health has gained prominence over the past decades. Three highly successful initiatives attained a global scale: Gavi, the Vaccine Alliance; the Global Fund to Fight Aids, Tuberculosis and Malaria; and Unitaid. Through innovative financial mechanisms, these early pioneers pooled an unparalleled amount of resources from private and public sources to expand healthcare services and life-saving medicines in developing countries.

Since these early examples, a few philanthropic foundations have been instrumental in developing and testing new financial partnerships for health. Innovative financial instruments have helped stimulate R&D for neglected and tropical diseases, optimise resource management and spending on the ground, and remove financial barriers to healthcare.

### BOX 3 DEFINITIONS OF INNOVATIVE FINANCE FOR DEVELOPMENT<sup>7</sup>

OECD	<p>“Mechanisms for raising funds or stimulating actions in support of international development that go beyond traditional spending approaches and share the following characteristics: 1) official sector involvement; 2) cross-border transfer of resources to developing countries; 3) mobilise additional finance; and 4) are operational.”</p> <p><i>Development Co-operation Report 2014</i>  <i>Mobilising Resources for Sustainable Development, OECD 2014</i></p>
Leading Group on Innovative Financing for Development	<p>“It is a mechanism for raising funds for development. The mechanisms are complementary to official development assistance. They are also predictable and stable. They are closely linked to the idea of global public goods and aimed at correcting the negative effects of globalisation.”</p> <p><i>Leading Group on Innovative Financing for Development, FAQ</i></p>
World Bank	<p>Innovative finance aims to “generate additional development funds by tapping new funding sources (that is, by looking beyond conventional mechanisms such as budget outlays from established donors and bonds from traditional international financial institutions) or by engaging new partners (such as emerging donors and actors in the private sector). Enhance the efficiency of financial flows, by reducing delivery time and/or costs, especially for emergency needs and in crisis situations. Make financial flows more results-oriented by explicitly linking funding flows to measurable performance on the ground.”</p> <p><i>Innovative Finance for Development Solutions</i>  <i>Initiatives of the World Bank Group</i></p>

#### ***Innovative finance mobilises additional private investors by lowering risk...***

Foundations have used innovative finance to attract private investors with lower risk tolerance, and leverage finite philanthropic capital. By distributing risks across many actors, foundations have mobilised capital from private (and even purely commercial) investors who would not otherwise invest in global health or who would have done so in a more limited manner. Equally important, innovative financial mechanisms with a positive financial return have allowed foundations to reinvest the profits multiple times over the longer term, stretching the reach of limited philanthropic resources (Mundle and Davis Pluess, 2017).

<sup>7</sup> For a complete overview of definitions and key concepts relating to innovative finance, please refer to Heinrich-Fernandes M. (2019), “Donor engagement Innovative Finance: Opportunities and Obstacles”, Working Paper, *Donor Committee for Enterprise Development, Private Sector Engagement Working Group*.

For an in-depth analysis of some innovative financial mechanisms, including blended finance and social impact investment, please refer to OECD (2019), “Social Impact Investment 2019: The Impact Imperative for Sustainable Development”, *OECD Publishing, Paris*, <https://doi.org/10.1787/9789264311299-en>

*... and offers an array of benefits that go beyond fundraising*

The benefits of innovative finance may go far beyond resource mobilisation. Through innovative finance, foundations and their partners have created incentives for pharmaceutical companies, researchers and entrepreneurs to invest in neglected life-saving products and technologies in markets they would not normally target. In addition, foundations are experimenting with mechanisms such as pay-for-performance models to increase the accountability of how funds are spent, and encourage health providers to focus on measurable outcomes. Finally, new financial products, such as micro-insurance and health savings accounts, have been pivotal in expanding access to healthcare services for poor and marginalised populations (Box 4).

*Innovative finance in philanthropy has much room to grow*

Despite all these potential benefits, innovative finance is not widespread in philanthropy, with only a few family and corporate foundations leading the way. Within large foundations, innovative finance represents a small portion of total giving, and many financial mechanisms are at an experimental stage. For these reasons, information on the financial and social performance for many of these instruments is still limited.

**BOX 4. INNOVATIVE FINANCE INSTRUMENTS USED BY FOUNDATIONS IN HEALTH A NON-EXHAUSTIVE GLOSSARY**

**Product Development Partnerships (PDPs)** are public-private partnerships that engage academic research institutions and the pharmaceutical industry in R&D. Together, they develop vaccines, medicines and other treatments for tropical and neglected diseases affecting primarily the developing world. Some PDPs create separate organisations with their own laboratories and project management teams.

*Examples* include Medicine for Malaria Ventures, financed by corporate social responsibility (CSR) initiatives and foundations, including BMGF, ExxonMobil Foundation, Rockefeller Foundation, and Johnson & Johnson Corporate Citizenship Trust, and a *PDP to fight Chagas Disease* financed by Carlos Slim Foundation and in partnership with the Autonomous University of Yucatan (Mexico), the Baylor College of Medicine (Texas) and the Centre for Research and Advanced Studies of the National Polytechnic Institute (Mexico).

**Programme-related investments (PRI)** are investments (repayable grants, loans, equity investments or guarantees) below market rate, used by foundations to finance non-profits or for-profits working on charitable purposes.

*Examples* include the Skoll Foundation's PRI to scale up the work of Riders for Health, an international NGO, in the Gambia.

**Challenges and prizes** offer a competitive process for health scientists and innovators to receive grants to develop game-changing solutions to healthcare problems.

*Examples* include Johnson & Johnson's GenH Challenge, and BMGF and USAID's "Ensuring Effective Health Supply Chains: A Grand Challenge for Development".

**Volume guarantees** are binding contracts in which buyers commit to purchase large orders from medical suppliers over a period of time. Suppliers have a precise estimate of demand and can reduce costs through economies of scale.

*Examples* include the Contraceptive Implant Volume Guarantee, financed by CIFF, BMGF, SIDA and Norad.

**Social Impact Bonds (SIBs) and Development Impact Bonds (DIBs)** are a pay-for-performance mechanism. Investors provide capital to a service provider to cover the upfront and continuous cost of a programme. Government or donors subsequently repay investors with interest if the programme achieves a set of measurable and pre-defined

outcomes. Generally, an independent evaluator assesses outcomes. The difference between SIBs and DIBs lies in who pays for outcomes: In SIBs, government is the outcome payer, while in DIBs, outcomes are paid by donors.

*Examples* include the Mozambique Malaria Performance Bond, financed by the Coca Cola Foundation, Nando's and other multinational enterprises and the Utkrisht Impact Bond, in India, developed with upfront capital from the UBS Foundation.

**Investment Funds** often pool capital from investors with different risk profiles (including bilateral and multilateral donors, investment firms and corporations) to invest in market development or other health-related initiatives, such as health infrastructure.

*Examples* include the Global Health Investment Fund, created with support from BMGF, CIFF, the Pfizer Foundation, and other corporate and governmental partners.

**Financial inclusion products** are affordable financial products and services that reduce financial barriers to healthcare. They include micro-insurance and micro-saving accounts, vouchers, loans and mobile money.

*Examples* include micro-insurance and health-savings accounts developed with support from the Ecobank Foundation.

*Source:* Mundle and Davis Pluess, 2017, and author.

