
GLOBAL FINANCING FACILITY
SUPPORTED BY WORLD BANK GROUP
COUNTRIES LEAD THE WAY:
DELIVERING ON THE GLOBAL PROMISE
OF BETTER HEALTH AND NUTRITION
2019-2020
ANNUAL REPORT

DIRECTOR'S LETTER

Muhammad Pate,
Director, Global Financing Facility

When I joined in 2019 as the Director of the Global Financing Facility for Women, Children and Adolescents (GFF), I couldn't have imagined that just one year later I would be writing to you with such alarm for the health and well-being of the world's population. It was just a year ago that world leaders and global health advocates gathered at the United Nations to reaffirm their commitments to achieving universal health coverage (UHC) by 2030 and scaling up investments in primary health care. A concerted years-long drive by governments and international partners had led to a 40 percent drop in maternal deaths in childbirth and a 46 percent drop in infant mortality rates. Many of us were feeling optimistic that this track record of progress combined with the renewed high-level of political priority for investing in health would translate into a decade of accelerated action toward the Global Goals.

Now, COVID-19 is unleashing substantial health, social and economic impacts in every corner of the globe. But it is the poorest countries and the most vulnerable communities around the world that stand to suffer the most from this protracted health crisis. The virus and its knock-on effects threaten to push as many as 100 million people into extreme poverty and reverse the hard-fought recent gains in reproductive, maternal, newborn, child and adolescent health and nutrition.

As of this writing, routine, essential health services for women, children and adolescents are being diverted and deprioritized, with a potentially devastating impact on health and equity. Recent monitoring and analysis from the GFF of more than 60,000 health facilities across 10 partner countries found substantial disruptions in vaccinations for young children, outpatient visits, care for pregnant women and new mothers, and safe deliveries by skilled health workers.

"COVID-19 IS DISRUPTING ESSENTIAL, LIFESAVING HEALTH SERVICES FOR WOMEN, CHILDREN AND ADOLESCENTS, WITH A POTENTIALLY DEVASTATING IMPACT ON HEALTH AND EQUITY."

Prior to the onset of the COVID-19 pandemic, as this annual report shows, the countries where the GFF partnership has been in place the longest were showing significant improvements in access to quality, affordable health services, as well as progress on critical indicators for reducing maternal and child mortality and improving nutrition. More children were receiving the needed immunizations and nutrition. More women were giving birth safely and accessing the lifesaving services needed before and after childbirth. And more women were able to access family planning services that help pave the way for healthier families and stronger economies. But this global progress is now in grave peril: As the 2020 Goalkeepers report said, the world was set back about 25 years in 25 weeks — and the end of the pandemic is not near.

This report confirms that the GFF's collaborative, country-led approach in its 36 partner countries has been working, and it shows what's at stake if we don't act urgently to protect these lifesaving, life-changing gains. For example, in Afghanistan, contraceptive protection increased by 55 percent and 36 percent more women attended postnatal visits. In Rwanda, tackling childhood development across sectors has resulted in 3.15 million children being screened for malnutrition. And in Ethiopia, community health insurance was expanded to cover 28 percent of the population, which resulted in greater use of health services for those insured and helped lessen the financial burden for families.

In the wake of COVID-19, the GFF's reason for being – to keep a laser focus on accelerating progress on reproductive, maternal, newborn, child and adolescent health and nutrition outcomes in the world's poorest countries and among the most vulnerable populations within these countries – is more critical than ever. By empowering countries to lead and enabling global health partners to achieve more working together, the GFF provides the catalytic platform the world needs to protect recent health gains, ensure countries can continue to deliver essential health and nutrition services during the pandemic, and support them to get back on track as quickly as possible.

"THE GFF IS PRIMED AND READY TO ENSURE THAT THE WORLD'S MOST VULNERABLE WOMEN, CHILDREN AND ADOLESCENTS ARE NOT LEFT BEHIND."

The GFF is primed and ready to ensure that the world's most vulnerable women, children and adolescents are not left behind. We are humbled to stand side-by-side with our country partners on the frontlines of this challenge, working closely with our global partners in the World Bank Group, the United Nations, bilateral donors, foundations, civil society and business, to build back better. Now is the time for all of us to double down on our shared commitment: To ensure the world is solidly on the path to realizing the goal that every woman, child, and adolescent — everywhere — can access the essential, quality, affordable health care they need to survive and thrive.

Muhammad Ali Pate,
Director, Global Financing Facility
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1818 H Street NW. Washington DC 20433

Telephone: 202-473-1000

Website: www.globalfinancingfacility.org

World Bank Publications
The World Bank Group
1818 H Street NW, Washington, DC 20433, USA
Fax: 202-522-2625
Email: pubrights@worldbank.org

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PRIORITIZING THE HEALTH NEEDS OF WOMEN, CHILDREN AND ADOLESCENTS

Five years ago in Addis Ababa, global leaders launched the Global Financing Facility for Women, Children and Adolescents (GFF) to help the world's poorest countries step up progress on reducing maternal and child mortality.

The GFF has pioneered a shift from traditional development approaches to a more sustainable way forward where governments lead and bring their global partners together to support prioritized, costed national plans. This approach has catalyzed high-impact investments for reproductive, maternal, newborn, child and adolescent health and nutrition in the world's most vulnerable countries.

By the end of 2019, the GFF's collaborative, country-led approach had already begun yielding significant dividends in improving the health of women, adolescents and children and helping close global health equity gaps. With support from donors, the GFF rapidly expanded nine-fold to 36 partner countries from just four in 2015. As of June 2020, the GFF had directly invested about US$602 million in grants linked to approximately $4.7 billion of World Bank IDA/IBRD financing and helped align much larger volumes of domestic and external financing in support of GFF partner country investment cases.

In the countries where the GFF partnership has been in place the longest, there have been significant improvements in access to quality health services for women, children and adolescents. For example, in Ethiopia, community health insurance was expanded to cover 28 percent of the population in 2019, which resulted in significantly greater use of health services for those insured and contributed to reducing the share of out-of-pocket expenditures from 34 to 30 percent. In just three years, the government of the Democratic Republic of Congo (DRC) increased domestic resources for health from 7 to 10 percent of the country's total budget, which has helped to expand service coverage and health outcomes in key areas.

Yet, these and other gains achieved over the past five years are now threatened by the worst global public health crisis in a century. COVID-19 has dealt a devastating blow to GFF partner countries, causing severe health and economic hardship and upending the lives of hundreds of millions of people. Women and girls are facing increased gender-based violence due to lockdowns, job losses, lack of social protection, school closures, increases in unpaid care and loss of access to sexual and reproductive health services.

Disruptions to essential health services and patient reluctance to seek care for fear of COVID-19 infection are putting women and children at higher risk of dying or enduring lifelong health problems. Recent analysis from the GFF confirms these disruptions in many lower-income countries, with childhood vaccination coverage and outpatient consultations hit particularly hard. For example, in Liberia childhood vaccination dropped by 32 percent and outpatient consultations fell in all countries monitored. Family planning, antenatal and child delivery services were also impacted. In Nigeria, women seeking medical care during pregnancy fell by 16 percent. As a result, many women were at greater risk of complications or death from pregnancy.

The GFF Response to COVID-19

Even before the pandemic, progress to improve the health and lives of women, children, and adolescents was still too slow. Over five million women and children were still dying every year to preventable or treatable diseases such as malaria and pneumonia. More than 800 women and adolescent girls were dying every day from preventable reasons associated with pregnancy, childbirth and lack of access to reproductive health care (WHO).

Now, COVID-19 has laid bare the fragility of health systems across the globe — and how quickly essential health services for women, children and adolescents can be interrupted or discontinued when already weak health systems are put under stress.

The GFF sounded the alarm early in the pandemic about the potentially devastating impacts from secondary health crises due to these anticipated disruptions in essential health services. In addition to this early advocacy, the GFF quickly pivoted to support its 36 partner countries to prioritize and use their additional World Bank financing and other donor resources more effectively, generate innovative solutions and support real-time, peer-to-peer country knowledge sharing on what's working. For example, in DRC, the GFF and partners helped the government to conduct resource mapping and expenditure tracking to understand how much funding was being diverted from essential services. In Myanmar, a GFF grant linked to a World Bank project helped the government engage private sector health service providers to step up delivery of quality primary care services to the most vulnerable populations affected by the pandemic.

To respond to supply side disruptions, the GFF supported partner countries to increase the provision of commodities and crucial protective equipment for health workers on the frontlines. For example, through a partnership with the International Finance Corporation (IFC), the GFF developed blended finance solutions to expand partner country access to personal protective equipment (PPE), oxygen and other lifesaving frontline health commodities.

In collaboration with global partners, the GFF has invested in data and analytics to regularly monitor service delivery disruptions and bottlenecks to help countries make evidence-based decisions on policy, programming and resource allocation. In a joint effort with the Reproductive Health Supplies Coalition and Avenir Health, the GFF produced a modeling too l to help countries understand and mitigate the effect of COVID-19 on contraceptives. The tool estimates that as many as 26 million women could lose access to family planning in GFF's 36 partner countries from the pandemic, leading to nearly 8 million unintended pregnancies.

In the early days of the pandemic, GFF also quickly mobilized a virtual learning exchange program so countries could share lessons in real time on how to adapt service delivery. Through this platform, some participating countries improved measures to provide services while maintaining social distancing, while others enhanced the use of mobile technology to facilitate telemedicine, and others reflected on how to better use and integrate community health workers to strengthen continuity of services.

Supporting GFF partner countries to navigate the impacts from COVID-19 will continue to be a top priority for the GFF. The results highlighted in this annual report reflect a period prior to the onset of the pandemic and only underscore the urgent need to protect these gains and double down on efforts to accelerate health outcomes for women, children and adolescents in the world's most vulnerable countries and communities.

HOW THE GFF DRIVES SUSTAINABLE CHANGE

The GFF's logic framework and theory of change serves as a roadmap to guide how to affect and measure sustainable change in each GFF partner country. The framework provides the basis for centralized data collection and results reporting and shows how GFF-supported investments and activities have contributed to better health indicators for women and newborns over time. At the framework's core lies the development and implementation of a government-led and costed national investment case. The investment case outlines the pathway for scaling up access to a basic package of essential health services as well as the critical financing and system reforms required to accelerate progress toward universal health coverage.

Through a formal group of diverse stakeholders, referred to as the country platform, the GFF supports governments in aligning the financial and technical support of donors and partners with the national investment case priorities. By using results-based approaches, the GFF enables countries to improve service delivery quality while building better data and expenditure tracking systems that drive accountability for results.

Driving Better Health and Nutrition Outcomes

Over the past few years, most GFF partner countries experienced positive trends in reducing deaths of children below the age of five, lowering adolescent pregnancy rates and improving child growth indicators. Indicators for reducing maternal and newborn deaths have also improved. Following is a summary of these GFF-powered country results as of the end of 2019.

GFF-supported investments and activities have contributed to better health for women and newborns.

– Major improvements are seen in indicators for reducing maternal and newborn deaths, including the use of skilled birth attendants and facility-based births as well as prenatal care. For example, in Liberia, the percentage of facility-based deliveries increased from 56 percent in 2013 to 80 percent in 2019 (DHS).

– Nearly all GFF partner countries reporting on prenatal care indicators showed improvements. Tanzania, for example, nearly doubled its coverage of four prenatal care visits from 36 percent in 2016 to 80 percent in 2019 (DHIS2).

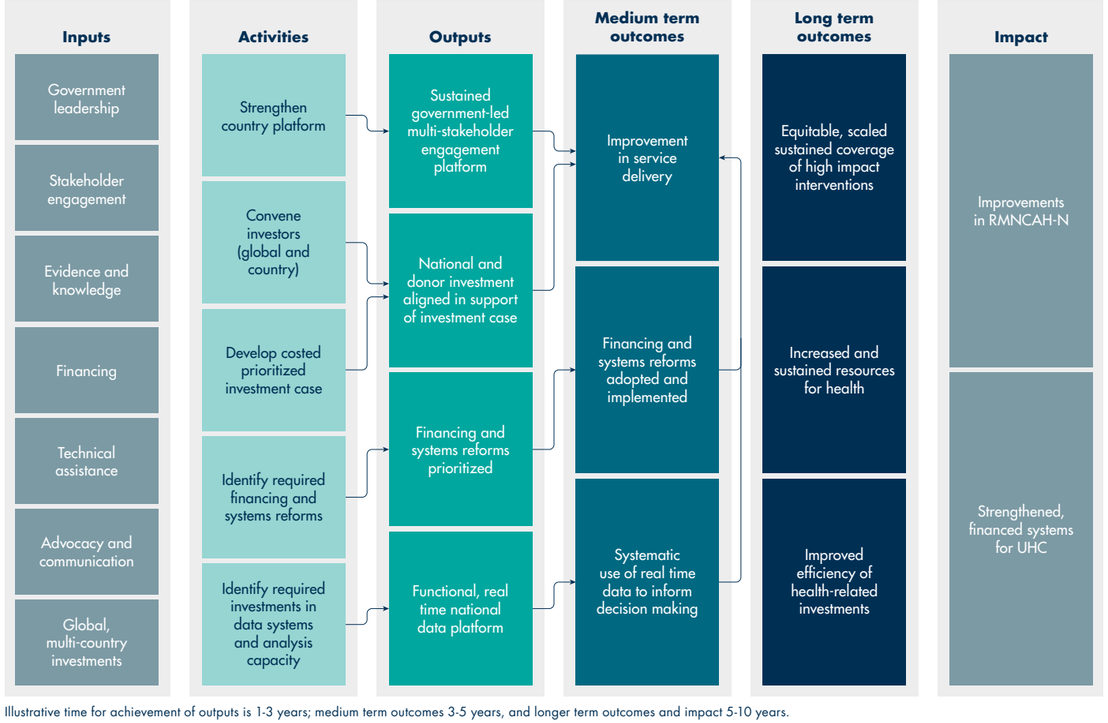
– Similarly, nearly all countries reporting on postnatal care in 2019 showed improvements; for example, in Afghanistan, the number of women receiving postnatal care within 24 hours increased by 37 percent between 2017 and 2019 (MoPH).

– Most countries that prioritized provision of sexual and reproductive health (SRH) services experienced improved SRH indicators. For example, from 2016 to 2019, couple-years protection (CYP) — which estimates the protection from pregnancy provided by contraceptive methods during a one-year period — improved in Uganda by 44 percent (HMIS).

Child nutrition and immunization coverage have improved considerably in GFF-supported countries.

– The majority of the 10 GFF partner countries providing statistics on nutrition indicators showed marked improvements. For example, Ethiopia showed an improvement in growth monitoring from 38 percent in 2016 to 54 percent in 2019 (MoH annual progress report). In Indonesia, the percentage of households with children under two with access to improved

Figure 1. **GFF's Logic Framework and Theory of Change**



Illustrative time for achievement of outputs is 1-3 years; medium term outcomes 3-5 years, and longer term outcomes and impact 5-10 years.

drinking water increased from 65.3 percent to 69 percent between 2017 and 2019 in priority districts (SUSENAS).

– All GFF partner countries reporting data on immunization showed improvements (except for Uganda, which already reported higher than 90 percent pentavalent-3 vaccination from 2016 onward). For example, in the priority northeastern states of Nigeria, where GFF has focused its efforts, the pentavalent-3 vaccination rate increased from 28 percent in 2016 to 49 percent in 2019 (NHMIS).

In those countries where the GFF has been engaged longest, there are positive trends in reducing under-five mortality, lowering adolescent pregnancy rates and improving child growth.

– Nine partner countries with effective GFF operations for more than three years — Bangladesh, Cameroon, Democratic Republic of Congo, Ethiopia, Kenya, Liberia, Nigeria, Tanzania, and Uganda — have shown progress in under-five mortality and child growth. In the last five years, these countries also experienced substantial improvements in child stunting and wasting. Adolescent pregnancies declined in most of these countries, and family planning coverage continued to increase. Maternal mortality appears to be declining, although lack of recent data makes it difficult to measure.

IN THE COUNTRIES WHERE THE GFF PARTNERSHIP HAS BEEN IN PLACE THE LONGEST, THERE HAVE BEEN SIGNIFICANT IMPROVEMENTS IN ACCESS TO QUALITY HEALTH SERVICES FOR WOMEN, CHILDREN AND ADOLESCENTS.

Selected Country Results

Rwanda

3.15 million children have undergone screening for malnutrition by community health workers in 2019. The number of newborns breastfed within the hour following birth increased by 15% from 2018 to 2019.

Ethiopia

Community health insurance was expanded to cover 28% of the population in 2019. This has resulted in significantly greater use of health services for those insured and contributed to reducing the share of out-of-pocket payments from 34% to 30%.

