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In the last months, we have seen a growing number of philanthropists and private foundations pledge their resources to control the COVID19 pandemic and ameliorate its impacts. From Jack Ma to Bill and Melinda Gates, from Dato Sri Tahir to Jack Dorsey and Zuckerberg, billionaires have acted to provide assistance.

Among the choir of praise for the 'generosity' of the planet's richest and their foundations, some have voiced critical remarks. Such amounts, no matter how staggering, are tiny when compared to the givers' fortunes; less wealthy individuals donate greater proportions of their incomes; donations are a fraction of public funding and official development aid (ODA); much of philanthropists' wealth is based on the exploitation of loopholes in the same economic system that is creating unprecedented inequities (as highlighted by this very pandemic); commitments do not necessarily results in actual donations or may just shift funds away from other programs; and taxes would be a more effective and fair method than reliance on gratuities out of accumulated wealth to fund social safety nets and public health.

Public discussion would also benefit from closer scrutiny of the effectiveness and strategic value of the approaches proposed. As we think about long-term responses beyond the immediate crisis, we may want to look back to now-forgotten initiatives. There is a history of strategic engagement with the prevention and control of emerging viruses, especially in East and Southeast Asia, from which we may learn about programs' strengths and shortcomings.

International foundations identified the risks associated with zoonotic infections quite early. In 1999, the Rockefeller Foundation began work in Southeast Asia–and later in Eastern and

Southern Africa–to monitor the emergence of new infectious diseases with pandemic potential. At the time, global preoccupation focused on HIV/AIDS, with attention to more familiar infectious diseases, such as tuberculosis, malaria and dengue concentrated in particular locations. Yet, experts and practitioners on the ground became concerned about the likelihood of new zoonotic outbreaks with transnational health and economic impacts disproportionately affecting the most vulnerable. It was argued that China and its surroundings could become a hotspot – owing to rapid market integration, increasing density and mobility of human and animal populations, wild animal trade and commercialisation of livestock. Responding to these concerns, the newly established regional office of the Rockefeller Foundation launched the Cross-Border Health (CBH) component of its 'Learning Across Boundaries in the Greater Mekong Sub-region (GMS)' program, integrating the surveillance work with grant-making on regional dynamics and their trans-national ramifications.

CBH granted an average of USD $2 million annually to GMS partners to build contextual knowledge and regional intervention capacity on transnational flows of diseases. It also funded advocacy of public health policies that would take into account gender and other societal structures. It stressed the needs of the less privileged, particularly migrants and ethnic minorities in mountainous border areas where infectious diseases are rife. Learning from the HIV epidemic, civil society groups were considered key stakeholders in building community resilience and it was stressed that mitigating fear and discrimination toward persons infected with, or affected by, infectious disease was crucial to control transmission. CBH's centre-piece was the establishment of an inter-governmental disease-control mechanism named Mekong Basin Disease Surveillance Consortium (MBDS) in time to play an important trust building role in the control of the SARS outbreak in 2002 and the avian influenza (H5N1) outbreak in 2003. Eventually, other funders joined forces in supporting MBDS and fostering inclusive health policies.

The SARS and H5N1 epidemics and their spread from China to Southeast Asia triggered a flurry of donor-supported initiatives in the region. The Asian Development Bank allocated a sizeable amount of resources in grant and loan funds to the governments of Cambodia, Laos, Myanmar and Vietnam to enhance health system responses to major public health threats. Significant resources, were also invested by bilateral donors – such as the now-defunct AusAID and USAid agencies—to strengthen animal health surveillance and routine detection in people, as well as tackling the socio-economic drivers of zoonotic diseases.

Over time, foundations and other grant-making institutions consistently supported collaborative transdisciplinary knowledge and institutional capacity building. In 2006, the Canadian International Development Research Centre (IDRC) launched the Asian Partnership on Emerging Infectious Diseases Research (APEIR), involving leading government, non-government and academic institutes in Southeast Asia and China. The network undertook policy-relevant research on emerging infectious diseases from an eco-health perspective, including on the thriving wildlife trade and its health, socio-economic and environmental impacts. Once it was recognised that wildlife has multiple functions and can be a source of protein for the poor, regulatory measures were argued for, rather than abstract bans –a finding that counters current frantic calls for the abolishment of wet markets, even those with no wild game.

Ten years after SARS and H5N1, this concentration of resources and approaches was recognised as having contributed to better preparedness and progress in achieving the core capacities required to detect and respond to emerging infectious diseases. The emergence of a shared concept of *One Health* (implying transdisciplinary collaboration between professionals in promoting human, animal and environmental health) was seen as significant progress towards a more comprehensive approach to zoonotic diseases. There was optimism that countries could work together to fill the missing gaps through closer cooperation.