### 3.2 NOVEL PARTNERSHIPS TO ADDRESS CRITICAL HEALTH CHALLENGES

Foundations are using innovative finance to counter market failures along the health continuum. These failures include underinvestment in life-saving medicines and technologies, the shortage of essential medical supplies, weak accountability of fund recipients and financial barriers to healthcare. The following section illustrates how philanthropy is leading novel partnerships to build stronger and more accessible healthcare systems in the developing world.

#### 1. Enabling research and development of life-saving medicines and technologies

Through innovative finance, foundations have accelerated and scaled up the development of new life-saving treatments and technologies. Such is the case of **product development partnerships (PDPs)**, which aim to catalyse R&D for vaccines, medicines and other treatments for neglected diseases primarily affecting the developing world. For example, several foundations and CSR initiatives, including BMGF, ExxonMobil Foundation, Rockefeller Foundation, and Johnson & Johnson Corporate Citizenship Trust, contributed to Medicine for Malaria Ventures (MMV). MMV has assembled the largest portfolio of antimalarial R&D and developed six new life-saving medicines (Medicines for Malaria Venture, 2018).

Foundations can also support late-stage innovations through loans and equity. Such is the mission of The Global Health Investment Fund, which was created with support from BMGF, CIFF, the Pfizer Foundation and other corporate and governmental partners. The fund provides debt and equity to companies offering products that have both a potential impact on public health in developing countries and a high probability of commercialisation.

## BOX 5 FIGHTING CHAGAS DISEASE THROUGH INNOVATIVE FINANCE

Carlos Slim Foundation is using innovative finance to invest in treatment for neglected tropical diseases. The foundation signed a product development partnership with the Autonomous University of Yucatan, the Baylor College of Medicine, and the Centre for Research and Advanced Studies of the National Polytechnic Institute to develop new vaccines and strengthen national vaccination programmes. The partnership is deploying a vaccine to prevent the complications of Chagas disease.

Chagas disease, also known as the American trypanosomiasis, is endemic to the poorest regions of the American continent. It is mostly transmitted through triatomine insects, or “kissing bugs”, affecting an estimated 8 million people and leading to the death of 10 000 people every year. This disease is a major cause of heart disease in Latin America. One in four patients eventually develops Chagasic cardiopathy, a severe and particularly fatal cardiac condition.

The foundation is funding the development of the vaccine, and will hold a share of the patent and industrial property behind it. Once the vaccine is fully developed and tested, the foundation plans to develop an agreement with the government of Mexico to produce it at low cost, so that it can benefit a large share of the population. Next steps include two alternatives. The first option is creating a spinoff company through a PPP. The second option is to license the patent to a for-profit company securing its production and commercialisation at a very low cost; in this case, dividends or earnings from the sales will be used to fund new research.

*Source: Carlos Slim Foundation, n.d.*

Beyond clinical research, innovative finance in the form of **challenges and prizes** can provide catalytic seed funding to scientists and innovators working on promising healthcare ideas. Such is the case of Johnson & Johnson’s GenH Challenge, which rewards healthcare innovations with funding and expert support. Winning solutions include Khushi Baby, a digital necklace for babies that stores medical records and helps track child immunisations and mothers’ health, and NutMox, a peanut-butter flavoured amoxicillin that can treat pneumonia in young children.

## 2. Improving the availability of medicines

Foundations and ODA donors have been developing partnerships using innovative finance tools to improve availability of essential medical supplies.

For instance, CIFF, BMGF, SIDA and Norad created a **volume guarantee** of USD 409 million to purchase large volumes of contraceptive implants from Merck and Bayer AG (SIDA, 2015). This initiative is helping ensure affordable access to these implants in developing countries.

**Competitive challenges** can also be an effective way to spark innovation in health distribution networks. BMGF and USAID have launched a challenge that rewards innovators that bring forward novel approaches to strengthen health supply chains. Winning solutions include mobile applications to track stocks of medical

supplies and forecast demand, and initiatives to train local shopkeepers on how to deliver essential medicines in remote areas (BMGF, n.d.). While prizes and challenges provide catalytic funding, these ventures will likely require additional risk-tolerant growth capital before they can access commercial finance.

### 3. Promoting accessible and high-quality delivery of services

The delivery of high-quality healthcare services is rooted in the capacity and availability of qualified personnel, information systems to support healthcare management, and adequate infrastructure and equipment in health facilities. Foundations are leveraging innovative finance tools to support social enterprises, which offer a range of innovative, quality and affordable market-based healthcare solutions specifically targeted at people on low incomes.

Through a **programme-related investment**, for example, the Skoll Foundation granted vital credit support to scale up activities of Riders for Health in the Gambia. Riders for Health partners with governments to manage and maintain vehicles used to provide healthcare services in rural communities. Initially, Riders managed governments' fleets. Over time, however, for greater effectiveness and efficiency, the social enterprise sought to manage its own fleet and lease it to governments. The Skoll Foundation provided a credit guarantee, which helped Riders secure a USD 3.5 million loan from Nigerian GT bank.

With a dearth of impact-first investors<sup>8</sup> for healthcare delivery in Africa, philanthropy can provide catalytic patient capital for the development of affordable private healthcare in the region. Early stage **social enterprises** that are able to raise seed funding and support from incubators and accelerators generally have more trouble accessing the capital and skills they need to scale. The Sumerian Foundation, in partnership with Vitol Foundation aim to address this major market gap, by providing patient and flexible growth capital and the mentoring support these ventures need to scale in ways that are both socially impactful and financially sustainable (Box 6).

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<sup>8</sup> Impact investors have been divided into “financial-first” and “impact-first” investors to describe the motivational criteria of the capital providers. Impact-first investors may look for financial returns, but societal impact takes precedence. In contrast, for finance-first investors financial returns are the priority. OECD (2019), *“Social Impact Investment 2019: The Impact Imperative for Sustainable Development”*, provides a more detailed analysis of the spectrum of capital, ranging from traditional philanthropy to fully commercial investors.

## BOX 6. SUPPORTING INNOVATIVE SOCIAL ENTERPRISES

### Providing patient and flexible growth capital

Vitol Foundation has pledged conditional matching funding to support the Sumerian Foundation's African Healthcare facility pilot. This pilot provides capital and business skills mentoring to social enterprises offering quality and affordable healthcare services for low-income communities in East Africa. The financial instruments will be tailored to the specific needs of each social enterprise. They will include repayable or convertible grants, revenue-share instruments, long-term flexible loans and guarantees, among others. Initially focusing on Kenya, the Sumerian Foundation is conducting due diligence on potential investees based on their impact potential, managerial capacity, track record of market demand and growth potential. Shortlisted investees include a chain of medical centres in Nairobi, and a private network of clinics and hospitals.

However, foundations may encounter barriers when entering the innovative financial market. At the outset, the lack of a standardised definition of social enterprise to differentiate at first glance between a traditional NGO and a social enterprise or social business with cost recovery ambitions, obscures efforts to assess potential investees for eligibility. Compounding this, foundations may lack the networks to identify good investment opportunities, or the time or local skills to conduct detailed financial due diligence. In addition, foundations may not be familiar with the monitoring and reporting standards to assess both social and financial impact targets. Acknowledging this, Vitol Foundation partnered with the Sumerian Foundation so the latter could lead most of these processes. It built on the experience of Sumerian Partners, its sister philanthropy advisor and capital management company.