Afghanistan

Transforming service delivery through NGOs led to greater efficiency and expanded health services. This contributed to a 55% increase in contraceptive protection (CYPs) and 36% more women receiving postnatal visits.

Burkina Faso

A revised investment case is helping to expand access to services for women, children and adolescents in conflict-affected areas through building more resilient community health systems.

Senegal

Increasing budget efficiency from 80.5% in 2017 to 93% in 2019 has helped improve most maternal health indicators. Deliveries in health facilities increased from 78% to 82% and assisted deliveries rose from 68% to 74%.

Liberia

Resources focused in six counties with the lowest outcomes. The number of women attending postnatal visits increased six-fold in those counties, narrowing the equity gap. Nationally, 20% more children were immunized and assisted deliveries rose by 24%.

Nigeria

A focus on closing equity gaps especially in conflict-affected regions in the north helped improve access to child health services between 2016 and 2019: 41% more children were fully immunized and pentavalent 3 coverage increased from 73% to 88%.

Democratic Republic of Congo

Budget allocated to health jumped from 7% to 10% in 2019, exceeding the initial target. This has helped to improve service coverage and health outcomes in several key areas.

Tanzania

Direct financing to health facilities helped improve quality and access to services, and expand coverage of maternal health interventions. From 2018 to 2019, women attending four antenatal care visits increased from 64% to 81% and iron and folic acid supplementation increased from 76% to 84%.

Mozambique

As a result of the prioritization in the investment case, service delivery was expanded. The number of women attending four antenatal care visits rose from 42% to 53% and deliveries in health facilities increased by 10% from 2017 to 2019.

Kenya

As a result of key financing reforms, Kenya increased budget allocation to health in 43 out of 47 counties. From 2017-2019, all counties increased their health budgets to at least 20% of their total budget, to reach their subnational target.

Uganda

Capacity building for more than 4,000 health workers and other stakeholders on youth friendly health services contributed to a 60 percent increase in adolescent family planning visits since 2016.

Bangladesh

Investments in health and nutrition contributed to a decrease in stunting and wasting. In Sylhet and Chattogram regions, feeding counseling visits for infants and young children increased almost three-fold from 2017 to 2019.

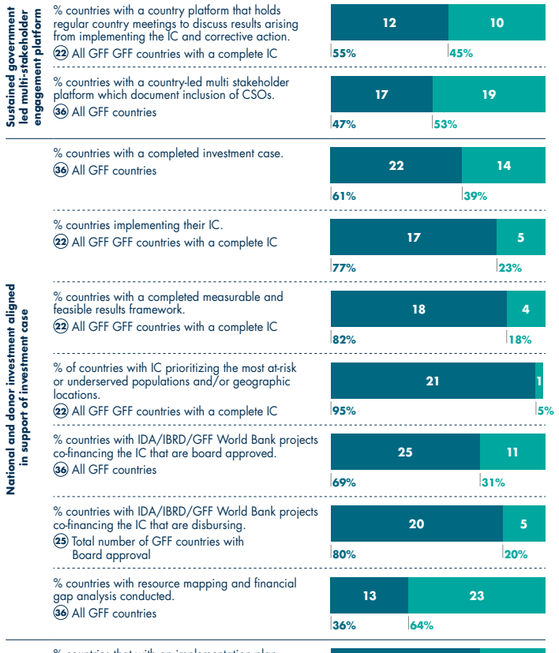
Indonesia

Converging access to health, nutrition, water and education services has helped reduce stunting among children under five from 30.8 to 27.7 percent and wasting from 10.2 to 7.4 percent.

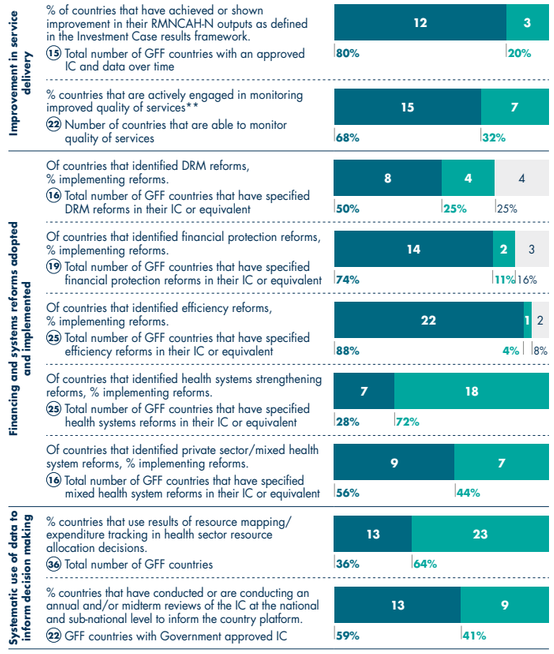
GFF Logic Framework Indicators

The tables below summarize the progress and achievements across the portfolio of the 36 GFF partner countries in terms of outputs, outcomes and impact indicators under the GFF Logic Framework, as of June 2020. They also include a summary of priority areas under country investment cases such as RMNCAH-N, Health Financing, Health Systems Strengthening, and Equity.

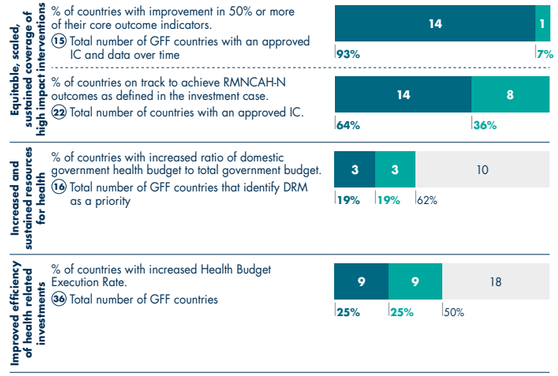
Output Indicators



Medium-term Outcome Indicators

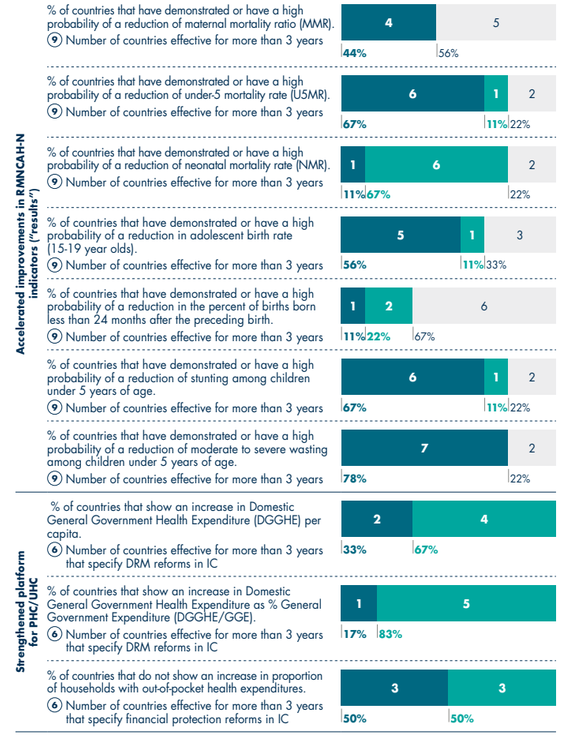


Long-term Outcome Indicators



Abbreviation	Definition
CP	Country Platform
CSO	Civil Society Organization
DRM	Domestic Resource Mobilization
GFF	Global Financing Facility
HF	Health Financing
IBRD	International Bank for Reconstruction and Development
IC	Investment Case
IDA	International Development Association
RMNCAH-N	Reproductive, Maternal, Newborn, Child, Adolescent Health and Nutrition

Impact Indicators



Investment Case Prioritization

	RMNCAH-N												Health Financing							Health Systems Strengthening											Equity			
	Newborn Health	Child health	Adolescent health	Maternal health	Health (other)	SRHR/Family Planning	Newborn nutrition	Child nutrition	Adolescent nutrition	Maternal Nutrition	Nutrition (other)	GBV	NDCs (prevention and control)	Public financial management	Donor pooling, coordination, alignment	Health insurance	Provider payment	Health benefit packages	Private sector engagement	Other	Quality of care	HRH	Infrastructure	Community health	CRVS	Supply chain management	HIS and M&E	Integrated disease surveillance	Emergency preparedness	Governance	Digital Health	Geographic focus	Gender focus	Socio-economic focus	Priority populations focus
Count of Yes	18	21	19	22	5	20	15	19	15	18	5	7	7	17	16	11	16	13	11	1	19	17	12	19	12	16	19	7	8	17	7	20	16	20	15
Afghanistan	✓	✓		✓		✓	✓	✓		✓			✓	✓	✓		✓	✓	✓		✓	✓		✓			✓			✓			✓	✓	
Bangladesh		✓	✓	✓		✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓			✓	✓				✓	✓		✓	✓		✓	✓	✓	
Burkina Faso	✓	✓	✓	✓		✓	✓	✓	✓	✓			✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓
Cameroon	✓	✓	✓	✓		✓	✓	✓						✓	✓		✓		✓		✓				✓	✓	✓	✓					✓		✓	✓
Central African Republic	✓	✓	✓	✓		✓	✓	✓	✓	✓		✓		✓	✓		✓	✓			✓	✓		✓		✓	✓	✓	✓	✓		✓	✓	✓	✓
Cote d'Ivoire	✓	✓		✓		✓		✓						✓	✓	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓			✓		✓		✓	
DRC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓
Ethiopia	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Guatemala		✓	✓	✓		✓		✓	✓	✓	✓		✓	✓								✓	✓	✓			✓			✓	✓	✓	✓	✓	✓
Indonesia	✓		✓	✓				✓	✓	✓	✓													✓	✓		✓			✓	✓	✓	✓	✓	
Kenya	✓	✓	✓	✓		✓	✓	✓	✓	✓		✓			✓	✓		✓	✓		✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓
Liberia	✓	✓	✓	✓		✓			✓	✓											✓			✓	✓				✓	✓		✓	✓	✓	
Madagascar	✓	✓	✓	✓	✓	✓	✓	✓		✓				✓	✓		✓	✓			✓	✓	✓	✓	✓	✓	✓	✓				✓			
Malawi		✓	✓	✓		✓	✓	✓	✓	✓				✓	✓		✓				✓	✓	✓			✓				✓		✓	✓		✓
Mozambique	✓	✓	✓	✓	✓	✓		✓				✓		✓	✓				✓		✓	✓		✓	✓	✓	✓					✓		✓	✓
Nigeria	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓			✓		✓	✓	✓	✓
Rwanda	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓				✓	✓	✓					✓	✓		✓	✓		✓			✓	✓	✓	✓	✓	✓
Senegal	✓	✓	✓	✓		✓	✓	✓	✓	✓		✓		✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Sierra Leone	✓	✓	✓	✓		✓	✓	✓		✓		✓		✓			✓				✓	✓			✓		✓	✓		✓		✓	✓	✓	✓
Tanzania	✓	✓	✓	✓		✓		✓	✓	✓				✓		✓	✓				✓	✓					✓					✓	✓	✓	
Uganda	✓	✓	✓	✓		✓	✓		✓	✓		✓			✓		✓	✓	✓		✓	✓	✓	✓	✓	✓	✓		✓	✓		✓	✓	✓	✓
Vietnam		✓		✓									✓			✓	✓	✓			✓		✓	✓		✓						✓	✓	✓	✓

Yes
No
Number of countries with no recent data available

THE GFF APPROACH TO SUSTAINABLE HEALTH FINANCING

The GFF uses the country investment case as a key tool for prioritizing and promoting the financing reforms needed to increase both the volume and efficiency of resources for health. The GFF approach combines immediate investments upfront to tackle the most pressing priorities while working with countries over time to build their capacity to use their own resources more efficiently and to self-finance their systems in the longer run.

Uniquely positioned as a partner of the World Bank, the GFF Trust Fund provides catalytic grants that leverage World Bank investment lending and budget support. The grants support implementation of the investment cases, capitalizing on the World Bank's convening power and sectoral knowledge to promote sustainable health financing reforms. The GFF also leverages partnerships at the global and country levels to build consensus around those reforms.

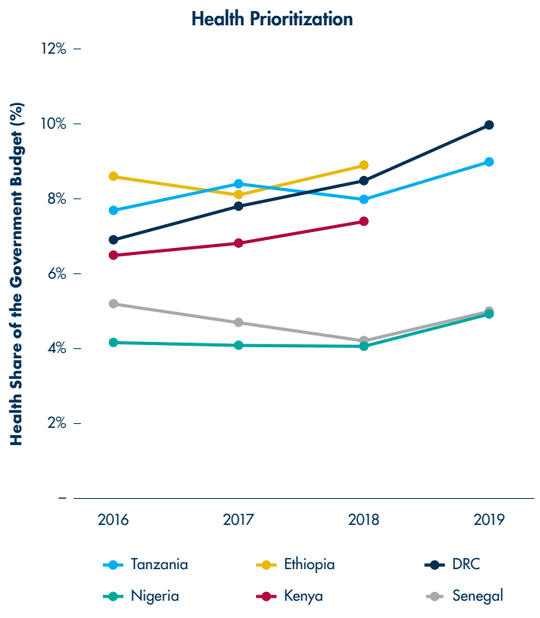
As of the end of 2019, of the 36 countries currently supported by the GFF:

Two-thirds of countries had begun implementing budget and financial reforms designed to improve efficiency in health expenditures and direct more resources to frontline health care providers.

- Democratic Republic of Congo (DRC), Nigeria and Tanzania created, expanded or reformed performance-based financing (PBF) programs resulting in increases in service coverage and improved quality of care.

- Cameroon and Madagascar changed the rules that govern the flow of funds that finance frontline providers, increasing the decentralization of resource management, and in some cases giving frontline providers autonomy to manage funds.

- Bangladesh, Ethiopia and Mozambique successfully introduced reforms to increase funding for primary care. For example, Bangladesh created 2,500 new midwives' postings, while Mozambique increased the number of technical level staff at Primary Health Care level by 3,300 in two years (from 2017 to 2019) (SIP), and Ethiopia increased the volume of external resources channeled through the government's budget and allocated to the regions.



Eight countries mobilized more domestic resources for the health of women, children and adolescents.

- Kenya increased budget allocation to health in 43 out of 47 counties. From 2017-2019, all counties increased their budgets to at least 20 percent of their total budget (MDTF report).

- In Cote d'Ivoire, the government committed to achieving a 12 percent share of resources allocated to health by the end of the investment case. The approved 2020 national budget for health includes a 16 percent increase over the previous year.[1]

- In DRC, where the GFF has supported evidence generation, technical assistance and capacity building in domestic resource mobilization and public financial management, the share of government resources allocated to health increased from 6.9 percent in 2016 to 10 percent in 2019 (BOOST).

GFF support enabled partner countries to identify and implement data collection and system reforms that benefit the health of women, children and adolescents.

- Ethiopia increased data completeness and timeliness of its health information management system from 68 percent in 2016 to 84 percent in 2018 (SARA 2018); while Kenya reported an increase in both completeness and timeliness of health data from 84 percent in 2016 to 94 percent in 2019 (KHIS).

- GFF support also enabled marked improvements in the supply chain for lifesaving health commodities in Tanzania, which increased the availability of 10 tracer medicines from 60 percent in 2016 to 96 percent in 2019 (DHIS2).

- A total of 12 GFF partner countries allocated financing for strengthening their Civil Registration and Vital Statistics (CRVS) systems, resulting in improvements such as decentralized registration services, standardized tools and processes, and more officials trained in the use of these systems.

THE GFF PROMOTES SUSTAINABLE HEALTH FINANCING BY WORKING WITH COUNTRIES OVER TIME TO BUILD THEIR CAPACITY TO USE THEIR OWN RESOURCES MORE EFFICIENTLY AND TO SELF-FINANCE THEIR SYSTEMS IN THE LONGER RUN.

1 Source: 2020 Budget of Cote d'Ivoire

Out of the 36 countries supported by the GFF:

- ***31** have completed RMET*
- ***8** linked RMET data to PFM systems and routine processes such as National Health Accounts*
- ***6** routinely implemented RMET, making data available to stakeholders*

Mapping Resources and Tracking Expenditures

A key aspect of the GFF's support is assisting governments in conducting resource mapping and expenditure tracking (RMET), which provides a comprehensive assessment of funding gaps and alignment of donor and government funding to implement the investment case. This data then helps inform decisions by governments and their partners on where to mobilize additional resources and how to improve the efficiency and equity of health spending. To ensure sustainability, the GFF provides technical assistance to help countries systematize, and ultimately integrate, RMET into broader health financing and public financial management systems. In addition, the GFF, World Health Organization (WHO) and other partners also aim to harmonize RMET with National Health Accounts. A few areas of success include:

Donor alignment: In Madagascar, the RMET process was institutionalized within the Ministry of Health, which oversees the data collection and analysis conducted by a civil society organization to help encourage buy-in from additional partners. In Malawi, the government, the GFF and other partners collaborated to streamline data collection, which in turn encouraged other stakeholders to share more information.