Gradually, however, funding initiatives declined in value and intensity due to internal and external factors. A leadership transition at the Rockefeller Foundation led to the premature ending of the renamed Disease Surveillance Networks (DSN) Initiative and IDRC 's AIPER was impacted by the closing of the regional office in Singapore. Some donors decided, sometimes hastily, that the desired goals had been achieved. More generally, there was a reduction of international aid and, above all, a retrenchment from the social sector in favour of economic, infrastructure and technological investments. Some data suggests that, aside from a spike in funding for Ebola responses, health aid remained largely flat between 2010 and 2016 and declined thereafter.

This decline was even stronger in Southeast Asia, now regarded as ready to "graduate" from aid (growing inequities, persistent vulnerabilities, and unresolved development challenges notwithstanding). Some foundations left the area and those who stayed embraced a more technocratic agenda less responsive to socio-cultural and institutional contexts and less supportive of local organisations, especially civil society groups. Program interaction with China was also reduced, owing to polarised views, more restrictive rules for overseas foundations and the significant growth of Chinese foundations.

Priority setting favoured mother and child health, reproductive health, and the three high-priority communicable diseases (HIV, malaria and tuberculosis). There was a novel emphasis on non-communicable diseases (NCDs) due to their rise in Southeast Asia, and concern about the related increase in health expenditures lead to a focus on Universal Health Care (UHC). Much needed investments in health financing schemes, however, too often came at the cost of former programs to strengthen health services. The privatisation and marketisation of health care—pursued by governments and donors alike—weakened interest in public health provision.

With regards to infectious diseases, funding in the region became more narrowly targeted to malaria and to a lesser extent dengue fever and tuberculosis. Other sanitary emergencies caught global attention, from H1N1 in the US to the Ebola outbreak in Africa. As the impact of SARS and H5N1 had been contained, attention to Asia lessened. Experts had warned that the capacity to predict and identify biological threats remained essential, even if the memory of SARS was fading. They were largely ignored.

COVID-19 comes thus in the midst of an unfinished agenda and makes the promising investments of the early 2000s look like a missed opportunity. Despite the popularity of conspiracy theories, the emergence of a new virus in China linked to wild game is not a total surprise. For international philanthropy and aid (as for governments and other stakeholders), it may be worth reflecting on why we were unprepared.

Learning from the past to plan a 'better future' after COVID-19, health and health care ought to have greater relevance in international aid. While donor funding is a small part of global spending on health, it is still an important supplement to government and private resources in low and lower-middle income countries such as the majority of those in Southeast Asia. A return to higher levels is needed. An open discussion should begin on the efficiency of concentrating resources in a vertical approach for a particular disease rather than adopting a broad-based horizontal approach that builds the system's capacity to deal with a wider range of health problems and their underlying causes. As strong national health systems that act for the common (and not private) good have proven essential during the current crisis, governments and donors should invest in them without further delay.

Foundations and semi-public grant-making organisations provide comparatively small financial resources. Past experiences have shown, however, their capacity to be responsive to local needs, directly support home-grown initiatives and organisations to address them, invest in critical issues, and use their convening power to maximise impact. They have dared to try untested approaches and propose alternative visions. The question is whether today they are still positioned to provide strategic, bold and socially-engaged funding as they used to in the 1990s and early 2000s.

During that period, foundations' programs linked medical interventions to issues of equity, rights, socio-economic justice and governance systems and supported civil society groups to ensure more balanced and rights-based decisions. This integrated and transformative funding approach is extremely relevant today when COVID-19 is highlighting the urgency to address the profound divides and fragility of vulnerable groups and to ensure civic space while promoting health safety. After the shrinking of direct funding to civil society in the last decade, a U-turn in donor practices is needed to stop the ongoing financial undermining of the third sector.

Past programs also remind us that if geographical and disciplinary boundaries are to be overcome, we need to invest in building the capacity to do so. COVID-19 has shown that the trust fostered by previous programs has waned and countries will have to regain it in order to coordinate COVID-19 containment strategies and their repeal, and the sharing of expertise and resources. Future research and action further require changes in the sectoral allocation of funds and the recognition that applied science is intrinsically related to socio-cultural and political processes. As governments and donors race to find better treatment, a vaccine and technological data-science tools, we should recall that to contain this and future epidemics and address their root causes and impacts, funding social interventions is equally important. Doing so, philanthropy can seize the opportunity not only to overcome the COVID-19 crisis, but also to contribute to a more eco-sustainable and just future.

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