*Source:* Vitol Foundation, n.d.

### Blended finance to spur innovation

Salauno's purpose is to save the sight of Mexicans of all ages by improving access to eye care for the underserved through innovative approaches and models of collaboration.<sup>9</sup> Based on a blended financing approach, combining resources and investments from the private sector and philanthropy, Salauno has been able to launch and scale an outreach model for effective primary care prevention, detection and treatment of diabetic retinopathy. Screening services include other pathologies, implying high leverage to increase access to eye care for low-income populations.

During implementation, 900 urban outreach campaigns and 150 rural outreach campaigns across greater Mexico City were executed, screening more than 47 000 patients from low-income areas. Technology components were included by developing "Big Data" analysis tools to better understand DR detection patterns and patient adherence to treatment, and to continuously assess efficiency of the model. Multi-sector collaboration has been key to the project. Partnering with IMSS, the largest public provider of health services in Mexico, and Fundación BEST, one of the biggest stakeholders in private provision of healthcare through primary care centres, has permitted leveraging large-scale clinic networks, infrastructure and local capabilities.

*Source:* World Diabetes Foundation.

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<sup>9</sup> For more information visit [www.salauno.com.mx](http://www.salauno.com.mx), and [www.worlddiabetesfoundation.org](http://www.worlddiabetesfoundation.org)

Beyond innovative approaches to mobilise resources, innovative finance includes strategies to spend these resources more effectively on the ground. Philanthropy has been pivotal in the emergence of **Development Impact Bonds (DIBs)** for health, a pay-for-performance mechanism that rewards outcomes rather than inputs. DIBs transfer the risk from the funder (generally a government or donor) to the service provider and the investor, thereby creating incentives for a more effective and transparent deployment of funds.

Philanthropy has played a critical role in the very few early examples of health DIBs in Africa and Asia. In Mozambique, for example, the Coca Cola Foundation, Nando's and other multinational enterprises are the outcome funders of the Mozambique Malaria Performance Bond. In India, the UBS Foundation provided upfront capital for the Utkrisht Impact Bond, while in Cameroon, the Conrad N. Hilton Foundation, the Fred Hollows Foundation and Sightsavers will pay for the outcomes of the Cataract Development Impact Bond. Finally, La Caixa Foundation is among the outcomes funder for the first Humanitarian Impact Bond, aiming to improve physical rehabilitation services in three conflict-affected countries in Africa.

Even if these mechanisms are relatively new in the health space, they can be costly and take a long time to develop, limiting their potential use by smaller funders. For example, services provided under the Utkrisht Impact Bond started in 2018, more than two years after the feasibility study (USAID, 2017). In Cameroon, outcome funders provided USD 2 million for operational costs (Gustafsson-Wright et al., 2017), and an additional USD 800 000 to cover legal and transaction manager fees, among other set-up costs (Oroxom, Glassman and McDonald, 2018). Finally, most of these bonds were launched in 2017 with a duration of three to five years. Therefore, information on their social and financial performance is not yet available.

#### **4. Removing financial and behavioural barriers to health**

By supporting micro savings and micro insurance products, foundations can significantly increase access to healthcare.

With limited social protection schemes in many developing countries, the cost of medicines and treatment remains a substantial barrier to healthcare, particularly for the poorest and most marginalised households. Sudden disease can be economically distressing for the whole family, and healthcare fees often prevent access to essential treatment. Nearly half of the world population cannot access vital healthcare, and emergency health expenses push millions of families into extreme poverty (World Bank, 2017).

Collaborations between health professionals willing to design and expand financial health products and the banking and insurance sector can be difficult. The two parties do not always “speak the same language”. From their position at the intersection of philanthropy and banking and insurance services, corporate foundations can play a particularly important role to develop these products.

Ecobank Foundation, for example, translates requests from other parties in a language that can appeal to its colleagues in Ecobank. In this way, it fosters new collaborations for financial inclusion. In addition, by bringing together teams with expertise in public health and financial inclusion, the foundation has helped the bank think through how existing products or those in the pipeline can address the specific health needs of the poor (Box 7).

Similarly, MetLife Foundation builds on MetLife's experience as a financial services provider to advance financial inclusion among those at the bottom of the pyramid. For instance, the foundation partners with Verb, a social innovation platform, on a global competition to reward innovations that can enhance financial

inclusion in many sectors, including accident insurance for low-income households. As part of this programme, MetLife employees can volunteer to participate as judges or mentors.

#### **BOX 7. INNOVATIVE FINANCIAL PRODUCTS TO EXPAND ACCESS TO HEALTH**

Ecobank Foundation is collaborating with micro-savings providers and mobile money platforms to translate their needs into a value proposition for its colleagues at Ecobank.

For example, Ecobank is supporting the TriSave pilot project in Ghana – a savings account for birth preparedness that targets pregnant women. Over a period of 9 to 18 months, expectant mothers receive financial literacy lessons on the need for budgeting, savings and financial decision making. The programme also helps participants set savings targets every three months.

Ecobank Foundation is also collaborating with mPharma to provide Mutti, a flexible payment scheme. mPharma created Mutti to provide access to safe, affordable and sustainable healthcare without putting a strain on individuals and their families. Mutti introduces flexible payment plans so patients can buy needed medicines and treatment. With a MuttiCard and a mobile money wallet, Mutti allows patients to pay for medication in instalments over the course of their treatment. Ecobank will share its customer base to help Mutti expand in countries where it is active.

*Source:* Ecobank Foundation, n.d.

### **3.3 EXPANDING INNOVATIVE FINANCE – PRIORITIES FOR FOUNDATIONS**

While some pioneering foundations are experimenting with a diversity of new financial tools, this new approach has not yet gained strong traction in the overall philanthropic sector. Capacity and entry cost are oft-cited barriers.

Foundations' leadership and staff need to first understand how different innovative financial mechanisms work and how they can help fulfil their social mission. When would a grant be more effective than an investment? How can they complement each other? How should the foundation structure its teams to support these investments? How can foundations conduct due diligence to assess market-based solutions likely to grow without the risk of losing their social purpose? How will the foundation measure success and failure, and how will it weigh social vs. financial success?

Shifting from a grant making to an investment strategy requires new skills to scope for potential investees, conduct due diligence and structure financial mechanisms. For foundations, this may require upskilling their teams or outsourcing some of these processes, which can carry significant costs.

However, the potential for innovative finance to raise and better deploy funds for health is too important to go unnoticed. Foundations can engage in five different ways to further improve the understanding, design and ultimate performance of innovative financial mechanisms. These are described briefly below.

**Pilot new instruments:** Upfront, risk-tolerant funding is instrumental to develop, test and adapt emerging instruments that may prove to be game-changing solutions in the longer term. Philanthropy can provide early-stage funding to develop and run promising innovative financial mechanisms. This support can bridge the gap for mechanisms that do not yet have the necessary performance track to attract commercial investors. Philanthropy can also act as a broker of ideas between implementing partners and the private sector; this has been the case with some corporate foundations in the finance and insurance sectors.