Resource mobilization: Both Malawi and Zimbabwe used resource mapping to analyze funding gaps in HIV/AIDS, tuberculosis and malaria strategies to inform their applications for funding from the Global Fund. In DRC, the government adopted the priorities of the investment case into its national health plan and budget process, and enabled partners to identify funding gaps and advocate for more resources.

Increased efficiency and equity of resources: In the DRC, RMET data for Maniema Province showed relatively low funding and very weak health outcomes for women and children, which prompted the governor to pursue additional funding.

Leveraging World Bank Financing and Expertise to Incentivize Reforms

The GFF Trust Fund provides grants to co-finance World Bank projects which can incentivize health financing reforms by linking disbursement of project funds to the implementation of specific reforms. In countries with weaker institutional capacity, GFF financing focuses on strengthening the fiduciary and financial management capacity of Ministries of Health. For example, in 2019 GFF support helped DRC, Liberia and Guinea establish dedicated health financing units to improve financial management and planning. In Tajikistan, a GFF grant co-financed the World Bank Early Childhood Development project to prevent budget losses in primary health care by reforming reallocation of unused funds.

The GFF also works closely with the World Bank to provide longer-term support to countries on domestic resource utilization and mobilization (DRUM). This effort focuses on countries with the fiscal space to increase health budgets. For instance, a GFF grant in Rwanda, the first country to receive this type of support, helped to enhance the financial sustainability of the country's community-based health insurance scheme. To ensure synergies, GFF has also been supporting a World Bank human capital development policy operation in Rwanda, which incentivizes efficiency reforms related to financial protection, including nutrition and social safety net programs.

Supporting Financing Reforms through Partnerships

Achieving sustainable financing reforms requires commitment and collective action by governments and their international development partners. As part of the Global Action Plan, the GFF has been intensifying its collaboration with Gavi, Global Fund, WHO and the World Bank under the GAP *health financing accelerator*, which focuses on implementing financing reforms and policies toward UHC. In 2019, the GFF, together with the World Bank, Global Fund and Gavi co-organized trainings and seminars for countries and partners to discuss opportunities and challenges for aligning resources. A joint training with CSOs on budget efficiency led to the development of a work program to scale up this support in more countries.

RESOURCE MAPPING AND EXPENDITURE TRACKING INFORM DECISIONS BY GOVERNMENTS AND THEIR PARTNERS ON WHERE TO MOBILIZE ADDITIONAL RESOURCES AND HOW TO IMPROVE THE EFFICIENCY AND EQUITY OF HEALTH SPENDING.

- **The GFF finances**
  32 BOARD-APPROVED WORLD BANK PROJECTS
- **Total of US$602 million GFF grants**
  LINKED TO $4.7 BILLION IDA/IBRD
- **GFF-IDA leverage ratio:**
  1 TO 7.86

Out of the 32 projects:

- ***18** use results-based approaches*
- ***7** disburse funds only when health financing targets are met to **incentivize reforms***

EMPOWERING WOMEN AND GIRLS THROUGH SEXUAL AND REPRODUCTIVE HEALTH SERVICES

As part of its commitment to gender equality, the GFF plays a key role in promoting universal access to sexual and reproductive health (SRH) in its partner countries, as well as creating more equitable health and social systems that shift norms toward increasing women's and girls' choice, access, voice and agency. Ensuring women and girls have access to SRH services is foundational for improving health outcomes for themselves and their families and a precondition for building sustainable human capital and driving economic growth.

High-quality family planning services are proven to have a tremendous impact on preventing maternal deaths, minimizing short-interval births (children born within 24 months of their mother's previous delivery) and reducing teenage pregnancy rates. In several GFF countries, family planning is one of the most prioritized SRH interventions. While countries have different strategies for expanding access to modern contraception and different metrics for tracking progress, nearly all GFF partner countries are seeing positive trends in SRH. Some notable results include:

- In Afghanistan, couple years of protection (CYPs) — the estimated protection provided by contraceptive methods during a one-year period — increased by 55 percent since 2017 (MOPH)
- In Ethiopia, the modern contraceptive prevalence rate for women living in rural areas increased by more than 5 percent in three years (DHS)
- In Sierra Leone, there was a 14 percent increase in women and girls seeking family planning services for the first time between 2017 and 2019 (HMIS)
- In Uganda, CYP grew by 44 percent since 2016 (HMIS)

The GFF supports partner countries with flexible financing and technical assistance to help integrate SRH services into comprehensive health benefits packages and implement the needed health systems and financing reforms to accelerate results. Areas of specific support include:

Supporting SRH integration into essential service packages

To improve access to quality of SRH interventions, the GFF partnership supports approaches that provide incentives for governments and health service providers to integrate SRH in their basic health service packages. These approaches also aim to strengthen equity while decreasing out-of-pocket expenses for women and girls. For example, in Nigeria, payments to health facilities in seven states (including six states in the North East) provided nearly 150,000 family planning services as part of an integrated primary healthcare package (HMIS). Other countries where this approach has shown encouraging results include Cameroon, Burkina Faso, Uganda, Senegal, Liberia, Democratic Republic of Congo (DRC), Tanzania, Mali, Nigeria, and Cote d'Ivoire. The GFF also supported countries to contract NGOs to deliver services in communities living in fragile settings such as in Afghanistan, DRC and Nigeria. For example, in Afghanistan, the GFF helped the government to reform its contracting system with NGOs, which expanded service utilization and contributed to improvements in key maternal and child health indicators.

Rights-based Strategic Purchasing

The GFF began supporting Burkina Faso, Cameroon and Mali to better measure family the quality of family planning services. Building on the work of USAID's Evidence Project, the GFF is partnering with the Population Council on an innovative tool for measuring client experience of family planning care. Initial checks indicate that self-reporting by people who use family planning can be used reliably as a measurement to tell whether they keep using contraception. The tool will be piloted in several GFF countries and has the potential to be used in provider payment systems to incentivize additional investments in service quality.

Generating Evidence to Guide Decisions in Family Planning

The World Bank's Development Research Group has partnered with a women's and children's hospital in Cameroon as part of a multi-disciplinary team to investigate cost-effective ways to improve the quality of contraceptive counseling. The team has developed a counseling app for nurses to structure family planning discussions with clients. The pilot study which started in December 2019 has resulted in more than 800 clients receiving counseling using the app. More than 80 percent of these clients were not using a modern contraceptive method prior to their visit. Of the 669 people meeting the eligibility criteria for the study, 53 percent have adopted a long-acting contraceptive method and 7 percent a short-acting method. The ensuing main study will focus on price elasticity of contraceptive take-up, effective counseling approaches, client satisfaction and 12-month unintended pregnancy rates. The study will also assess how to measure the quality of family planning counseling in hospitals using performance-based approaches.

Addressing barriers to demand for SRH services

While the supply of high-quality SRH interventions is important for countries to achieve results, the GFF is also focused on increasing demand. For example, the GFF supports supported the education sector in Bangladesh to improve learning and retention of girls in school as a key strategy for driving further improvements in adolescent and maternal health outcomes. Support for social and behavior change communication addressed social norms and misconceptions in countries like DRC, Afghanistan, and Nigeria.

Promoting accountability for SRH results

With its support for broader health systems and financing reforms, the GFF promotes accountability for SRH priorities through financial disbursements based on results. For example, in Kenya, county resource allocations were determined based

on family planning and maternal health results. Mozambique used family planning and school based SRH metrics to determine national disbursements and Ethiopia released funding based on improvements in indicators, such as the rural modern contraceptive prevalence rate.

Secure contraceptive supply and strengthen distribution systems

GFF funding has helped countries address their contraceptive supply gaps. For example, in DRC, Kenya and Uganda, the GFF co-financed projects to increase access to contraceptives. In Afghanistan and Nigeria, contraceptive financing was provided through service delivery contracts with NGOs. The GFF also supported broader supply chain reforms across a range of markets, including product distribution models and innovations in last-mile distribution, in collaboration with partners such as the Bill & Melinda Gates Foundation, Merck for Mothers, the UPS Foundation and USAID.

Partnering with Civil Society to Maximize the Impact of Health-related Country Investments

Civil Society Organizations (CSOs) play an indispensable role in advancing progress in reproductive, maternal, newborn, child and adolescent health and nutrition. From its inception, the GFF has partnered with CSOs who work to elevate the voices of affected but often marginalized populations. CSOs also help promote accountability and contribute to research, evidence and technical assistance as well as service delivery and demand generation for access to high quality health services — particularly in hard-to-reach areas and fragile settings where the poorest and most left behind populations live.

In GFF partner countries, CSOs help ensure investment cases prioritize affected populations and hold governments accountable to execute plans and allocate sufficient budget for women, children and adolescent health. Increasingly, more GFF partner countries are including social accountability and advocacy activities in their investment case, with CSOs leading implementation. CSOs have also been instrumental in delivering last-mile services and supporting community-based primary health care.

The GFF's governing body, the Investors Group, also includes CSO representation through two principal and two alternate members, along with a newly designated youth representative seat and an alternate. Through this engagement, CSOs help to shape the GFF's overall strategic directions and strengthen its impact.

GFF-CSO Engagement in Action

With the support of its partners, the GFF has taken several steps to expand and deepen engagement with CSOs, including the following:

Global strategy, engagement and advocacy

- Supported by the Partnership for Maternal Newborn and Child Health (PMNCH), a global CSO coordinating group and steering committee has guided civil society engagement in the GFF process, enhanced access to information, built capacity, and ensured CSO involvement at all levels including nomination of and support to the CSO and youth representatives.

- Civil society is increasingly engaged with the GFF to influence country policies and to strengthen capacity and share knowledge and evidence

Financial support and capacity building

- In 2019, PMNCH and the GFF awarded nearly US$600,000 in small grants to local CSOs across nine countries to strengthen civil society participation and engagement in their respective GFF country platforms — multi-stakeholder groups that collaborate to develop and implement country investment cases.

- PAI, an international CSO advocating for women's health and reproductive rights, launched the GFF–CSO Resource and Engagement Hub, a multiyear initiative to amplify and support CSO coalition contributions to GFF country-level investment outcomes through grants, technical assistance, training, and capacity building.

- Several international CSOs — including PATH, E4A MamaYe, WEMOS, Save the Children, and the ACTION Global Health Advocacy Partnership — provided financial and technical assistance to local CSO partners to improve engagement, advocacy transparency and accountability around the GFF process.

Civil society plays an increasingly important role in amplifying the impact of the GFF partnership. The following examples illustrate how CSOs have successfully engaged in the GFF process and contributed to results to date:

- In Cote d'Ivoire, the health CSO coalition FENOSCI supported dialogue on health financing reforms and contributed to the development of the investment case by leading capacity building activities and coordinating community feedback to develop a unified campaign for increased resources for health. This advocacy has contributed to a 16 percent increase in the country's 2020 health budget. FENOSCI will work with communities to monitor progress and strengthen accountability for budget spending and execution in health facilities.

- In Kenya, the CSO coalition engaged in the GFF process has developed a scorecard for assessing investment case design and implementation. In addition, the coalition has supported a campaign that helped establish a functional multi-stakeholder country platform.

- In Nigeria, CSOs in Bauchi State now participate in the prequalification and assessment of health facilities and are collaborating with partners to shape the development of a basic minimum package of health services.

- In Senegal, the local CSO coalition supports the Ministry of Health in monitoring investment case implementation in selected priority regions. CSO advocacy to increase domestic resources for health has led to local mayors committing more budget resources toward family planning, and to religious leaders calling for a percentage of mosque revenues to fund health programs for women and children.

Going forward, the GFF will intensify its efforts to ensure meaningful engagement of CSOs at country and global levels. In late 2020, an updated GFF-Civil Society Engagement Framework will outline concrete actions to strengthen GFF collaboration with civil society and also promote youth engagement in the GFF process. The GFF will also lead a dedicated effort to engage and support more women-led organizations in the GFF process. In addition, the GFF plans to award a second round of small grants to further strengthen collaboration and support CSO activities to help protect access to essential health services during the COVID-19 pandemic.

CSOs ARE INDISPENSABLE FOR ADVANCING PROGRESS IN REPRODUCTIVE, MATERNAL, NEWBORN, CHILD AND ADOLESCENT HEALTH AND NUTRITION. FROM ITS INCEPTION, THE GFF HAS PARTNERED WITH CSOs WHO WORK TO ELEVATE THE VOICES OF AFFECTED BUT OFTEN MARGINALIZED POPULATIONS.

LAYING THE FOUNDATION FOR STRONGER HEALTH SYSTEMS: CIVIL REGISTRATION AND VITAL STATISTICS

Civil Registration and Vital Statistics (CRVS) systems are fundamental to building resilient health systems and fair societies. They facilitate improved service delivery, advance health outcomes monitoring, and enhance human rights protection. Without legal documentation, millions of women and children could become excluded from social services such as health coverage and access to education and social protection programs, leaving them more vulnerable to human rights violations. While many countries made notable strides in strengthening their CRVS systems, broad gaps remain, particularly in registering deaths, recording causes of death and adopting new digital technologies. Accurately recording deaths and causes of death is even more imperative during health crises when governments struggle to assess priorities and target interventions.

The GFF Response to Improve CRVS

To assist countries in strengthening their CRVS systems, the GFF adopted a comprehensive health systems approach, which advocates for prioritizing CRVS systems in country investment cases and makes the necessary funding available to implement activities. The GFF also helps address gaps in country governance and capacity for planning and monitoring outcomes, promote the uptake of new technologies and integrate CRVS across the health sector. Over the past few years, GFF support has helped several countries make notable improvements in CRVS, such as:

- expanding civil registration service points to increase coverage;
- transitioning to electronic systems;
- adopting international standards for recording of causes of death occurring in health facilities and at home;
- building the capacity of health officials; and
- raising awareness among communities.

Significant results from the eight countries currently implementing CRVS reforms — DRC, Cameroon, Ethiopia, Kenya, Liberia, Mozambique, Rwanda, and Uganda — include the following:

- In Ethiopia, between 2016 and 2019, newborn birth registrations rose from 12 percent to 20 percent, and death registrations also increased from 11 percent to 13 percent.[2]
- In Kenya, between 2016 and 2018, birth registrations within six months of birth increased from 64 percent to 73 percent (2018 Vital Statistics Report).
- By 2019, Liberia had opened 27 fully equipped birth registration centers covering 19 hospitals, 3 medical centers, and 4 health centers. As a result, between 2018 and 2019 the number of registered newborns increased seven-fold, from just under 8,000 to nearly 55,000.
- In Uganda, between late 2016 and early 2020 newborn birth registrations increased from 10 to 15 percent, with death registrations rising slightly from 11 to 13 percent.

Rwanda: Strengthening CRVS to Support Public Administration

Even though Rwanda was already using electronic systems to capture vital life events, birth registration for children under five years old was only at 56 percent in 2014, with only 3 percent of children receiving birth certificates. The government prioritized assigning a unique national identification number at birth, which, among other benefits, facilitates the identification and enrollment of children in nutrition and social programs by linking information to health and social protection systems, among others.

A US$3 million GFF grant complemented US$6.5 million from the government to ensure that CRVS systems were successfully integrated with the national identification system. Technical assistance helped the government to amend a national law to

2 The statistics for Ethiopia, Liberia, and Uganda were derived based on data provided on request from respective governments.

GFF Support for Stronger CRVS Systems

- More than
  US$37 MILLION IN GFF GRANTS FOR STRENGTHENING CRVS IN 12 COUNTRIES,
  leveraging US$38 million in World Bank financing

- **12 OUT OF THE 22 COUNTRIES**
  with completed investment cases have included CRVS as a priority area;

- **8 COUNTRIES HAVE IMPLEMENTED REFORMS**

- **GFF funding varies, based on country gaps and needs.**
  DRC, ETHIOPIA, MOZAMBIQUE, AND UGANDA
  received the largest GFF and World Bank support. Smaller grants in countries such as Liberia, Kenya, and Burkina Faso target specific interventions that will produce the greatest impact

allow health officers to serve as civil registrars, recording births and deaths in their respective health facilities. With GFF support, the upgraded digital registrations were linked to the existing system, which includes marriage and divorce registrations and an electronic document management system. In addition, GFF funding supported behavior change communications campaigns, along with training of government officials at various levels to more effectively register and monitor births. More than 4,500 officials across the country have been trained in civil registration and how the upgraded system links to the national nutrition program — making the application process for support easier for families.

With research to identify knowledge gaps completed, the design and implementation of communications and awareness raising campaigns is currently underway. While still in the early stages, CRVS reforms already resulted in remarkable progress. In the *Rwanda Vital Statistics Report 2019*, published in June 2020 by the National Institute of Statistics of Rwanda, birth registrations in 2019 reached 87 percent completeness, with 78 percent of births registered on time (within 30 days of birth).

DRC: Improving Birth Registration for School-aged Children

In 2014, DRC recorded a 25 percent birth registration rate for children under the age of five, among the lowest in Africa. Legally securing registration of a newborn after the allowed 90-day time period had passed was complex and costly, requiring the infant's parents to pay a fine and appear before a special court. The government committed to strengthening CRVS systems with the aim to register at least 2.4 million children by the end of 2020, and issue 1.2 million birth certificates, with 240,000 of these for children under five years old. To support this effort, the GFF provided a US$10 million GFF grant in 2016 linked to the World Bank-financed Human Development Systems Strengthening Project to support CRVS reforms through a costed national strategy and a review of the legal framework to guide reforms.

With GFF support, the government invested in catch-up campaigns to register children in pre-primary and primary schools (and any unregistered siblings), leveraging the 80 percent school attendance rate. GFF technical assistance helped the government to simplify late birth registration processes. Digital systems were also set up, connecting health facilities to civil registration centers. This enabled quick resolutions of late registration court cases and delivery of birth certificates to parents. Approximately 700 staff from the Ministry of Education, 94 from the Ministry of the Interior, and various cadres drawn from tribunal courts, magistrates and court clerks have been trained to facilitate registration and issuance of certificates. In addition, the government established a center of excellence for digitizing paper records. Trial runs in rural areas, which linked the civil registration system, health services, and the community, helped to model new, simplified processes and improve data quality.

A progress check in early 2020 on the catch-up campaign still underway showed a total of 1.5 million children have been registered, with 740,000 birth certificates issued, including 148,000 for children under five years old.

UNLOCKING THE POWER OF THE PRIVATE SECTOR TO TRANSFORM HEALTH SYSTEMS

The GFF works with partner countries to identify the most effective ways to strengthen health systems to deliver services for women, children and adolescents. For many GFF partner countries, the private sector offers the reach, resources and ingenuity needed to accelerate progress to improve health outcomes. In addition to delivering services and financing health initiatives, the private sector also participates in supply chain logistics, manufacturing of medical equipment and commodities, telecommunication systems, and others.

As a key part of the GFF model since its inception, the private sector is represented on the GFF Investors Group and actively participates in country platforms. The GFF also leverages technical partnerships with private global partners such as the Bill and Melinda Gates Foundation, Merck for Mothers, Laerdal Global Health and the Rockefeller Foundation to support country-specific programs. More recently, many GFF partner countries have begun exploring opportunities where private sector capacities can be leveraged to deliver quality health services and products. High-risk environments and capacity limitations, especially in fragile and conflict-affected areas, have previously deterred both countries and private sector partners from realizing this potential. The GFF is facilitating greater public-private collaboration to build understanding, trust and the enabling environment which will enable the private sector to complement the public sector to scale up delivery of affordable, quality health services and commodities.

Leveraging the private sector to build resilient health systems

Cameroon: Using Innovative Financing to Mobilize Private Sector Resources

By using innovative financing instruments, countries can mobilize additional resources for health, including from the private sector. In 2019, the GFF in collaboration with the government of Cameroon, Grand Challenges Canada, Nutrition International, the World Bank and other partners launched a groundbreaking Development Impact Bond for newborn health. The bond, implemented with upfront financing by Grand Challenges Canada, seeks to save the lives of at least 2,200 infants each year by expanding the use of skin-to-skin contact after birth. Known as Kangaroo Mother Care or KMC, skin-to-skin contact prevents neonatal deaths by reducing the risk of infections, keeping the baby warm and ensuring weight gain, among other benefits. Since 2019, the bond has operated in eight hospitals, enrolling approximately 700 infants in the program and training over 50 private clinicians in quality KMC delivery, demonstrating the program's effectiveness for mothers and babies enrolled in the program. Early results include:

- The number of infants receiving at least eight hours of skin-to-skin contact tripled to 39 percent
- Mothers experienced an increase in exclusive breastfeeding and appropriate maternal nutrition
- 73 percent of newborns receiving KMC have returned for their 40-week follow-up appointment
- 78 percent of newborns have reached an appropriate weight by their 40-week follow-up appointment

Investing in Data to Inform Policy and Partnerships

The lack of reliable data on the private health sector's size, scope and activities in many GFF partner countries is a major constraint to public-private collaboration, including for developing national investment cases. To address this information gap, the GFF focused significant financing and technical assistance to help countries such as Bangladesh, Cote d'Ivoire, DRC, Ethiopia, Myanmar, and Uganda to conduct assessments that inform policy reforms and partnership opportunities. For example, in Cote d'Ivoire, the GFF conducted a rapid assessment to define the private sector's contribution to the investment case. In Mozambique, market assessments focused on specific private sector investments, such as outsourcing last-mile distribution of the supply chain.

Cote d'Ivoire: Building Country Capacity and Systems

In Cote d'Ivoire, the GFF has facilitated the ongoing participation of the private sector in the country platform to develop the investment case through an umbrella association representing a wide range of private health actors. This led to a comprehensive private sector assessment and a private sector engagement strategy that identified several opportunities as well as the path towards success.

Partnerships with Global Actors to Scale up Innovations at Country Level

The GFF draws on the reach of global partnerships, helping to fast-track the uptake of country-level innovations in financing, technologies, products, and service delivery models. For example, in 2019, the GFF joined Laerdal Global Health and the Government of Norway to launch a US$25 million "Innovation to Scale" challenge as part of its Innovations Partnership. This partnership has recently expanded with new commitments of US$5 million from Merck for Mothers and US$2.5 million from the Rockefeller Foundation to enable countries such as Mali, Myanmar, Rwanda and Tanzania to invest in scalable and sustainable innovations to transform primary healthcare systems for women, children and adolescents.

FOR MANY GFF PARTNER COUNTRIES, THE PRIVATE SECTOR OFFERS THE REACH, RESOURCES AND INGENUITY NEEDED TO ACCELERATE PROGRESS TO IMPROVE HEALTH OUTCOMES.

Examples of GFF Support to Private Sector Engagement

Strengthening public-private dialogue to build trust	Investing in analytics to inform policy and partnerships	Building country capacity and systems to manage public-private partnerships	Using innovative financing to de-risk markets	Enhancing partnerships with global private players to scale up country-level innovations
Ethiopia – Technical assistance to government on public-private engagement – Strengthening private sector federation	**Bangladesh** – Assessment on private sector, policy challenges, and opportunities for public-private partnership	**Cote d'Ivoire** – Technical assistance to support private facility licensing – Inclusion of private sector in performance contract design	**GFF–IFC** – Joint investments in private health sector actors to improve health and nutrition outcomes in GFF partner countries	**Last-mile delivery** – Supply chain partnership between GFF, UPS Foundation, Merck for Mothers, Gates Foundation to leverage private sector solutions
Cote d'Ivoire – Private sector part of country platform to develop investment case – Strengthening enabling environment for private federation	**Cote d'Ivoire** – Assessment to inform private sector contribution to investment case – Policy reforms for improving enabling environment and oversight	**Kenya** – Technical assistance to government on private sector engagement and public-private partnerships	**Nigeria, Cote d'Ivoire, Democratic Republic of Congo** – Contracting private sector to deliver essential health and nutrition services	**Health and nutrition** – Scaling innovations partnership between GFF, Laerdal Global Health, Merck for Mothers, and Rockefeller Foundation
Myanmar – Technical assistance on public-private dialogue around COVID-19 joint action plan	**Mozambique** – Supply chain assessment on using the private sector for last-mile delivery of health products and drugs	**Bangladesh** – Assessment of Ministry of Health capacity to engage private sector – Technical assistance and training for ministry staff on private sector engagement	**GFF Partnership with World Bank Treasury** – Sustainable Development Bond, raised over US$2 billion from global investors – Linked to GFF co-financing and loan buydown grants	

COUNTRIES LEAD THE WAY

While the majority of GFF partner countries have experienced progress over the past year, this section takes a more in depth look **at eight GFF partner countries**, illustrating how they have achieved promising results in improving health outcomes for women, children, and adolescents and promoted sustainable health financing reforms.

The **Country Snapshots** provide an overall description of the progress and challenges facing each country and discuss how the GFF partnership has contributed to better outcomes by helping countries to increase domestic resource mobilization, align and leverage support from multiple partners and funding sources around investment cases, and link financing to results.

While the eight selected countries have been affected by the pandemic in different ways, the snapshots in the report focus on the progress made in the past year based on available country data. This data was generated earlier in the year thus not taking into account the impacts of COVID-19. For example, the most recent data from Liberia and Afghanistan shows a significant drop in the number of children vaccinated – 32 percent less children in Liberia and 10 percent less children in Afghanistan. The number of outpatient consultations fell in many countries as well. The largest reduction was observed in Liberia, with a 35 percent drop in consultations for children under five years of age. In addition, many countries are facing difficult funding allocation decisions. For example, in DRC, funding for routine health services has increasingly been shifted to the COVID-19 emergency response.

The GFF is doubling down on its efforts to help countries in this difficult journey to ensure that essential services for women, children and adolescents are protected as part of countries' COVID-19 response and recovery efforts.

COUNTRY SNAPSHOT

AFGHANISTAN: ACCELERATING SUSTAINABLE TRANSFORMATION OF HEALTH SERVICE DELIVERY

Despite two decades of conflict and low domestic spending on health, Afghanistan has improved health outcomes in several key areas, including fewer deaths for both mothers in childbirth and children under five. Yet progress on maternal and neonatal mortality has slowed, with Afghan children continuing to suffer from chronic malnutrition. The Global Financing Facility (GFF) has worked with the Afghan government to transform its health service delivery model to help expand access to quality care in most of the country's provinces while also improving efficiency and accountability. These changes have contributed to improvements in several core maternal and child health indicators, such as more attended births, improved access for women and girls to contraceptives, and increased antenatal and postnatal care.

Improving Health Outcomes Across the Country

In the face of a fragile political climate, Afghanistan has made notable progress in improving maternal and child health and nutrition and strengthening service delivery. Between 2015 and 2018, mortality rates for children under five and newborns dropped sharply by 35 percent and 34 percent respectively (AHS 2015, AHS 2018). Since 2013, stunting declined from 40 to 36 percent and wasting from 9.5 percent to 5 percent.[3] Though these key indicators have improved, the modern contraceptive prevalence rate has stagnated with nearly a quarter of Afghan women having an unmet need for family planning (AHS 2018). Quality of services also remains a top concern in many provinces across the country.

Afghanistan's health system has benefited from the support of multiple donors who have contributed to substantial health progress over the last two decades. However, increasing the government's budget for health – currently at 2.3 percent of the total budget – remains an issue as the country struggles with low revenue and continued need for security-related expenses. This had driven Afghanistan's out-of-pocket expenses to a staggering 75.5 percent of total health expenditures, which are among the highest in the world.[4]

With domestic health spending likely to remain low for the foreseeable future, in 2018 the government initiated a major reform to expand quality services: contracting independent service providers, non-governmental organizations (NGOs), to deliver basic and essential health services in 31 of the country's 34 provinces where the government does not currently provide these services. The reforms included strategic purchasing of services that pays providers based on good performance and holds them accountable to quality standards. New performance-managed contracts have been under implementation since January 2019.

Aligning Partner Support Around Priorities

Afghanistan's first-ever investment case for women's, children's and adolescent health aligns resources to address the country's key health priorities. It is funded by the Afghanistan Sehatmandi Project, a US$600 million investment over three years to improve the delivery and quality of health, nutrition and family planning services in 34 provinces across the country. The project is co-financed by a US$35 million GFF catalytic grant linked to larger contributions from the World Bank's International Development Association (US$140 million), the Afghanistan Reconstruction Trust Fund (US$425 million), which includes contributions from Canada, the European Union and USAID and other bilateral partners.

Through its support to the project, the GFF has helped the government to strengthen accountability and efficiency in the health sector and nurture a culture of data use to help inform decisions. A first-ever resource mapping and expenditure tracking exercise for the provinces has enabled the government to better understand the impact of investments on the quality of basic health services and identify funding gaps to improve alignment of external resources around health priorities. The GFF has also supported the government and development partners on scaling up existing innovations in health services, including the expansion of high-impact interventions to prevent post-partum haemorrhage, reduce the incidence of neonatal sepsis and expand the range of available modern methods of contraception.

3 Afghanistan National Nutritional Survey 2013, AHS 2015
4 Health Financing core data sourced from GHED-WHO

Improving Efficiency, Accountability and Access to Services

The GFF supports the Ministry of Public Health to transform Afghanistan's unique contract-based health service delivery system. Contracts are now selected through a competitive process with a portion of payments linked to performance on 11 key services, after quality is verified by an independent, third-party monitor. This major reform has enabled the Ministry of Public Health to play a stewardship role in monitoring service quantity and quality. It is also spurring a more profound institutional transformation as the ministry has established a dedicated unit for the first time to oversee this contract type.

The change in the way contracts are managed has led to remarkable gains in efficiency and accountability: between 2018 and 2019, the ratio of health service providers subject to semi-annual reviews jumped from 0 to 100 percent, which helped inform decisions on contracting. As a result, the percentage of NGOs receiving timely payments jumped from 0 to 73 percent from 2018 to 2019 (MoH GCMU).

More importantly, the new system has accelerated improvements in several health areas such as institutional deliveries, caesarean sections, antenatal care, postnatal care, family planning and under-5 consultations:

Increased Access to Services

- 25 percent more children under five have visited outpatient care facilities supported by the Sehatmandi project.[5]
- Vaccinations administered to newborns rose 8 percent in health facilities; however, 5 provinces reported declines.
- Growth monitoring for children under two and child feeding counselling was introduced in 2019 to accelerate the reduction of stunting. In 2019, this was rolled out in all 34 Sehatmandi-supported provinces and more than

5.6 MILLION GROWTH MONITORING VISITS

were reported in Sehatmandi-supported facilities nationally.

More Effective Family Planning

- The total number of

COUPLE YEARS PROTECTION,

which estimates the protection from pregnancy provided by contraceptive methods,

INCREASED BY 55 PERCENT

in Sehatmandi-supported facilities across the country, with increases reported in 32 provinces.

Improved Maternal Care

- **32 PERCENT MORE ANTENATAL VISITS**

were recorded across the country with only two provinces showing declines.

- **36 PERCENT MORE POSTNATAL CARE VISITS**

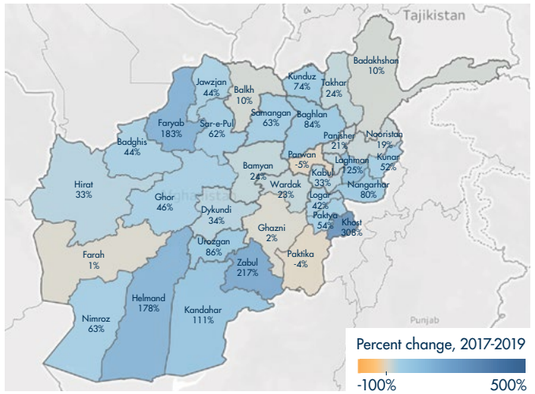
were recorded at Sehatmandi-supported health facilities

- The total number of institutional deliveries increased by 30 percent nationally and the number of caesarean sections rose by 63 percent to 3.2 percent from a base of 2.5 percent in 2017 – still short of the 10 percent benchmark that has been identified by WHO as supporting optimal mortality outcomes.

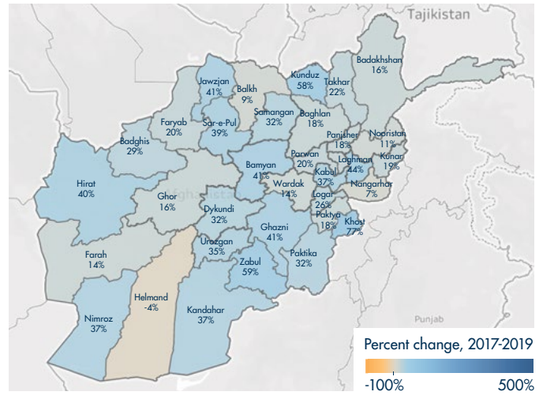
The GFF is now working with the government on an expanded investment case that looks beyond the program supported by Sehatmandi, with the aim of improving alignment and coordination between this program and work financed by other partners. By aligning a greater share of health resources around a common plan focused on high-impact interventions and supporting national systems for quality improvement, strategic purchasing, public financial management, and the production and use of data, Afghanistan expects to further accelerate the progress experienced in recent years.