**Mitigate risk:** Innovative financial mechanisms are more likely to mobilise private capital if they offer attractive returns and mitigated risks. Philanthropy can provide de-risking capital, such as in the form of equity, grants or guarantees that can cover for first losses, to improve the risk-return profile of innovative financial mechanisms and incite others to invest.

**Provide patient growth capital:** Philanthropy is free from the short-term constraints often faced by government funding, or business through market pressure. This enhances its ability to provide patient capital and support market-based healthcare solutions over the long term. In addition, foundations have the flexibility to fund relatively small enterprises that can have a transformational impact on health, yet that are too small to attract commercial investors.

**Facilitate peer learning:** Foundations can sponsor conferences, platforms or dialogues to discuss the strengths and drawbacks of different models. These events can highlight how foundations build internal capacity for financial due diligence, and how they streamline innovative finance into their giving strategies. They can also create a marketplace to spur new collaborations between philanthropy, private investors, entrepreneurs and health professionals.

**Support market enablers in developing countries:** Foundations can support capacity building for local impact investors, accelerators and incubators. The sustainability of innovative finance depends largely on the ability of local financing markets and intermediaries. Financial intermediaries (local banks) and capacity building intermediaries (accelerators and incubators) can play a central role in structuring financing models, managing funds in recipient countries and building the capacity of social enterprises in financial planning, governance and strategy development.

### 3.4 DIGITAL HEALTH

This section provides an overview of how foundations are supporting digital health; some of the potential benefits and challenges of these approaches; and how philanthropy can further leverage its impact in supporting digitalisation in the health sector.

#### *Healthcare can benefit from digital strategies*

Healthcare stands to gain significantly from digitalisation. The number of digital health products has doubled in the past five years in lower- and middle-income countries (LMICs). There are also more than 165 000 mobile applications for health services and demand from patients and providers is expanding.

Digital health, or e-health, encompasses all the uses of information and communication technologies (ICTs) in health. These include using digital devices to support health promotion and prevention among patients, monitor and train community health workers, and share information across the health system (OECD and IDB, 2016; World Bank, 2016).

The possible benefits of digital health are manifold. Digital health can help prevent stock-outs of essential medical supplies and control sales of counterfeit drugs. It can also facilitate collection of essential data to control and predict outbreaks, and to manage and plan healthcare delivery. In poorer countries, ICTs can expand the reach of often small numbers of trained healthcare workers, and provide distance courses and clinical decision support to less skilled personnel (World Bank, 2016). With chronic diseases requiring lifetime management and compliance with treatment, digital health can also facilitate personalised care and empower patients to manage their own health.<sup>10</sup>

#### BOX 8. EXAMPLES OF DIGITAL HEALTH

**Telehealth** is the remote provision of health services, using ICTs. Healthcare providers can interact with their patients in real time, or at different times (asynchronously), for example through email or voice recording. Telehealth can help expand access to healthcare, particularly to populations living in rural and remote areas where healthcare personnel and infrastructure are scarce or non-existent.

**mHealth** is the use of mobile devices – mobile phones, tablet computers and other wireless devices – in healthcare and public health. Examples of mHealth include text message appointment reminders and mobile-based performance dashboards for healthcare managers.

**Digital records** store patients' medical history and physicians' information in a digital form.

**E-learning for health**, which includes the use of ICTs for education and training, such as distance-training courses for healthcare providers.

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<sup>10</sup> For a comprehensive classification of digital health interventions and a broad overview of examples, see the World Health Organization (2018) "Classification of Digital Health Interventions, a shared language to describe the uses of digital technology for health", [www.who.int/reproductivehealth/publications/mhealth/classification-digital-health-interventions/en/](http://www.who.int/reproductivehealth/publications/mhealth/classification-digital-health-interventions/en/)

**Big data for health** refers to regularly or automatically collected datasets of an unprecedented size. It involves rapidly assimilating and merging data from diverse sources to improve health and health systems performance.

Source: WHO, 2016.

### 3.5 CASE STUDIES IN DIGITAL HEALTH

The examples below illustrate how foundations are supporting digital health initiatives that can lead to a more accessible and better quality healthcare system.

#### 1. Strengthening health product supply chains

As with innovative finance, **ICT tools** can avert stock-outs effectively, and prevent dangerous counterfeit medicines from reaching the shelves. These are relatively simple technologies, often used through mobile phones. They allow remote health centres or dispensaries to report stock levels and procure additional products.

The Carlos Slim Foundation developed Casalud, a comprehensive healthcare model that uses technology to manage and prevent non-communicable diseases (NCDs) in Mexico. The model harnesses technology to enhance every step in the healthcare continuum: from timely detection of the disease and precise diagnostics, to effective disease management in the longer term. To improve monitoring of NCD medicine supply chains, Casalud has introduced AbastoNET, an online information system to manage stocks of essential NCD medicines in primary health centres. This platform produces daily and monthly metrics on inventory and filled prescriptions, which are used by centre directors to inform their procurement plans. The foundation has worked closely with the government as a full-fledged partner rather than a mere donor. It developed Casalud's mHealth tools, including AbastoNET, helped the government deploy them, and created an online dashboard to monitor their results.<sup>11</sup>

#### 2. Promoting accessible and high-quality delivery of services

Digital health is a particularly promising solution to the human resource crisis. The shortfall of about 7.2 million healthcare workers – especially acute in remote and rural areas – is expected to soar to 12.9 million by 2035 (WHO, 2013). Although nearly half of the global population lives in rural areas, only 25% of physicians practise there (Agarwal et al., 2015).

Several philanthropies, including the Agha Khan Development Network, the Sanofi Espoir Foundation and the Novartis Foundation, have been championing e-learning and telemedicine in low-income countries (Box 9 and 10). Most recently, Co-Impact, a collaboration of philanthropists, began partnering with the Echo Institute in India to scale up a digital learning model for primary clinicians.

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<sup>11</sup>For a comprehensive case study on the Casalud Programme, refer to: McClellan Mark B. and Roberto Tapia Conyer "Mexico: Preventing chronic disease through innovative primary care models" Center for Health Policy at Brookings, April 2015

E-learning can empower community health workers with fewer qualifications to perform certain medical procedures in areas where fully trained doctors are scarce (Broadband Commission, 2018). In addition, health management information systems allow managers to supervise their teams, and mobile applications can provide diagnosis and treatment decision support to less qualified health staff. Similarly, telemedicine has expanded due to the ubiquity of mobile phones and other digital devices. This has helped curb the shortage of health workers in many isolated regions. Patients can consult a doctor remotely, and community health workers can receive real-time advice on diagnosis and treatments from specialists.

Although foundations support a diversity of e-health approaches to improve service delivery, recent “big bets” have focused on digital solutions targeting **community health workers**. For instance, the Audacious Project created by a coalition of philanthropic funders, has committed a USD 50 million matching grant to non-profit organisations Last Mile Health and Living Goods. This will help deploy 50 000 community health workers equipped and trained to use mobile health. They expect to reach 34 million people across six countries in East and West Africa by 2021. Funding partners include Elma Philanthropies, the Skoll Foundation, the MacArthur Foundation and BMGF, among others.