5 RMNCAH-N results data for Afghanistan, including for the maps, are from the Ministry of Public Health unless otherwise indicated.

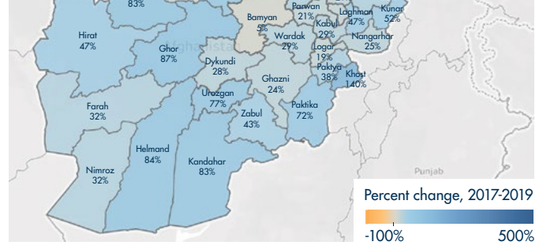
Couple Years Protection Change Over Time (2017-2019)



Outpatient Visits for Children <5, Change over Time (2017-2019)



Postnatal Care Change over Time (2017-2019)



COUNTRY SNAPSHOT

BANGLADESH: CLOSING EXISTING GAPS WHILE TACKLING NEW CHALLENGES

Bangladesh has made rapid advancements on several health indicators. Yet, the pace of progress has slowed, and the country now faces new challenges, especially in adolescent health and nutrition. The Global Financing Facility (GFF) is supporting the government to strengthen health systems, improve service delivery and reduce regional inequalities. The GFF is also facilitating a collaboration between the health and education sectors to help improve adolescent health through targeted school-based programs. To ensure sustainable progress, the GFF is helping to strengthen the efficiency of existing health spending while generating evidence to inform policy, build capacity, and advocate for additional funding.

Progress Made but Challenges Remain

Over the past decade, Bangladesh has made notable improvements in women's, children's and adolescents' health and nutrition. Progress is largely credited to community-based cost-effective programs. For example, between 2014 and 2018, improved child nutrition led to a decrease in stunting from 36 to 31 percent and wasting was nearly halved from 14 to 8 percent (DHS 2014, DHS 2018).[6] In addition, from 2010 to 2018 maternal deaths decreased by 22 percent. Yet, progress in some areas has slowed with neonatal deaths increasing by seven percent and deaths among children under five only slightly reduced (DHS 2014, DHS 2018).

Some of the gains have been attributed to the government's focus on educating girls and creating more opportunities for women in the labor force. However, school retention among girls remains a challenge. Girls with less schooling are more likely to marry and have children early, which is associated with higher maternal mortality. Malnutrition is also a threat to women and adolescent girls – almost one in five women and one in three adolescent girls were undernourished in 2014 (DHS 2014).

Wide regional disparities in health outcomes across the country further compound these challenges and financing gaps still constrain access to quality health care and financial protection for families. For example, household out-of-pocket payments cover 67 percent of the country's overall health care expenses, which poses a huge obstacle to families trying to escape poverty. In 2017, the government expended just three percent of its resources in health (GHED-WHO). The share of government budget allocated for health has been slightly increasing since 2017, with 5 percent allocated to health in 2019 and 5.8 percent budgeted for health in 2020 (MTBF). Budget execution may continue to pose challenges, and Bangladesh continues to benefit from external financing in support of its health strategy.

A Sector-wide Approach for Improving Health and Nutrition Outcomes

Bangladesh has been implementing a sector-wide approach where development partners and lenders are collectively contributing funding to close remaining gaps in health and nutrition. The US$1 billion sector-wide approach funded by several international partners, such as the World Bank, Canada, the Netherlands and the United Kingdom is part of a larger US$14.2 billion health program. The GFF Trust Fund is contributing a US$15 million catalytic grant in co-financing for the US$500 million Health Sector Support Project financed by the World Bank.

This sector-wide approach serves as Bangladesh's investment case to engage and guide the GFF and other partners working to improve and expand health and nutrition services. The plan prioritizes equity issues plaguing certain regions, such as Sylhet and Chattogram where health outcomes are lagging. In 2019, the stunting rate stood at almost 50 and 38 percent in Syhlet and Chattogram respectively, compared to the national rate of 31 percent (Bangladesh nutrition scorecard). The plan also focuses on improving and expanding nutrition services delivered to infants, children and mothers through government systems, and primary and antenatal care services.

In addition to the US$15 million grant, the GFF is also providing a US$10 million grant to co-finance the Transforming Secondary Education for Results Program, which provides health services to adolescents through schools. This additional support has enabled the Ministries of Education and Health and Family Welfare to develop programs that focus on incentives for vulnerable girls to stay in school, investment in separate toilets for girls and facilities for menstrual hygiene, inclusion of adolescent health in the curriculum, teacher training, counselling, and awareness-raising on gender-based violence.

Promoting Health Financing Reforms and Strengthening Health Systems

More government spending in health is needed to achieve steady and sustainable progress in the health of women, children and adolescents. Although the investment case does not prioritize an increase in domestic resources, the GFF is supporting evidence generation and advocacy that can inform decisions on resource mobilization. For example, the GFF is supporting implementation of Bangladesh's Health Care Financing Strategy. The GFF is providing analyses on health equity and financial protection, public financial management bottlenecks, a plan to engage with the private sector, and dialogue on domestic resource mobilization.

The GFF is also helping to promote greater efficiency in procurement and budget planning, preparation and execution. This support has already produced important changes. For instance, the share of the budget allocated to repair and maintenance of frontline health facilities (district-level and below) has increased from 2016; the percentage of national competitive tenders using an electronic system (e-government) rose to almost 18 percent; and an asset management system is now in use in four referral facilities in the districts (MTBF).

In addition, the GFF has helped the government to explore ways to strengthen engagement with the private sector, a key player in delivering health services in the country. Building on previous experience with public-private collaboration, the GFF has supported initial dialogue on strategies to strengthen this partnership to help expand access to quality care.

6 Data in this paragraph sourced from the Demographic and Health Surveys 2014 and 2017/18 and the Sample Vital Registration System (SRVS 2018).

Stronger Health Systems, Better Health and Nutrition Outcomes

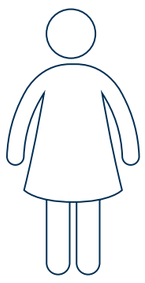
The collective force of these efforts is already helping to improve the delivery of health services and outcomes.

Better Health Systems

- MORE THAN 2,500 MIDWIFE POSITIONS have been created across the country, a major step toward improving maternal health outcomes. In the past three years, the number of Upazila (sub-district) health complexes that employed at least two accredited midwives rose from zero to 306 (MOHFW).

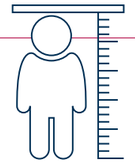
- In 2019, action plans were approved for emergency obstetric and newborn care services in targeted district hospitals in Sylhet and Chattogram. As a result, seven district hospitals had capacity to provide these services compared to 0 in 2017.

Improved Adolescent Health



- Between 2014 and 2018, THE BIRTH RATE AMONG ADOLESCENT GIRLS SLIGHTLY DECREASED FROM 113 TO 108 for every 1,000 girls, nationally. The government continues to prioritize school-based adolescent health programs in Sylhet and Chattogram, including teacher training and peer-to-peer adolescent girl support.

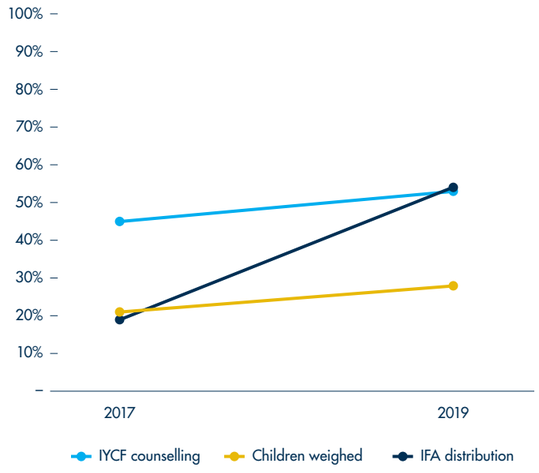
Better Child Health and Nutrition



- Nationwide, STUNTING AMONG CHILDREN UNDER FIVE DECREASED FROM 36 TO 28 PERCENT between 2014 and 2018 (DHS 2014, DHS 2017/18).

- In Sylhet and Chattogram, child nutrition has improved between 2017 and 2019/20:[7]
  - 25 percent of children under two received specific nutrition services
  - The number of children weighed increased from 21 to 28 percent. Infant and Young Child Feeding counseling rose almost threefold from 19 to 54 percent
  - The number of children receiving iron folic acid increased from 45 to 54 percent
  - 15 districts reached at least 85 percent coverage of measles-rubella vaccination among newborns in 2020 (from 14 districts the year before).

Nutrition Indicators, Sylhet and Chattogram



7 Subnational data for Sylhet and Chattogram are sourced from the Bangladesh Nutrition Scorecard.

COUNTRY SNAPSHOT

BURKINA FASO: BUILDING RESILIENT HEALTH SYSTEMS IN CONFLICT-AFFECTED REGIONS

Burkina Faso has made substantial progress in women and children's health and nutrition over the past two decades. Coverage of essential services has improved, and more children have been immunized and benefited from nutrition interventions. However, worsening insecurity as a result of increased armed conflict has impacted health service delivery in the country's six regions, leaving many women and children behind. The Global Financing Facility (GFF) is working with the government to strengthen the resilience of health systems and implement health financing reforms to expand coverage of quality services for vulnerable populations in those regions. These stepped-up efforts on equity are a critical part of Burkina Faso's path towards achieving universal health coverage.

Progress Made but Challenges Remain

Burkina Faso has made substantial progress in key health outcomes for women and children. Attended deliveries in health facilities rose from 66 to 84 percent between 2010 and 2015 while the number of women receiving four antenatal care visits increased from 28 to 38 percent between 2015 and 2017 (DHS 2010, EMDS 2015, AS/MS). In 2016, more than twice as many children under two were fully immunized (86 percent) compared to only 43 percent in 2003 (MIS 2018, DHS 2003). From 2010 to 2015, under-five mortality dropped by more than a third (36 percent) and neonatal mortality by 28 percent (DHS 2010, EMDS 2015). Maternal mortality fell slightly, and on average, women had less children while access to contraception almost doubled from 15 to 27 percent (MIS 2017/18). Despite this progress, malnutrition continues to affect many children. While stunting declined from 25 to 21 percent wasting remained stagnant at 8.6 percent (Enquête Nutritionnelle Nationale).

Despite limited financial resources, Burkina Faso has increased domestic spending for health from US$10 to US$16 per capita between 2015 and 2017 with most of this spending (85 percent) allocated to primary and outpatient care (GHED-WHO). However, in the same period, total health spending as a share of the overall government expenditures increased only slightly from 12 to 14 percent while the share of household out of pocket expenses remained flat at about a third of the overall spending (GHED-WHO). With support from the GFF, Burkina Faso is working to prioritize ways to expand access to services without putting families in financial hardship.

Focusing on Women and Children in Conflict-affected Areas

In recent years, political unrest and insurgency has disrupted health service delivery in the country's Boucle du Mouhoun, Eastern-Center, Northern-Center-Nord, East, North and Sahel regions. Today, 6 of the 13 country's regions are facing insecurity despite government efforts to address the issue. As of June 30, 2020, approximately 1.3 million people lacked access to primary health care, the majority (85 percent) being women and children (UNHCR 2019). Driven by a strong commitment to reach universal health coverage, the government worked with the GFF and partners to develop an investment case to prioritize and improve access to quality services for these vulnerable populations. The investment case is financed by a US$20 million GFF grant linked to an US$80 million World Bank investment, the Health Services Reinforcement Project.

Shaping a cohesive country platform

The GFF has helped the government to establish an inclusive stakeholder group of representatives from government ministries, health agencies, the private sector, donors, and civil society, led by the Minister of Health. This group collaborated to develop the initial investment case in 2019 that prioritized interventions to strengthen lagging health outcomes. Through dialogue and consultations, the GFF played a key role in empowering civil society to monitor progress and deliver on the objectives on the investment case.

Revising the investment case to reach those in need

Based on lessons learned, the government is revising the investment case to better address (i) health system resilience to provide the additional support needed in regions affected by insecurity; and (ii) financing reforms, particularly the financial protection of populations. The new investment case aims to expand an existing community-based health insurance program and provide free access to essential health services for mothers and young children. It will also include strategic purchasing of services to encourage health providers to increase both the volume and quality of services by linking payments to performance. The new investment case, which prioritizes closing access gaps, will also help mobilize resources for the country's gradual progress towards universal health coverage.

Prioritizing the most disadvantaged populations

The new plan prioritizes resources and high-impact interventions in six regions where maternal and child health lags the most and access to services are the lowest – Boucle de Mouhoun, Centre-Est, Est, Sahel, Nord, and Centre-Nord, which include the Northern regions that are home to those displaced by conflict. The focus is on building more resilient community health systems for continuous delivery of essential services to women and children. For example, in regions such as the Sahel, insecurity has forced health workers to be redeployed – resulting in major disruptions to service delivery. The region also has insufficient health facilities and a very low ratio of community health workers per capita – approximately 8.6 workers for every 10,000 people (AS/MS 2018). Almost half of the population lives more than 10 kilometres away from a health facility (AS/MS 2017), making access to services even more challenging.

Identifying funding gaps

The GFF and the Bill and Melinda Gates Foundation have supported the government to map resources to inform budget allocation decisions for 2020 and 2021. The mapping showed stronger alignment among partners, and an increase in donor financing and domestic resources to finance priorities. However, the data also revealed a funding gap of 30 percent – or an additional US$30 million needed by 2021 – mainly because the scope of activities and associated costs have expanded. The GFF will continue to work with the government on funding sustainability and to integrate annual assessments of funding allocations in line with the government's own budget process.

Promoting Health Financing Reforms to Build Resilience

Under the new investment case the GFF will focus its support on a series of reforms to ensure equitable access to quality primary health care, especially in priority regions. These include delivering free health services to pregnant women and children under five by scaling up a new community health insurance program; upgrading performance-based contracts to improve quantity and quality of services; and strengthening community health systems.

- **Improving social protection:** the government will pay health insurance contributions for pregnant women and children under five, as well as for the poorest households. The government also plans to add family planning to the range of essential health services covered by the program.
- **Reforming strategic purchasing:** the existing performance-contracting system will be reformed so that more women and children have access to additional health services. Under the revised scheme, health facilities will receive up-front funding and the services delivered will be monitored by non-governmental organizations. Reforms will also aim to increase the number of private health facilities offering services and medical supplies more accessible for women and children.
- **Strengthening community health:** focus will be placed on building more resilient community health systems by training competent health care professionals, increasing the number of women employed in facilities, and ensuring that facilities are adequately staffed.

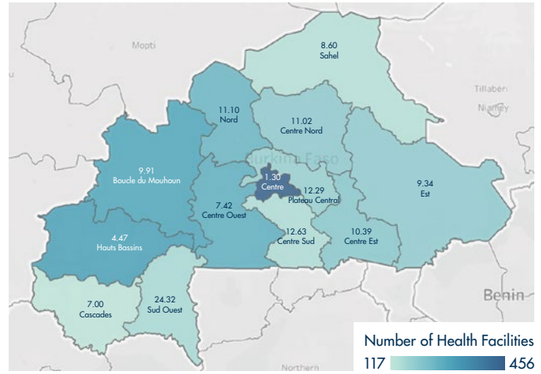
Promote the use of better data in decision-making

The GFF is providing technical assistance to the government to strengthen the civil registration system, particularly in remote areas, to collect crucial information on vital statistics such as community health workers. To promote more and better data use in decision-making, the GFF has initiated a partnership with Countdown to 2030 to conduct annual and mid-term reviews of the country's investment case. It also aims to build the capacity of the Institute of Population Sciences of the University of Ouagadougou to contribute to data analysis. Finally, the GFF and the World Bank are supporting the country's population census to collect sociodemographic data and information on public infrastructure, including health facilities.

Realizing the Revised Investment Case: Next Steps

Building on earlier gains, Burkina Faso will monitor progress on key service delivery indicators and promote accountability and dialogue with all stakeholders. Together, these efforts will help strengthen the resilience of health systems to expand coverage of quality services for vulnerable populations.

Community Health Workers Per 10,000 Inhabitants[8]



8 Data for the map is sourced from the AS/MS 2018.

COUNTRY SNAPSHOT

DEMOCRATIC REPUBLIC OF CONGO: MAINTAINING PROGRESS TOWARD HEALTH EQUITY

Building on recent progress, the Democratic Republic of Congo (DRC) has continued to invest in the health and nutrition of women, children and adolescents. With support from the Global Financing Facility (GFF), the government has not only further increased domestic resources for health but also strengthened the efficiency of existing resources to support the most pressing health priorities. This has helped to expand quality health services in the country's worst affected areas while protecting households from financial hardship. As a result, more women and children are visiting health facilities and benefiting from assisted births and other lifesaving services.

Keeping the Momentum

The Democratic Republic of Congo (DRC) has endured chronic political instability and armed conflict, as well as multiple Ebola outbreaks over the past couple of years that have put additional pressures on already strained health systems. Yet, as a result of the government's efforts and commitment, deaths of children under age 5 dropped by one-third from 2014 to 2017 and the teenage pregnancy rate fell by one-fifth. However, about 42 percent of children are still stunted as a result of chronic malnutrition.[9]

The exceptional challenges in DRC have historically made it difficult to increase domestic spending on health. Making it even more important that existing resources are efficiently used and are allocated for high priority needs. The government, with support from the GFF, developed a national plan to prioritize key health system and financing reforms to accelerate progress in health and nutrition outcomes across the country's 26 provinces. The 2019-2022 plan also set a goal to increase the country's budget allocation to health percent from 7.6 to 8.6 percent and budget efficiency to 90 percent. The plan also seeks to lessen the financial burden of health care costs to families (catastrophic health expenditures) from 4 to 3 percent.

Progress in Health Financing Reforms

The GFF is supporting DRC's national plan with a total of US$60 million in grant financing linked to US$340 million support from the World Bank's International Development Association (IDA). Other GFF partners and donors, including USAID, Gavi and the Global Fund, are also financing the plan's priorities. Two years into implementation, the plan has successfully guided policy makers through difficult budget allocation choices and health financing reforms to achieve results in several areas:

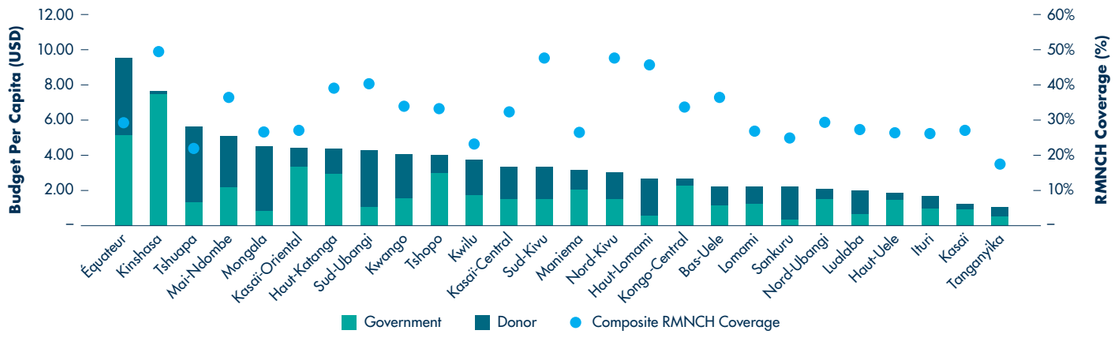
– **Greater efficiency, transparency and more equitable allocation of existing national health budget resources:** The GFF's support to the Ministry of Health has helped the government transition to program-based budgeting, a process that makes spending more transparent and helps ensure it goes towards priorities specified in the investment case. In 2019, the national budget execution rate – the measure of whether the budget is being spent as it was allocated -- was operating at only half the efficiency of the donor budget (which stood at almost 100 percent). There were also major inequalities in resource allocation among provinces, resulting in weak health outcomes. Based on the new budget process, the governor of Maniema province, one of DRC's poorest provinces, pledged more resources and more efficient spending of existing resources for health. Similarly, Lualaba province has committed to increase domestic allocation to health and plans to pilot program-based budgeting to better link resources to results. This information has also enabled the Ministry of Health to advocate for a larger share of the national budget for health. (Figure 1).

– **More sustainable reforms:** The transition to a more transparent, efficient and result-oriented budgeting process is enabling the government to generate more reliable, annual data to track spending and results and ensure sustainable financing for essential health services. The government also established a new fiduciary unit to manage budget flows and improve resource use both in the provinces and at national level.

– **Increase in domestic resources for health:** The GFF supported the Ministry of Health to map resources and track expenses, an exercise that revealed sizeable funding gaps to implement the plan's priorities. This was a catalyst to convince the government to increase domestic resources for health from 7 to 8.5 percent between 2017-2018 and to a further 10 percent in 2019, exceeding the plan's target of 8.6 percent by 2022 (Budget PBB). The government has also tripled its spending on vaccinations from US$4.4 million to US$9 million in 2019 and subsequently to US$16.4 million in the first half of 2020.

– **Decrease out-of-pocket expenses:** With GFF support, the government designed and rolled out contracts for the strategic purchasing of services in 11 provinces. Making payments to health providers contingent upon their performance has helped expand quality services while reducing the economic burden on households. Other GFF partners, such as the European Union, are also supporting strategic purchasing reforms in the country.

Province Budget Per Capita x RMNCH Coverage[10]



RMNCH Coverage shown in Figure 1 is a composite of several coverage indicators, comprising ANC attendance, use of family planning methods, care-seeking for diarrhea, and care-seeking for fever/malaria.

9 Child mortality, teenage pregnancy, and stunting data sourced from the DHS 2014 and the MICS 2017-18.

10 Budget data in the graph sourced from the Budget of DRC, 2020. RMNCAH-N data in graph from MICS 2017-18.

Expanded Access to Health Services

Improving the allocation and efficient use of health spending in the DRC has already reduced the cost of care for many patients, strengthened service quality, and increased the uptake of services through the rollout of performance-based financing in 11 provinces, among other interventions. The World Bank and the GFF contributed to better outcomes by focusing their investment on those 11 provinces.

Increased Access to Primary Health Facilities

- The average number of

  OUTPATIENT ADMISSIONS

  in facilities where payments were linked to performance

  ROSE FROM 59 TO 67 PERCENT

  between 2018 and the first quarter of 2020.[11] The increase in admissions ranged among provinces, from 21 percent in Haut Katanga to 84 percent in Sud Ubangi.

Improved Maternal and Child Health Care

- Between 2017 and 2019, across the country

  18 PERCENT MORE WOMEN ATTENDED THEIR FIRST ANTENATAL VISIT

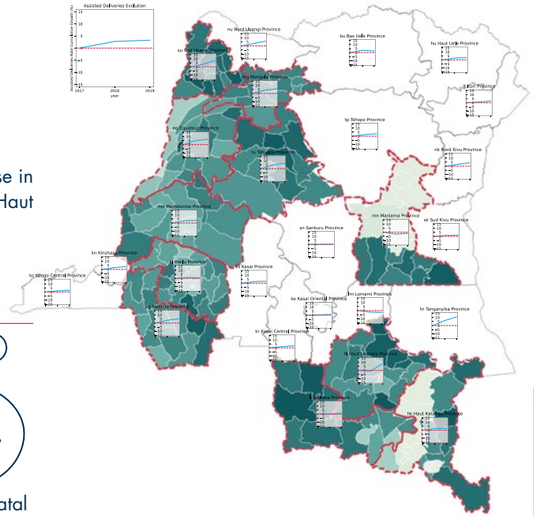
  and 30 percent more women attended at least four antenatal visits (see map 1a). Postnatal care almost doubled from 30 to 56 percent.

- Three percent more women gave birth with the help of a skilled provider, bringing coverage to 91 percent in 24 out of 26 provinces in 2019 (see map 1b).

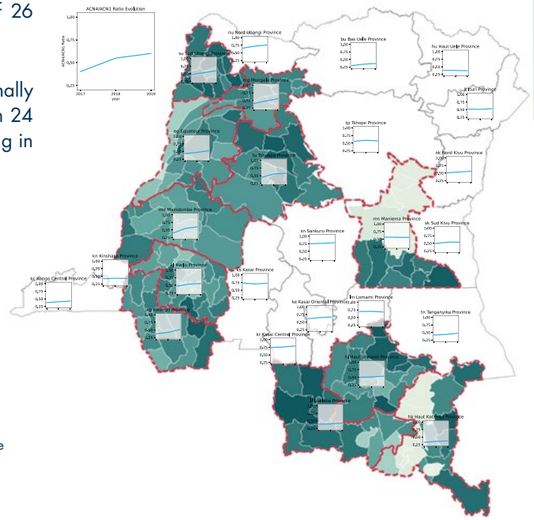
- The malaria mortality rate declined by 58 percent nationally to reach 0.04 percent in 2019. Declines were reported in 24 of the 26 provinces, with the only substantive rise occurring in Sankuru Province, from 0.17 to 0.24 percent.

Disparities among provinces still exist while quality remains a critical issue in several facilities due to limited skills and shortages of medicine and equipment. Going forward, greater attention needs to be paid to equity by focusing more resources on provinces where progress is lagging.

Map 1a: **ANC4 visits: Rate of change, 2017-2019; with performance-based financing service coverage of outpatient visits to PBF facilities shaded by zone**



Map 1b: **Assisted Deliveries by Province: Rate of change, 2017-2019; with performance-based financing service coverage of outpatient visits to PBF facilities shaded by zone**



11 All RMNCAH-N data for DRC, including the maps, is sourced from the HMIS routine monitoring system unless otherwise noted.

COUNTRY SNAPSHOT

ETHIOPIA: PROMOTING HEALTH FINANCING REFORMS TO ENSURE SUSTAINABLE PROGRESS

Building on progress in several key health areas, the government of Ethiopia developed a transformational plan for its health sector to further accelerate gains, with support from the Global Financing Facility (GFF) and other partners. The plan serves as Ethiopia's investment case for women's, children's and adolescent health to help prioritize and guide where investments are needed to expand quality health services, particularly in regions with the lowest progress and the greatest financial needs. The GFF helped to facilitate significant reforms that narrowed health financing gaps and strengthened data systems for monitoring progress. In addition, the GFF helped to drive dialogue with the private sector to mobilize more investments in health. These efforts have contributed to better health outcomes, including service delivery, more attended births, increased use of contraception and improved participation of children under two in growth monitoring programs.

Country Leadership Drives Better Health Outcomes

Steady economic growth, combined with strong government stewardship, has enabled Ethiopia to achieve better health outcomes for women and children. Between 2000-2016, under-5 and infant mortality rates declined by 42 percent and 28 percent respectively. During the same time period, women's fertility rate dropped from 5.5 to 4.6 children. However, Ethiopia is still lagging in several areas such as family planning, adolescent health and stunting.[12] Ethiopia's per capita spending on health stood at US$32, lower than the average in Sub-Saharan Africa and it is almost equally split among donors, out-of-pocket expenses and government resources. Domestic resources for health as share of total expenditure increased from 7.5 percent to 8.6 percent between 2000 and 2017 but was mainly driven by external resources channeled through the government (on-budget).[13] Progress toward universal health coverage will require financing reforms to increase domestic resource mobilization for health and to align existing donor resources around equitable service delivery.

Spurring Health Transformation through Targeted Support

Ethiopia was the first country to join the GFF and its Health Sector Transformation Plan is designed to help the country reach universal health coverage by prioritizing expansion of equitable and quality health services and strengthening health systems and infrastructure. The plan is being implemented with the support of a US$60 million GFF grant which has mobilized a US$150 million contribution from the International Development Association (IDA), the World Bank's fund for the poorest countries. It is also backed by the Sustainable Development Goals Performance Fund, a pooled fund with 11 donors managed by the Federal Ministry of Health.

In collaboration with partners and the World Bank, the GFF has played a key role in the plan's implementation. Specifically, the GFF's partnership with Ethiopia has helped to:

- **Incentivize results** by incorporating relevant indicators in the World Bank project and linking payments to better outcomes.
- **Prioritize interventions** in areas with the lowest progress, specifically family planning and adolescent health, and link payments to specific results. This has led to the development of the country's first national adolescent health policy.
- **Narrow the gap** in health outcomes between lagging regions and the rest of the country. For example, the GFF has supported the lowest-performing regions of Afar, Oromia and Somali to increase deliveries attended by skilled birth providers.
- **Strengthen health systems** by allocating resources to pharmaceutical supply and distribution systems and health infrastructure. The GFF also helped to upgrade civil registration and vital statistics (CRVS), including helping the Federal Vital Events Registration Agency to transition to an electronic registration system.

Facilitating Health Financing Reforms and Enabling Private Sector Engagement

To help the government increase its own resources and use existing funding more efficiently, the GFF, with support from the World Bank and the Bill and Melinda Gates Foundation, has provided technical assistance and analysis to drive the dialogue on health financing reforms and identify funding gaps and barriers to efficient budget execution. The GFF also supported the nationwide expansion of the existing community-based health insurance, a voluntary health insurance scheme designed to reduce out-of-pocket payments for people in the informal sector.

With this support, the government has managed to implement specific health financing reforms:

- **Removal of financial barriers and increased service coverage:** By the end of 2019, the community-based health insurance (CBHI) was expanded to five of the nine regions in Ethiopia, such as Amhara, Benishangul-Gumuz, Oromia, Southern Nations, Nationalities, Peoples Region, and Tigray, as well as the Addis-Ababa Dire-Dawa city administrations. This expansion resulted in coverage for 28 percent of the country's population, compared to only about one percent of the population in 2015. Expanding the insurance program resulted in greater use of health services – visits to health facilities among those insured were 43 percent higher than the national average. Higher insurance coverage also contributed to reducing the share of out-of-pocket payments from 34 to 30 percent from 2010 to 2017.[14]
- **Significant increase in domestic resources for implementing the investment case:** In just over a year, domestic budget allocations to support the plan improved increased by 10 percent. This helped reduce the financing gap to implement the plan.
- **Established new public-private partnerships for health:** A private sector health assessment was conducted to understand the enabling environment for leveraging private sector investment in health, including an assessment of regulations and policies needed to de-risk markets. This dialogue led to the creation of a federation for private sector stakeholders, which includes private hospitals, pharmaceutical companies, civil society organizations and others.
- **Improved data to inform decision-making:** The GFF supported the update of the BOOST database which enabled the government to provide health financing data at all levels in a more systematic way to inform policy reforms. A service availability and readiness assessment conducted in 2019 with the support of the GFF partnership also showed that data collection, use and reporting had improved, with 84 percent of health centers reporting health data on time, exceeding the initial target of 80 percent

12 All RMNCAH-N impact data sourced from DHS 2000, DHS 2016.

13 Core Health Financing data sourced from WHO-GHED.

14 Data on service coverage sourced from Ethiopian Health Insurance Agency Annual Administrative report 2019.

Contributing to Improved Health Outcomes

The GFF partnership with Ethiopia has played a key role in the country's steady progress towards universal health coverage. With GFF support, as of February 2020 Ethiopia had accelerated service coverage of maternal and child health services, exceeding targets outlined in the transformation plan.

Increased Antenatal Care, Assisted Deliveries, and Modern Contraceptive Use

- The number of women receiving

  FOUR ANTENATAL VISITS INCREASED FROM 32 TO 43 PERCENT.

  Similarly, the number of pregnant women receiving iron folic acid tablets grew from 42 to 60 percent.[15]

- Deliveries attended by skilled birth providers rose from 19 to 33 percent in the low-performing regions of Oromia, Afar, and Somali, and almost tripled from 18 percent to 50 percent nationally.
- Use of modern contraceptive methods rose to 41 percent, with 27 percent of those women using modern injectable methods.

Improved Child Health

- The number of under-two children enrolled in the Growth Monitoring Promotion program rose from 38 to 54 percent. In addition,

  THE NUMBER OF DISTRICTS IN MORE DEVELOPED REGIONS DELIVERING VITAMIN A SUPPLEMENTS TO CHILDREN MORE THAN DOUBLED FROM 48 TO 100 PERCENT.

  Wasting prevalence also decreased by 3 percent to reach 7 percent in 2019.

- Immunizations for under-two children improved across the board. The number of children receiving pentavalent 3 increased from 54 to 61 percent; two-thirds of children had received complete doses of the rotavirus vaccine and 60 percent received complete doses of the polio vaccine.