Foundations are also supporting the development of digital tools that improve healthcare governance through **better and timelier data** (Box 11). For example, the Aga Khan University (AKU) and the provincial government of Sindh, in Pakistan, developed *Teeko* – a mobile app and a web portal that monitors vaccinators and immunisation. Using GPS technology, *Teeko* offers real-time data on vaccinators’ field visits and on the number of children immunised. Based on the pilot’s success, the government adopted *Teeko*’s source code to develop its own application, *Tibbi*, which it will provide to all public health facilities of the province.

It is worth noting, however, that the benefits of data require further skills and investments. A well-functioning digital health information system needs skilled staff in informatics and technology, statistical analysis and epidemiology. It also entails that all staff in the information chain receive training and comply with their data entry. Compliance is indeed a major challenge: by facilitating monitoring, digitalisation may increase scrutiny on workers’ performance, which may in turn result in low adoption and in some cases sabotage (Labrique et al., 2018). Similarly, clinician resistance is recognised as a major barrier for implementation of digital information systems (Mechael et al., 2010).

Philanthropy is taking steps to address some of these challenges. The Cloudera Foundation, for example, is providing funding, software and technical support to Swiss NGO Terre des Hommes to improve use of data for the quality of healthcare in Burkina Faso. Through the Integrated e-Diagnostic Approach (leDA) project, Terre des Hommes provided computer tablets to hundreds of health facilities to improve diagnosis and treatment of preventable diseases for children under five. The foundation will help leDA apply predictive analytics and machine learning with the data collected by health professionals to improve the quality of care. It will also guide the Ministry of Health on how to spot health threats and improve allocation of resources to reduce child mortality and morbidity.

Another hallmark example is The Data for Health initiative, launched by Bloomberg Philanthropies and the Australian government, which aims to partner with governments from LMICs to help them collect and use more and better health data. Specifically, it brings together public health experts and governments to collect vital statistics and conduct public health surveys on risk factors for premature death. The USD 100 million initiative also improves governments’ ability to monitor health trends and plan public health interventions

at the national level. In Morocco and Zambia, for example, the initiative launched the first national mobile phone survey on risk factors for non-communicable disease.

## **BOX 9. EMPOWERING HEALTHCARE PROVIDERS THROUGH E-LEARNING**

### **Improving maternal and childhood healthcare**

In 1995, WHO and UNICEF developed the Integrated Management of Childhood Illness (IMCI) as a key strategy to improve child health. Since 2004, the Novartis Foundation for Sustainable Development has worked with WHO to develop the IMCI Computer Adaptation and Training Tool (ICATT). This e-learning platform aims to train healthcare professionals and facilitate adoption of WHO guidelines on maternal and childhood health issues. The ICATT platform can be adapted to specific national guidelines, context and language, and can be distributed through DVDs or USB sticks. With remote courses and shorter training times, ICATT can facilitate the scale-up of IMCI and lower training costs. Tanzania, Peru and Indonesia were pioneers in piloting the software, and today 12 additional countries are introducing this technology. Novartis Foundation and the University of Geneva are measuring the effectiveness of ICATT's distance-learning approach relative to traditional in-person training courses in Burkina Faso, Cameroon and Mali.

Similarly, the Sanofi Espoir Foundation funded PRECIS, a programme that uses blended learning (e-learning and tutoring) to train nurses and midwives in Côte d'Ivoire. Implemented by the non-profit AMREF, the programme has equipped e-learning centres with computers, and provided USB and 3G keys to students and tutors ensuring permanent access to the content of the online platform. PRECIS is implemented under the aegis of the West African Health Organization, and in accordance with its policy to harmonise training for health personnel in the region. National and local authorities are also closely involved in the design and delivery of the training curricula.

*Source:* Novartis Foundation, n.d., Sanofi Espoir Foundation, n.d.

### **Building clinical and managerial skills in underserved, marginalised regions of South-Central Asia**

Through its Digital Health Programme, the Aga Khan Development Network (AKDN) uses ICTs to increase access to quality health services in remote and rural regions of South-Central Asia. It uses telehealth and e-learning to empower both patients and healthcare providers. Its digital health programme focuses on building managerial and clinical skills of physicians, nurses and other health professionals. Today, the programme covers 41 health facilities across Afghanistan, Kyrgyz Republic, Pakistan, Tajikistan, Kenya and Tanzania.

AKDN has a Digital Health Resource Centre (AKDN dHRC) that supports the Digital Health Programme through customised training courses for healthcare providers, and R&D on low-cost digital health products. AKDN dHRC founded an Innovation Lab where engineers and developers design and test mHealth apps that can improve health outcomes in poor communities, and enhance the monitoring and accountability of healthcare personnel. AKDN co-funds many of its own programmes. However, it also directly delivers health and digital health services through its network of non-profit, private healthcare facilities. As a direct health service provider, the AKDN team has significant technical experience and a thorough understanding of the realities on the ground. This experience, mixed with its funding capacity, increases AKDN's ability to bring forward new digital health solutions.

*Source:* AKDN, n.d.

## BOX 10. SCALING TELEMEDICINE PROGRAMMES

### The need for strong local ownership: The Ghana Telemedicine Programme

As part of a broad partnership with government, mobile companies and academia, the Novartis Foundation launched a telemedicine pilot in Amansie West District, Ghana. Through ICTs, community health workers can reach experienced doctors, nurses and midwives around the clock for medical advice on diagnosis and treatment. With this support, they can handle emergency cases that would otherwise be too complex and avoid unnecessary hospital referrals.

After a successful pilot, the Ghana Health Service decided to scale up nationally. The Novartis Foundation worked with the Ghanaian government to set up and staff six teleconsultation centres across the country, reaching 6 million patients and avoiding 31% of unnecessary referrals. The programme is expected to reach national coverage by 2019. The success of the pilot and progressive roll-out lies to a large extent on the close involvement with government from the onset, the simplicity of the solution and its user-friendly approach.

*Source:* Novartis Foundation, n.d.

### The role of public-private partnerships: Chipatala cha pa Foni (CCPF) in Malawi

As part of a larger consortium, Vitol Foundation and Johnson & Johnson partnered with VillageReach to prepare the Chipatala cha pa Foni programme (CCPF, or Health Centre by Phone) to scale nationally in Malawi. Through CCPF, families in remote communities can use a toll-free telephone hotline to connect with trained health workers for information on a variety of health topics and medical referrals. Women and caregivers can also sign-up to receive personalised text or voice messages on maternal and child health, tailored to their due date or their child's age. In addition, CCPF for Adolescents focuses on HIV prevention through health services and information on sexual and reproductive health. Following a successful pilot implementation, Malawi's Ministry of Health decided to scale the programme nation-wide in 2015.

Public-private partnerships have been instrumental in creating a scalable and sustainable system. In 2016, CCPF partnered with Airtel, a leading mobile network operator. Airtel had previously launched a similar mHealth programme, Dial-a-Doc, that was merged with CCPF services to become Airtel CCPF. By joining forces with Airtel, CCPF has been able to reach Airtel's extensive base of subscribers across Malawi. CCPF has also reduced operational costs, as Airtel provides free airtime on its network. Besides Airtel, CCPF maintains partnerships with other mobile network operations that also provide the required technology and telecommunications services to deliver the programme. In 2019 CCPF implementation will transition to the Government of Malawi.

*Source:* Vitol Foundation, n.d.

### **BOX 11. PROMOTING BETTER AND TIMELIER DATA**

FHI Foundation's Catalyst Fund incubates innovations from FHI 360 staff, providing seed funding to tackle some of the most pressing development challenges. The M360 school information system, for example, comprises a series of mobile apps that capture education and health data from schools in remote or conflict-affected areas. It tracks students' study habits and factors influencing academic success, such as nutrition and sanitation facilities. The data are summarised and shared with upper administrative levels to inform decision making. More than 8 000 schools in Tanzania are currently using the m360 tool.

M360 is exploring opportunities in Guatemala for an epidemiological surveillance system with instant alerts. Through the app, nurses would report suspected diagnoses. If m360 detects approximately 30 suspicions of a disease, it would trigger an instant alert to all levels of the health system. This would avoid the current waiting period for an outbreak to be detected, which can span over a week or more. These data could also sync with education data (school attendance) for detections in the education system.

*Source:* FHI Foundation, n.d.

### **3. Financial and behavioural barriers to health**

Lack of distribution networks and high premium costs can put traditional financial services out of reach for those living in isolated or marginalised areas. The same is true for health insurance and savings accounts. The rapid proliferation of cell phones and mobile money, however, is paving the way for accessible financial services tailored to meet the financial needs of the poor, who often do not have health coverage.

In addition to financial access, encouraging health-promoting behaviours may prevent diseases and improve patients' compliance with treatment, avoiding future healthcare costs. Information on healthy lifestyles, reminders for treatment adherence and prevention campaigns to improve early detection of diseases all empower individuals to care for their own health and well-being on a continuous basis. ICTs – in the form of text messaging, websites, social networks and videos – offer a novel channel to raise awareness, and modify attitudes and behaviours.

Foundations have been promoting digital health programmes to address both financial and behavioural barriers to health in a variety of ways. These range from funding proof-of-concept pilots to providing direct support for technology and content development.

### **BOX 12. DIGITAL FINANCIAL SERVICES TO DEMOCRATISE ACCESS TO CARE**

Since 2012, the Dutch Postcode lottery has been supporting PharmAccess Foundation. Within its digital health portfolio, the foundation provides a mobile health savings and payment platform to underserved communities in Nigeria, Tanzania, Kenya and Namibia.

In Kenya, for example, the foundation introduced M-TIBA, a mobile wallet. It is easily accessible through mobile phones, enabling individuals to get insurance, save money and pay for healthcare services. Other funders, such as governments and foundations, can also channel resources directly to beneficiaries through M-TIBA.

*Source:* Dutch Postcode lottery, n.d.

Johnson & Johnson's MomConnect programme is another prime example of how simple mobile technology can empower patients on a large scale (See Box 13). This mHealth programme targeting mothers and their children has benefited more than 2 million women in less than four years. This represents more than 60% of eligible mothers in South Africa.

Although government ownership has been critical to achieve such an impressive scale, philanthropy played an important role in laying the foundations for the MomConnect programme. In 2011, Johnson & Johnson, the United States Agency for International Development (USAID), the mHealth Alliance, the United Nations Foundation and BabyCenter launched the Mobile Alliance for Maternal Action (MAMA). This programme sent text messages to future mothers on parenting and child development. Three years later, the South African Department of Health built upon the content, technology and partnerships of the MAMA programme to design MomConnect. In addition, MomConnect brings together a consortium of implementing and funding partners with previous experience in piloting similar mobile health programmes for maternal and child health. This experience was instrumental to integrate best practices into MomConnect from the onset, which are captured by the Principles for Digital Development.<sup>12</sup>

With MomConnect operating at scale, philanthropy has played a true complementary role. The South African government covers the programme's running cost, while foundations fund technology improvement and maintenance, as well as development of new content.<sup>13</sup>

### **BOX 13. DIGITAL TOOLS TO EMPOWER PATIENTS AND HEALTH PERSONNEL**

Despite great strides in maternal and child health in South Africa in the last decade, one out of three mothers has HIV. Maternal and infant mortality also remain unacceptably high. The South African National Department of Health, with Johnson & Johnson support, acted on a bold vision to address these issues through two key initiatives.

#### **MomConnect**

Launched in 2014, MomConnect is a first-of-its-kind, government-owned initiative to improve uptake and quality of care for mothers and their children in South Africa. Johnson & Johnson played an early, catalytic role through seed funding and content support by BabyCenter, and continues to provide funding and strategic input. MomConnect provides a mobile platform to improve the lives of moms and their babies.

When expectant mothers visit the clinic to confirm their pregnancies, a nurse helps them sign up to MomConnect on their mobile phones for free. This connects mothers automatically to the National Pregnancy Registry. Mothers receive targeted text messages with parenting advice and information on baby development, and can ask questions and give feedback via the same message platform.

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<sup>12</sup> <https://digitalprinciples.org/>

<sup>13</sup> For more information, see Barron, P. and A. LeFevre (2018), "Digital health in South Africa: The case of MomConnect: Past, present, and future", *BMJ Global Health*, Vol. 3 supplement 2, April.

## NurseConnect

Sitting at more than 25 000 users, NurseConnect is a companion programme to MomConnect for nurses and midwives. They receive valuable weekly SMS messages to support their clinical practice, provide motivation and encouragement, and share updates from the department – including recent messages on Listeriosis. Nurses can provide feedback, ask questions or submit compliments or complaints on their experiences in the workplace via a dedicated helpdesk.

MomConnect and NurseConnect are now available on WhatsApp rather than just SMS, enabling the use of images, icons and longer-form content for engagement that is richer, more immediate and more personal than ever before.

*Source:* Johnson & Johnson, n.d.

## The Community-based Hypertension Improvement Project

Often, digital solutions fulfil several functions simultaneously. For example, the Community-based Hypertension Improvement Project (ComHIP) in Ghana, funded by the Novartis Foundation and developed by FHI360 uses a mobile device that facilitates blood pressure screening of adults and enrolls hyper sensitive patients in care. It also enables healthcare providers at different nodes of the health system to track their interactions with patients. In addition, the system supports health staff in accessing relevant content, such as clinical guidelines. It transmits text messages to hypertension patients promoting healthy lifestyles and adherence to medication. And it aggregates data to generate reports in real time via a web-based application.

*Source:* FHI 360, n.d.

### 3.6 EXPANDING E-HEALTH: RECOMMENDATIONS FOR FOUNDATIONS

Philanthropic foundations can play an important role in expanding and improving digital health in resource-constrained settings. Some of the emerging good practices, which resemble principles of development for effectiveness of ODA, include the following:

**Align with other donors:** Philanthropic foundations and other bilateral and multilateral donors are aligning their funding strategies in the digital health space (Digital Investment Principles, n.d<sup>14</sup>). Foundations active in the digital health space can follow these principles to inform their investments in digital health. This entails favouring solutions that are in line both with national priorities, and with existing projects or concurrent investments, open source and interoperable with government systems. They should also be financially sustainable.

**Adopt a long-term vision:** Support to digital health requires a long-term engagement, from proof of concept to building sustainable digital health systems. Foundations can adopt longer funding cycles, to support and invest to cultivate tech-savvy leaders, and a digitally literate healthcare workforce.