15 RMNCAH-N results data for Ethiopia, including for graphs, are sourced from DHS surveys unless otherwise noted.

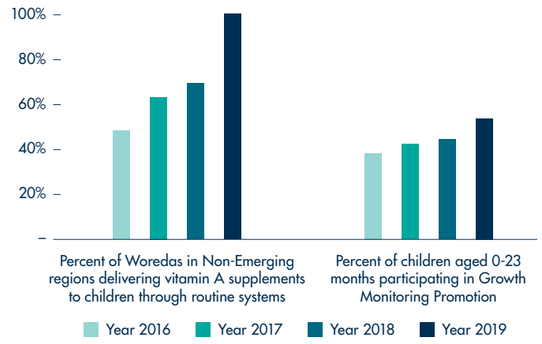
Strengthened Health Data

- Health facility

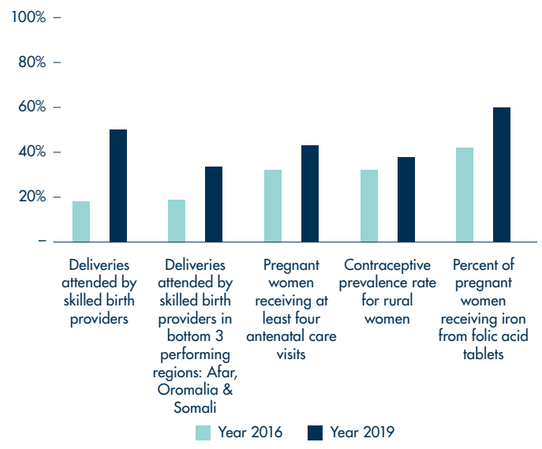
  DATA COLLECTION, USE, AND TIMELY REPORTING JUMPED FROM 68 TO 84 PERCENT

  between 2016 and 2018 (SARA 2018). The number of primary health care facilities having access to essential drugs increased from 42 to 48 percent (MoH).

Service Delivery, Routine Monitoring Systems 2016-2019



Service Delivery, DHS 2016, DHS 2018-19



COUNTRY SNAPSHOT

INDONESIA: ACCELERATING THE FIGHT AGAINST CHILDHOOD STUNTING

Indonesia has achieved remarkable progress in women's and children's health over the past decade. Yet, malnutrition is still a major concern and stunting has remained stubbornly high despite considerable government efforts to address the problem. An ambitious national strategy is ensuring that households with pregnant women or children under age two can access a package of diverse services essential to prevent stunting. The strategy aims to benefit 48 million mothers and children in 514 districts across the country and allow children to grow to their full potential. The Global Financing Facility (GFF) is providing catalytic support to the government to strengthen political commitment, coordination and accountability at all levels, scale up innovative information systems, and adopt the health financing reforms needed to accelerate impact.

Aligning Sectors towards a Single Goal

Over the past decade, Indonesia has made significant progress in health outcomes. Between 1990 and 2017 mortality of children under 5 declined dramatically by 67 percent and life expectancy increased from 63 years in 1990 to 69 years in 2015. Though the government has invested substantially in nutrition for mothers and young children, one out of three children under five were stunted in 2018; almost 18 percent were underweight; and 10 percent had a low weight-for-height ratio.[16] These indicators have serious implications for the country's potential to build its human capital, increase productivity and promote economic growth.

Experience and global lessons show that stunting requires leadership across multiple sectors and all levels of government. Based on this, the government made a high-level political commitment with the launch of an ambitious US$14.6 billion national strategy to accelerate stunting reduction. Led by Indonesia's president and vice president, the strategy coordinates 23 ministries across sectors such as health, water and sanitation, early childhood education, social protection, and food security. The aim is to ensure that every household in the country has access to a core package of services proven to be effective in reducing stunting. The program started by targeting the 100 worst-affected districts and will scale up rapidly to reach all of Indonesia's 514 districts by 2022. As of 2019, the program already covered an estimated 3.9 million mothers and 10.6 million children under age two.

Catalyzing Change through Political Commitment and Capacity Building

To bolster the national stunting reduction strategy, the GFF has committed US$20 million linked to a US$400 million project financed by the World Bank -- Investing in Nutrition and Early Years Program for Results. The GFF support is focused on specific catalytic actions including strengthening national coordination and accountability, scaling up specific interventions to close gaps in service delivery, and reforming health financing. For example, the GFF supports a series of 'Stunting Summits' in the 100 priority districts to secure political commitments from district leaders, which have led to concrete action plans and coordinated resource mobilization efforts to achieve the program's goals. In addition, the GFF has supported the vice president's office to establish a data-driven performance monitoring system and improve the availability of key health and nutrition outcome data, which helps flag and respond to bottlenecks and promote government accountability.

GFF-funded technical assistance is also supporting the scale-up of specific interventions to close gaps in health and nutrition service delivery. In order to better understand current gaps and challenges, the GFF is helping local governments to strengthen the capacity of their human development workforce, who go door-to-door to map households with women and children under two, identify service gaps, share information on nutrition, and incentivize families to access services. From 2018 to 2019, the number of workers employed by the program grew 20-fold from about 3,500 to almost 73,000 workers, covering 97 percent of all villages, and 95 percent of these workers had been trained in relevant nutrition areas. Building on an existing scorecard system to monitor results, the GFF has helped Indonesia roll out innovative technology solutions such as a digital application that will enable real-time results monitoring in all 75,000 villages. To date, 39 percent of all villages have already implemented this digital application.[17]

The GFF is also supporting behavior change communications on nutrition, early childhood stimulation, and sanitation and hygiene practices for vulnerable families. In 2019, 72 priority districts had implemented locally adapted behavior change communication activities. Almost 2,000 teachers have been trained in early childhood health and 843 teachers were certified.

Moreover, the GFF is supporting programs to ensure food security for households. In 2019, vitamin-rich and protein source food was introduced in the food assistance program and has been delivered to 20 million beneficiaries nationally.

Increased Resources and Spending Efficiency Helped Align Services

To promote more integrated service delivery, the GFF has supported the Ministry of Finance to pass a new regulation that requires local governments to align their planning and budgeting process with the national strategy's priorities. The GFF also worked with the government to introduce a new budget transfer instrument, a significant reform which makes it easier at the district level to coordinate service provision across sectors. In 2019, using this new budget transfer model, the government made available US$88 million to local governments. Part of this fiscal transfer was allocated to the Village Fund – a special fund set to make direct cash transfers to villages. As a result, the average share of spending on nutrition in villages increased to 26.2 percent in priority districts. Overall, national spending on stunting-specific interventions rose from US$8.4 per capita in 2017 to US$12.3 per capita in 2018 (WHO-GHED).

The GFF has also supported the establishment of smarter systems to track resources and performance. In 2019, the Ministry of Finance published a review that links nutrition spending to achievements and shows how the budget was spent. This has enabled the government to improve coordination and ensure the best use of resources.

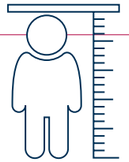
16 All impact data for Indonesia sourced from the Demographic and Health Survey (DHS).

17 Unless otherwise noted, RMNCAH-N data for Indonesia is sourced from the SUSENAS 2017, the Riskesdas 2018, and the SUSENAS 2019.

Successful Implementation Yields Positive Outcomes

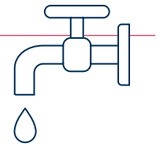
Early indications suggest that Indonesia's strategy, supported by the catalytic role of the GFF and other partners, is yielding positive results for women, children and adolescents.

Progress in Maternal and Child Health and Nutrition Services



- Between 2018 and 2019, the STUNTING RATE FOR CHILDREN UNDER FIVE DECLINED FROM 30.8 TO 27.7 PERCENT
- Between 2017 and 2019, the number of infants (0-6 months) who were exclusively breastfed increased significantly from 60.2 percent to 66.7 percent. The initiation of breastfeeding within one hour of birth rose from 42.7 percent in 2016 to 58.2 percent in 2018.
- The percentage of babies aged 6-23 months who were fed a minimum acceptable diet rose from of 56.2 percent in 2018 to 58.2 percent in 2019 nationally, and in the 100 priority districts from 52.6 percent in 2017 to 55.9 percent in 2019.
- The number of children aged 1-3 years receiving complete immunizations increased nationally from 37.3 to 47 percent between 2017 and 2019 and from 39.2 to 48 percent in the 100 priority districts.
- Coverage of iron supplementation (more than 90 iron tablets over the course of pregnancy) during pregnancy increased from 35.5 to 37.7 percent between 2016 and 2018.

Improved Access to Clean Water, Sanitation

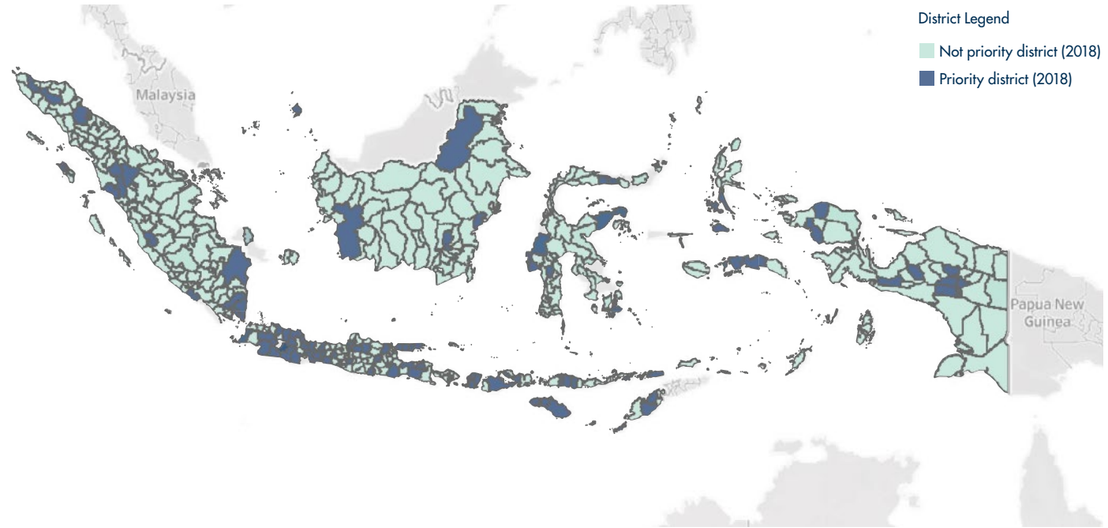


- Between 2017 and 2019, the percentage of households with children under two with ACCESS TO IMPROVED DRINKING WATER ROSE FROM 70 TO 72 PERCENT AT THE NATIONAL LEVEL, AND FROM 65.3 TO 69 PERCENT IN THE 100 PRIORITY DISTRICTS.
- The percentage of households with access to improved sanitation rose from 62.4 to 66.6 percent at the national level, and from 54.3 percent to 58 percent in the 100 priority districts.

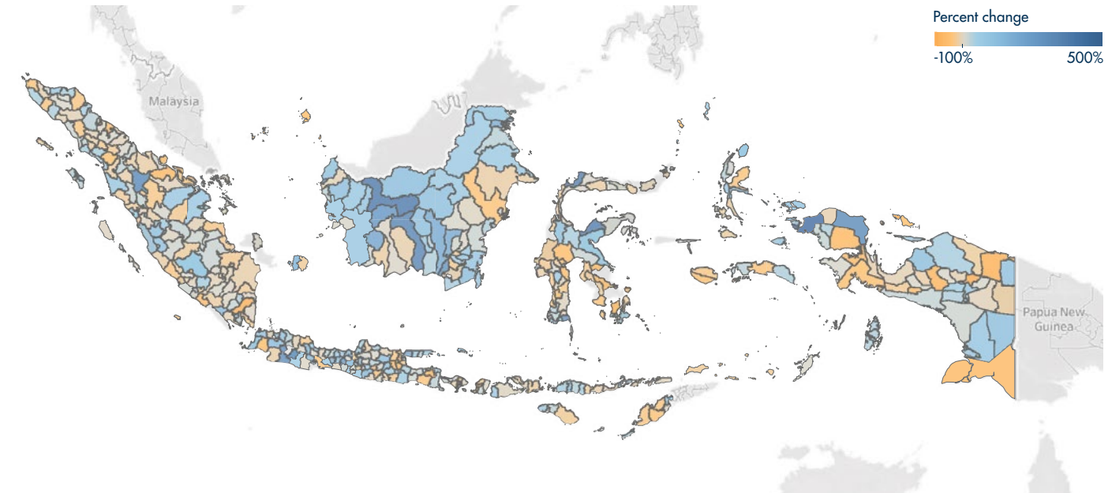
Increase in Birth Registration

- The percentage of children under five issued a BIRTH CERTIFICATE INCREASED FROM 69.5 TO 71.7 PERCENT AT THE NATIONAL LEVEL, AND FROM 62.9 TO 65 PERCENT IN THE 100 PRIORITY DISTRICTS.

Indonesia Year 1 Priority Districts



Minimum Acceptable Diet, Percent Change 2017-2019



COUNTRY SNAPSHOT

LIBERIA: ALIGNING PARTNER SUPPORT AROUND EQUITABLE SERVICE DELIVERY

Since 2016, the Global Financing Facility (GFF) has been working with the Liberian government to address the country's most pressing health needs. Through the country's investment case, the GFF is helping to close gaps in service delivery and health outcomes for women and children by focusing available resources on six counties where progress has lagged. The investment case has helped to accelerate significant health improvements in those counties – 10 percent more children under two were immunized; adolescent fertility dropped by 14 percent; assisted deliveries rose by 24 percent; and the number of women receiving postnatal care increased six-fold.

Addressing Health Priorities in a Challenging Environment

Liberia is still recovering from years of conflict that ended in 2003. This troubled period was followed by an Ebola outbreak in 2014-2016 that further eroded an already strained health system. With targeted support from the GFF and international partners, Liberia was able to reduce pregnancy among 15-19-year-old girls by 14 percent from 2013 to 2019.[18] Improved nutrition programs led to a decline in stunting from 31.6 to 30 percent and wasting dropped from 5.6 to 3 percent. However, outcomes in maternal, child and neonatal mortality were disappointing: in 2013, maternal mortality was 1,072 for every 100,000 live births and between 2013 and 2019, under-five mortality decreased only slightly from 94 to 93 per 1,000 live births and neonatal mortality rose by 42 percent. Much more remains to be done, especially in counties where outcomes are lagging the most.

By 2017, household out-of-pocket expenses had accounted for almost half of Liberia's relatively high per capita health spending of US$57 (WHO-GHED), with external donors shouldering one-third of this cost. At the same time, Liberia is struggling with large disparities in access to care, health outcomes and financing across its 15 counties. While efforts are underway to increase national spending for health in the long run, limited fiscal space poses a major challenge. This makes GFF's support for Liberia to promote effective coordination and prioritization of existing external resources more critical than ever to ensure women, children and adolescents have access to essential health care.

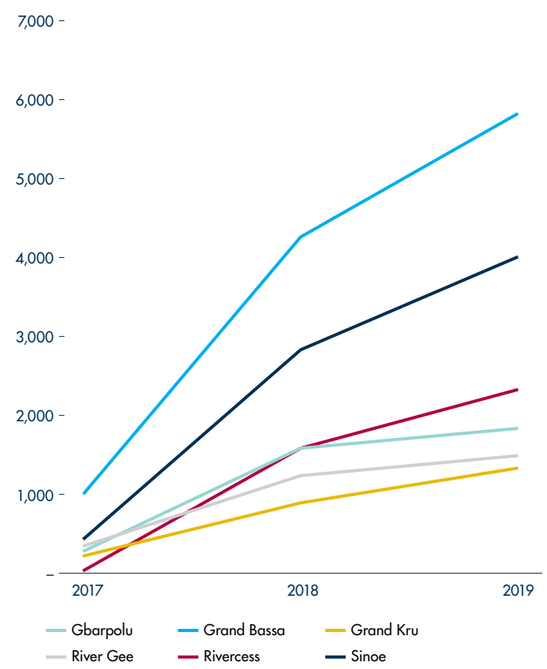
Promoting Equitable Access to Health Services by Closing Financing Gaps

While the Liberian government is supporting all 15 counties in the country, there are major health disparities across counties. The GFF has been supporting the government to develop an ambitious investment case that focuses on the six counties with the lowest health and nutrition outcomes – Gbarpolu, Grand Bassa, Grand Kru, River Gee, Rivercess, and Sinoe. This sharpened focus is to help provide the additional financing needed for key priorities in those counties: emergency obstetric and neonatal care, adolescent health, emergency preparedness, civil registration and vital statistics (CRVS), and community engagement and data-use for decision making. Complementing these efforts, a USAID-supported project is financing an essential package of health services in six counties to cover 1.8 million people with family planning, maternal and child health, and malaria prevention and treatment.

With domestic health spending severely constrained, the GFF helped the government to map resources and develop an action plan for increasing the efficiency of development assistance. The plan helped align existing resources to close the funding gaps for the priority areas outlined in the investment case. As a result, external funding commitments increased consistently over time, doubling over a three-year period from US$27million in FY2017/18 to US$30M in FY2018/19, and more recently to US$55 million in FY2019/20. In addition, the government has also increased domestic health spending as a share of public expenditure from 10.5 percent in FY2016/17 to 14.1 percent in FY2018/19. A forthcoming digital resource mapping and tracking tool will enable the government and partners to access real-time information on resource allocation and expenditures to aid policy decisions about directing funds where they are needed most.