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<sup>14</sup> <http://digitalinvestmentprinciples.org>

**Join forces with the private sector:** Public-private partnerships can be a powerful strategy to scale digital health solutions. ICT companies can contribute with equipment and infrastructure, technical expertise, insights into cutting-edge technologies and trends, and a broad customer base. Foundations have developed PPPs to ensure sustainability of digital health solutions beyond the grant period.

**Share with peers:** Foundations can participate in international communities of practice, like the Digital Impact Alliance and the Digital Health and Interoperability Working Group of the Data Collaborative. These groups gather philanthropic donors, multilateral agencies, governments and implementing organisations. Finally, foundations can encourage their grantees to systematically register their projects in the WHO Digital Health Atlas, which aims to support digital health co-ordination, documentation and planning.

## 4. CONCLUSION

Philanthropy's central role in tackling pressing health challenges in developing countries is irrefutable: foundations ranked as the third leading funder for health and reproductive health, just after the United States and the Global Fund to Fight AIDS, Tuberculosis and Malaria. However, significant financial gaps stand in the way of achieving SDG 3. These are compounded by the scope of the current global health challenges and the ill preparedness of many health systems to address them. Therefore, it is critical to understand how philanthropy is harnessing novel approaches to finance and deliver accessible and quality healthcare in developing countries. Drawing on insights from the first meeting of the netFWD's health working group, additional interviews and material from leading foundations, and OECD's data on Private Philanthropy for Development, **this policy note dives deeper into two novel approaches in philanthropy: innovative finance and digital health.**

**Innovative finance is not yet a widespread approach in philanthropy**, as foundations often do not have the capacity, experience or time to scope for potential investees, conduct due diligence and structure financial mechanisms. For some foundations, this may require upskilling their teams or outsourcing some of these processes, which can carry significant costs.

**However, pioneering foundations are using a number of innovative financial mechanisms to mobilise additional funds from new sources, invest in market-based healthcare providers and optimise the use of resources on the ground.** Through philanthropic capital, foundations are shouldering the initial risks of piloting new financial mechanisms and attracting private investors. Beyond mobilising resources, foundations are deploying innovative financial mechanisms to trigger R&D on life-saving treatments and improve the availability of essential medical supplies in low-income and remote settings. Foundations have also sparked innovations in health through challenges and prizes, and are supporting health social enterprises through patient growth capital. In addition, in some instances, foundations have catalysed new financial products for the poor by acting as a bridge between banking and insurance companies and health services providers.

**In digital health, leading foundations are investing their funds following two complementary approaches: "pilot-oriented philanthropy" and "impact-at-scale philanthropy".** Under the first approach, foundations are supporting and often directly developing digital health innovations and collaborating to deploy demonstration pilots. In addition, some foundations are also seeking to change healthcare systems at scale. To that end, they are collaborating with governments and other development actors to develop and widely deploy comprehensive models that harness technology to enhance every step in the healthcare continuum: from timely and precise diagnostics, to effective disease management in the longer term. The two approaches are complementary and often subsequent: the rapid pace of technology innovation opens the door to continually update and improve digital apps. Yet, the potential of digital innovations to sustainably transform healthcare delivery depends largely on government ownership and adoption within its existing systems and processes.

**Overall, harnessing novel approaches to finance and deliver healthcare requires long-term investments and close collaboration with the private sector.** Longer funding cycles would allow foundations to provide patient growth capital in support of promising market-based solutions. It could also help foundations invest in capacity building for local market enablers, and better support the emergence of a new cadre of tech-savvy leaders and a digitally-literate health workforce. In addition, private companies, including investment firms and mobile network operators, appear as essential partners to grow the pool of additional capital for health, and scale effective digital strategies.

**This policy note shed some light on these novel trends, yet important questions remain.** It appears that only a handful of foundations are implementing innovative financial ventures in health, and even fewer are openly learning from their experience. What is the sum of resources mobilised through unconventional financing strategies? How can investors better share information on the social and financial performance of innovative financial mechanisms for health? How can foundations address the obstacles they face in innovative finance?

Similarly, foundations active in digital health have shared more broadly the lessons learned in piloting and rolling out digital health solutions, but are there other key areas where philanthropy could invest to further support health-system strengthening through digitalisation? What are effective philanthropic approaches to strengthening the digital skills of government and health staff? Should foundations support government planning and co-ordination of digital health strategies? These questions were beyond the scope of the policy note, yet answering them will be essential for foundations to make smarter investments in support of high quality healthcare for all.

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## ANNEX A

### OECD data on private philanthropy for development

This policy note draws on results of the OECD Survey on Private Philanthropy for Development (2018b, 2019) by the OECD Development Co-operation Directorate (DCD) in co-operation with the OECD Development Centre.

#### Methodology 2013-15 data

The survey recorded information from the 147 largest philanthropies worldwide working for development during 2013-15. Data were collected between 2016-17 through two questionnaires:

- A data questionnaire collected activity-level (or project-level) data. These included data on geographic and sectoral allocation, financial instrument used, channels of delivery and modality of giving. The format and definitions used in the questionnaire were compliant with the OECD-DAC statistical standards to ensure comparability with ODA flows.
- A qualitative questionnaire with 24 multiple choice questions on foundations' activities, transparency and accountability practices and co-operation with other development actors.

The survey collected inputs from 143 foundations for the data questionnaire and 82 foundations for the qualitative questionnaire. Four foundations filled only the qualitative questionnaire due to capacity constraints or confidentiality concerns.

#### Methodology 2017 data

Building on the encouraging results of the survey covering the 2013-15 period, the OECD DCD has been reaching out to the largest philanthropic foundations working for development. The aim is to establish regular and sustainable data-sharing partnerships on their grant making and programme-related investments. As a result, in 2018, 22 new foundations started reporting to the OECD on a regular basis, which means the OECD DAC statistics on development finance now includes 26 foundations. This survey provides the main features of these foundations' activities in 2017.

#### Scope of the survey: Private philanthropic flows for development

A working definition of private philanthropic flows for development was developed for the OECD data questionnaire. This aimed to ensure comparability with OECD DAC statistics on development finance such as ODA, as well as to avoid double counting at the international level.

Private philanthropic flows for development refer to transactions from the private sector that aim primarily to promote the economic development and welfare of developing countries. They originate from foundations' own sources, notably endowment, donations from companies and individuals (including high net worth individuals and crowdfunding) and legacies, as well as income from royalties, investments (including government securities), dividends, lotteries and the like.

Following this definition, philanthropic activities funded by other philanthropic foundations or governments were out of scope. Furthermore, charitable giving from religious institutions was only included if aimed at supporting development and improving welfare.

For more information, see [www.oecd.org/dac/financing-sustainable-development/development-finance-standards/beyond-oda-foundations.htm](http://www.oecd.org/dac/financing-sustainable-development/development-finance-standards/beyond-oda-foundations.htm)

## Purpose definition of flows targeting health and reproductive health

### Basic health

**Basic healthcare:** Basic and primary healthcare programmes; paramedical and nursing care programmes; supply of drugs, medicines and vaccines related to basic healthcare; activities aimed at achieving universal health coverage.

**Basic health infrastructure:** District-level hospitals, clinics and dispensaries and related medical equipment; excluding specialised hospitals and clinics.

**Basic nutrition:** Micronutrient deficiency identification and supplementation; infant and young child feeding promotion, including exclusive breastfeeding; non-emergency management of acute malnutrition and other targeted feeding programmes (including complementary feeding); staple food fortification, including salt iodisation; nutritional status monitoring and national nutrition surveillance; research, capacity building, policy development, monitoring and evaluation in support of these interventions.

**Health education:** Information, education and training of the population for improving health knowledge and practices; public health and awareness campaigns; promotion of improved personal hygiene practices, including use of sanitation facilities and handwashing with soap.

**Health personnel development:** Training of health staff for basic healthcare services.

**Infectious disease control:** Immunisation; prevention and control of infectious and parasite diseases, except malaria, tuberculosis, HIV/AIDS and other STDs. It includes diarrheal diseases, vector-borne diseases (e.g. river blindness and guinea worm), viral diseases, mycosis, helminthiasis, zoonosis, diseases by other bacteria and viruses, pediculosis, etc.

**Malaria control:** Prevention and control of malaria.

**Tuberculosis control:** Immunisation, prevention and control of tuberculosis.

## Health, general

**Health policy and administrative management:** Health sector policy, planning and programmes; aid to health ministries, public health administration; institution capacity building and advice; medical insurance programmes, including health system strengthening and health governance; unspecified health activities.

**Medical education/training:** Medical education and training for tertiary-level services.

**Medical research:** General medical research (excluding basic health research and research for prevention and control of NCDs).

**Medical services:** Laboratories, specialised clinics and hospitals (including equipment and supplies); ambulances; dental services; medical rehabilitation. Excludes non-communicable diseases.

## Non-communicable diseases

**NCDs control, general:** Programmes for the prevention and control of NCDs which cannot be broken down into:

- **Control of harmful use of alcohol and drugs:** Prevention and reduction of harmful use of alcohol and psychoactive drugs; development, implementation, monitoring and evaluation of prevention and treatment strategies, programmes and interventions; early identification and management of health conditions caused by use of alcohol and drugs, excluding narcotics traffic control.
- **Other prevention and treatment of NCDs:** Population/individual measures to reduce exposure to unhealthy diets and physical inactivity and to strengthen capacity for prevention, early detection, treatment and sustained management of NCDs, including: Cardiovascular disease control: prevention, screening and treatment of cardiovascular diseases (including hypertension, hyperlipidaemia, ischaemic heart diseases, stroke, rheumatic heart disease, congenital heart disease, heart failure, etc.). Diabetes control: prevention, screening, diagnosis, treatment and management of complications from all types of diabetes. Exposure to physical inactivity: promotion of physical activity through supportive built environment (urban design, transport), sports, healthcare, schools and community programmes and mass media campaign. Exposure to unhealthy diet: programmes and interventions that promote healthy diet through reduced consumption of salt, sugar and fats and increased consumption of fruits and vegetables e.g. food reformulation, nutrient labelling, food taxes, marketing restriction on unhealthy foods, nutrition education and counselling, and settings-based interventions (schools, workplaces, villages, communities). Cancer control: prevention (including immunisation, HPV and HBV), early diagnosis (including pathology), screening, treatment (e.g. radiotherapy, chemotherapy, surgery) and palliative care for all types of cancers. Implementation, maintenance and improvement of cancer registries are also included. Chronic respiratory diseases: prevention, early diagnosis and treatment of chronic respiratory diseases, including asthma. Excludes: tobacco use control, control of harmful use of alcohol and drugs, research for the prevention and control of NCDs.
- **Promotion of mental health and well-being:** Promotion of programmes and interventions that support mental health and well-being resiliency; prevention, care and support to individuals vulnerable to suicide. Excluding treatment of addiction to tobacco, alcohol and drugs.

- **Research for prevention and control of NCDs:** Research to enhance understanding of NCDs, their risk factors, epidemiology, social determinants and economic impact; translational and implementation research to enhance operationalisation of cost-effective strategies to prevent and control NCDs; surveillance and monitoring of NCD mortality, morbidity, risk factor exposures, and national capacity to prevent and control NCDs.
- **Tobacco use control:** Population/individual measures and interventions to reduce all forms of tobacco use in any form. Includes activities related to implementation of the WHO Framework Convention on Tobacco Control, including specific high-impact demand reduction measures for effective tobacco control.

### Population policies/programmes and reproductive health

**Family planning:** Family planning services including counselling; information, education and communication activities; delivery of contraceptives; capacity building and training.

**Personnel development for population and reproductive health:** Education and training of health staff for population and reproductive health care services.

**Population policy and administrative management:** Population/development policies; census work, vital registration; demographic research/analysis; reproductive health research; unspecified population activities.

**Reproductive healthcare:** Promotion of reproductive health; prenatal and postnatal care, including delivery; prevention and treatment of infertility; prevention and management of consequences of abortion; safe motherhood activities.

**STD control, including HIV/AIDS:** All activities related to sexually transmitted diseases and HIV/AIDS control e.g. information, education and communication; testing; prevention; treatment, care.

For more information see: [www.oecd.org/dac/stats/purposecodessectorclassification.htm](http://www.oecd.org/dac/stats/purposecodessectorclassification.htm)

## Other key concepts and definitions

### Channels of delivery

Channels of delivery refer to the first implementing partner of foundation giving. This is the entity with implementing responsibility over the funds. It is normally linked to the extending agency by a contract or other binding agreement, and is directly accountable to it.

For more information, see paragraph 164 of [www.oecd.org/dac/financing-sustainable-development/development-finance-standards/DCDDAC\(2016\)3FINAL.pdf](http://www.oecd.org/dac/financing-sustainable-development/development-finance-standards/DCDDAC(2016)3FINAL.pdf) (OECD, 2018a).

### Country income group classification

Countries are structured, according to their income level as defined by the World Bank, in the following income group categories:

- Least developed countries (LDCs): a group established by the United Nations. To be classified as an LDC, a country's income, economic diversification and social development must fall below established thresholds.
- Other low-income countries (LICs): all non-LDCs with per capita gross national income (GNI) of USD 1 045 or less in 2013 (World Bank Atlas basis).
- Lower middle-income countries (LMICs): countries with GNI per capita (World Bank Atlas basis) between USD 1 046 and USD 4 125 in 2013. LDCs that are also LMICs are only shown as LDCs, not as LMICs.
- Upper middle-income countries (UMICs): countries with GNI per capita (World Bank Atlas basis) between USD 4 126 and USD 12 745 in 2013.

For more information, see <http://data.worldbank.org/news/2015-country-classifications> and [www.oecd.org/dac/stats/daclist.htm](http://www.oecd.org/dac/stats/daclist.htm).

### Official development assistance (ODA)

The DAC defines ODA as those flows to countries and territories on the [DAC List of ODA Recipients](#) and to [multilateral institutions](#) which are:

- i. provided by official agencies, including state and local governments, or by their executive agencies; and
- ii. each transaction of which:
  - a) is administered with the promotion of the economic development and welfare of developing countries as its main objective; and
  - b) is concessional in character and conveys a grant element of at least 25% (calculated at a rate of discount of 10%).

For more information, see [www.oecd.org/dac/financing-sustainable-development/development-finance-standards/officialdevelopmentassistancedefinitionandcoverage.htm](http://www.oecd.org/dac/financing-sustainable-development/development-finance-standards/officialdevelopmentassistancedefinitionandcoverage.htm).

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