The GFF is also providing technical assistance on longer-term health financing reforms through a US$16 million grant to back implementation of the investment case, linking this funding to the World Bank-financed Health System Strengthening Project. The focus is on building the government's capacity to reform and scale up strategic purchasing of services based on the performance of services providers. This is incentivizing expansion of quality services to underserved populations and increasing funding for the frontlines. In three of the six priority counties, payments to service providers are linked to performance on key maternal, child, and adolescent health indicators and service quality at both hospital and primary health care level.

Figure 1 **Women Attending PNC, Priority Counties[19]**



18 All RMNCAH-N impact data for Liberia sourced from the DHS 2013 and DHS 2019.
19 Data for all graphs and maps for Liberia sourced from the DHIS2 system.

Encouraging Health Outcomes

The sharpened focus on aligning resources around priorities has already helped improve health outcomes and service delivery and is narrowing the gap between lagging counties and the rest of the country. The GFF is now working with the government to scale up the successful performance-based model nationally. The Demographic Household Surveys 2013 and 2019 show some key positive outcomes.

Institutional Deliveries

- Between 2016 and 2019, the number of assisted

DELIVERIES IN HEALTH FACILITIES INCREASED BY INCREASED BY 24 PERCENT

in the six priority counties (DHIS2). Nationally, assisted deliveries in health facilities rose by 43 percent between 2013 and 2019 (DHS).

Antenatal and Post Natal Care

- Between 2017 and 2019, the total number of women across the country who had

FOUR ANTENATAL CARE VISITS INCREASED ALMOST FIVE-FOLD (FROM 19,000 TO ALMOST 84,000)

and tripled in the six priority counties (from almost 3,000 to more than 12,000). The number of women receiving postnatal care by skilled birth attendants within 24 hours of delivery increased almost 6-fold from almost 16,000 to more than 100,000 nationally and from almost 2,500 to 17,000 in the six priority counties (DHIS2).

Childhood Immunization

- Between 2016 and 2019, the number of newborns who were fully immunized increased by 20 percent across all counties (DHIS2). From 2013 to 2019,

BASIC IMMUNIZATION COVERAGE FOR CHILDREN UNDER TWO INCREASED FROM 55 TO 65 PERCENT TO REACH 134,500 CHILDREN (DHS).

Still, more efforts are needed to bridge the gap, as only two priority counties had coverage above the national average.

Family Planning

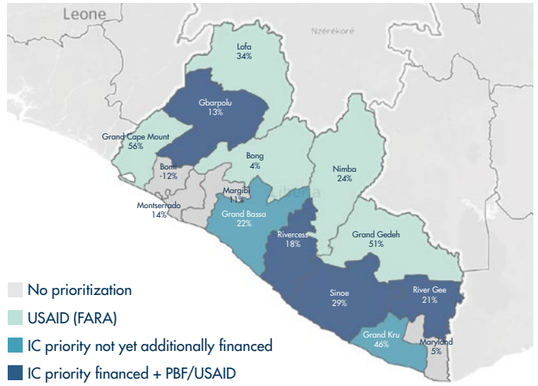
- Between 2016 to 2019,

FAMILY PLANNING VISITS INCREASED BY 60 PERCENT (DHIS2).

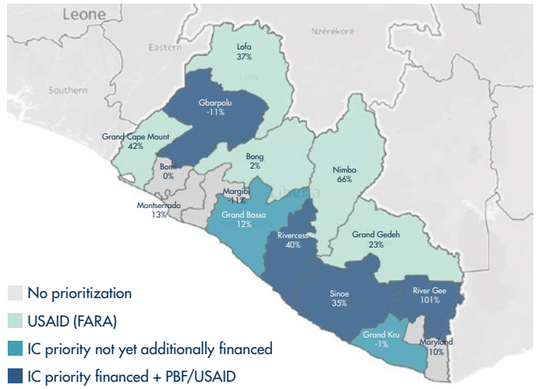
nationally. Only one priority county (Rivergee) showed progress in this indicator with the rest reporting a decline. Significant improvements were reported in counties supported by the USAID FARA program, which focuses specifically on family planning services.

- Between 2013 and 2019, the contraceptive prevalence rate rose from 19 to 25 percent across the country and in all six prioritized counties. The highest increase recorded was in Grand Kru (25 percent), Grand Bassa and Rivercess (16 percent). Across the country, adolescent fertility rates dropped by 14 percent (DHS).

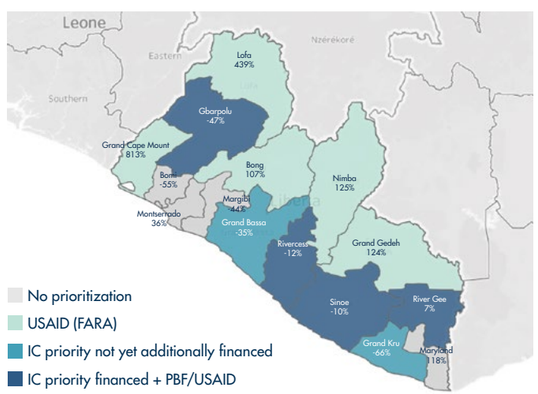
Deliveries with Skilled Birth Attendant, Percent Change 2016-2019



Children Fully Immunized, Percent Change 2016-2019



Family Planning Clients Counselled, Percent Change 2016-2019



COUNTRY SNAPSHOT

RWANDA: BENDING THE CURVE ON STUNTING TO BUILD HUMAN CAPITAL

Rwanda has made remarkable progress in health over the past two decades. Maternal mortality has decreased, access to prenatal care is almost universal, and increased contraceptive use has resulted in fewer pregnancies. Yet, while more infants and children are surviving now more than ever, many children under five remain stunted. The Global Financing Facility (GFF) is supporting Rwanda's efforts to accelerate stunting reduction, build human capital and secure a healthier, more productive future for its children. Rwanda's approach to tackle stunting goes beyond the health and nutrition sectors to include social protection measures and strengthening civil registration and vital statistics. GFF's catalytic role helps maximize the impact of these investments to deliver a core package of diverse services to families that need them the most. This is translating into better nutrition for children and expanded access to services, particularly for the poorest families. In parallel, the GFF is supporting key policy and public financing reforms that are laying the foundation for sustained impact.

Remarkable Progress in Health but Chronic Malnutrition Persists

Rwanda has invested heavily in its health systems, improved access to primary health care and deployed tens of thousands of community health workers to the frontlines. These efforts have led to significant progress for the health of women, children and adolescents. For example, between 2000 and 2014, maternal mortality decreased by 80 percent. In 2014, over 95 percent of pregnant women received antenatal care and 90 percent benefitted from a skilled birth attendant. Family planning services are also widely available, giving women greater access to modern contraceptives. While Rwanda has also improved infant and child survival, childhood stunting remains stubbornly high at 38 percent. In the poorest families, it affects nearly half of children under five.[20]

Maximizing the Impact of a Multisectoral Approach to Stunting

The Rwandan government, in partnership with the GFF, the World Bank, and The Power of Nutrition, developed an integrated national plan to combat chronic malnutrition. The plan, which also serves as the country's investment case, coordinates partners and sectors such as health, nutrition and social protection to deliver a core package of services for women and children. The plan focuses on high-stunting districts, vulnerable populations, and the critical early years of a child's life – beyond which stunting becomes largely irreversible.

The GFF is contributing a total of US$18 million to the plan. A US$10 million grant is linked to the US$25 million Stunting Prevention and Reduction Project financed by the World Bank's International Development Association (IDA). The project helps to reform the community health workers program and scaling up multi-sectoral interventions in 13 districts with high stunting rates and food-insecure households. Another US$8 million GFF grant is co-financing the World Bank IDA US$80 million Strengthening Social Protection Project to support innovations in social protection services and strengthening civil registration and vital statistics in 17 districts. The GFF is maximizing the impact of these investments through its support to identify priority interventions that reach the most vulnerable and align incentives among households, communities, service providers, and local governments. At the same time, GFF technical assistance is supporting strategic policy reforms, efficient and sustainable financing, and results monitoring.

Scaling up High-Impact Interventions

Through support to the social protection project, the GFF helped to establish and scale-up cash transfers to vulnerable families to incentivize the use of health and nutrition services. For example, direct cash transfers are linked to antenatal and postnatal visits and regular checkups to measure children's weight and height. In 2019, more than 20,000 beneficiaries in the poorest households were registered to receive cash transfers. An expansion in the eligibility criteria in 2020 enabled the program to reach 73,000 beneficiaries, including 12,000 pregnant women and 61,000 children under two. In partnership with the World Bank's Identification for Development (ID4D) Program, the GFF also supported the development of a national electronic payment system for cash transfers to significantly reduce transaction costs and increase efficiency. Based on these improvements, the Rwandan government has approved an expansion of the program to double the registered beneficiaries in 2023 and 2024.

GFF is also supporting the rapid expansion of a government program that ensures families receive key services in the early years. The program provides younger children in poor households with food, early stimulation and a play environment through well-trained caregivers and home-based early childhood development settings. By February 2020, over 25,600 early childhood development settings were active across all 30 districts of Rwanda.[21] Around 216,000 caregivers were available to provide early childhood development services through these settings to children below the age of six. Through an upcoming human capital development project, the government is scaling up the number of these settings in each district to what is required for serving all families.

20 RMNCAH-N impact data for Rwanda sourced from the Demographic and Health Surveys.

21 All RMNCAH-N routine monitoring data for Rwanda sourced from the DHIS2 routine monitoring system unless otherwise specified.

The GFF is also supporting innovative, low-cost and easy-to-use tools such as special mats, which help families monitor their child's growth and enable them to intervene early to prevent stunting. Since 2019, more than 15,000 mats were distributed to households from only around 1,000 in 2018 (NECDP). Also, more than 24,000 community health workers have been trained to use the mats and as a result, around 140,000 children aged 3 to 18 months were screened monthly for malnutrition.

Improving Service Delivery and Data Monitoring

The GFF is supporting Rwanda's community health workers – who are central to the country's plans to improve delivery for health and nutrition services. However, a lack of training, inadequate incentives and periodic shortages of commodities had previously limited their impact. The GFF is funding training, certification and accreditation, and strengthening the incentive payment systems. As of 2020, all 26,000 health workers in the 13 priority districts had been trained on maternal, infant and young child nutrition.

The GFF is also strengthening Rwanda's Civil Registration and Vital Statistics (CRVS) to increase birth registrations and ensure that beneficiaries can receive social services. With GFF technical assistance, the government has decentralized birth registration and made it simpler by amending a national law which assigns civil registrar functions to health facility officers to record births and deaths. In partnership with ID4D, GFF is also helping to improve information systems for more efficient enrollment of eligible families in the nutrition cash transfer program and for monitoring compliance. The upgraded CRVS system has now been linked to the nutrition program to make it easier for families to receive timely cash transfers they need to purchase food. To advance the implementation, more than 4,500 officials have been trained on the integrated system. The impact of these investments in stronger systems is clear: the first Rwanda Vital Statistics Report published in 2020 showed that birth registration was at 87 percent, with 78 percent of births registered on time in 2019.

Increasing Financial Efficiency and Sustainability

The GFF has also funded a nutrition expenditure review and used this information to help the Ministry of Finance set up and institutionalize a system to tag and track the budget allocated to nutrition. This is helping to improve spending efficiency, monitor performance and ensure that resources are targeted to the most vulnerable groups.

In addition, the GFF is helping to increase the efficiency of Rwanda's community-based health insurance scheme, a program that has historically played a crucial role in expanding access to healthcare and improving health outcomes. The GFF is focusing on making enrollment more equitable and that the poorest households do not fall deeper into poverty because of health expenses.

Progress on Expanding Children's Nutrition Services

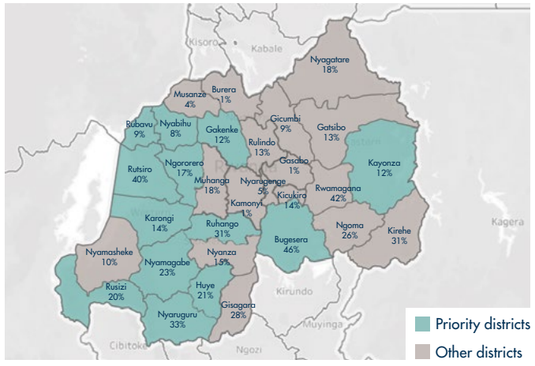
Rwanda's renewed efforts to accelerate progress against chronic malnutrition are already reflected in early improvements in service utilization.

- In 2019, about

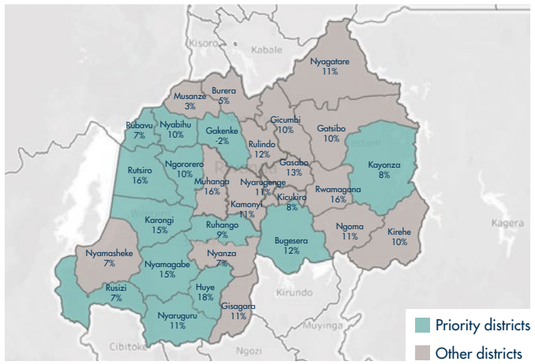
315,000 MORE NEWBORNS ACROSS THE COUNTRY WERE BREASTFED WITHIN ONE HOUR OF DELIVERY,

a 15 percent increase from 2018. For newborns delivered at health facilities 93.2 percent were breastfed within an hour of birth, a significant increase from 84.6 percent in 2018.

Fortified Blended Food Recipients, Percent Change 2018-2019



Newborns Breastfed Within 1 Hour of Delivery, Percent Change 2018-2019



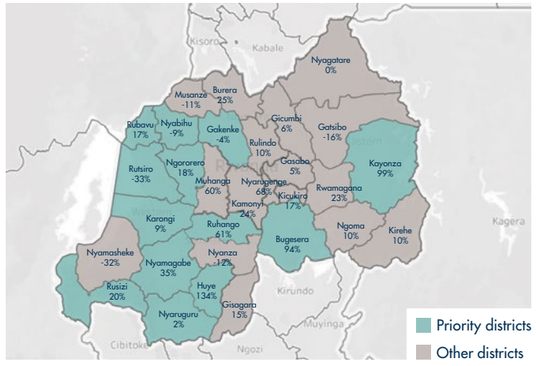
- In 2019, almost 220,000 newborns were visited by a community health worker at home on the third day after birth, an increase of 17.6 percent from 2018. In priority districts, 21 percent more newborns were visited.

- The number of

CHILDREN RECEIVING FORTIFIED FOODS INCREASED BY 3.3 PERCENT

from 2018 to 2019. The expansion of the eligibility for receiving services in the 13 priority districts, resulted in an 18 percent increase in enrollment compared to a 3.7 percent increase in non-priority districts. The number of women receiving support increased 19.5 percent nationally and 54 percent in priority districts.

Home Visits to Newborns by CHW within 3 Days, Percent Change 2018-2019



INTRODUCTION TO THE

COUNTRY DATA PROFILES

The Country Data Profiles section provides the most current and available information on each GFF partner country's progress on reproductive, maternal, newborn, child and adolescent health and nutrition (RMNCAH-N) coverage and impact indicators. It also includes progress on core and country-specific health financing indicators and describes where each country stands in terms of implementing its investment case and resource mapping.

GFF Catalytic Role: provides details on GFF support for the implementation of country investment cases. Details on past and ongoing work are provided for countries that joined the GFF from 2015 to 2018. For countries that joined in 2019, the focus is what is being planned.

RMNCAH-N Coverage Indicators: presents trend data for coverage indicators. All country data profile pages include a standard set of 9 RMNCAH-N coverage indicators from available population-based surveys from 2010 to 2019. Additional key nutrition-specific and/ or education-specific indicators are presented for countries where the GFF co-finances a nutrition-focused World Bank project or where education is a strong focus of the IC.

Standard 9 RMNCAH-N coverage indicators

- Antenatal care: 4+ visits
- Careseeking for symptoms of pneumonia
- DTP3 coverage (three doses of diphtheria-tetanus-pertussis vaccine)
- Institutional Delivery
- Oral rehydration salts treatment of diarrhea
- Postnatal care for mothers
- Skilled attendant at delivery
- Vitamin A supplementation, full coverage
- Demand for family planning satisfied with modern methods

Resource Mapping (RM), a key component of the GFF approach, helps countries assess funding gaps, align donor and government resources, and improve the efficiency and equity of health spending. Resource mapping data for each country varies based on whether countries have completed one or two resource mapping exercises.

Core RMNCAH-N Impact Indicators are collected by countries and partners using population-based surveys. These include Demographic Health Survey (DHS), Multiple Indicators Cluster Surveys (MICS), SMART, and malaria indicator survey (MIS).

Core GFF RMNCAH-N impact indicators

- Maternal Mortality Ratio
- Under-5 Mortality Rate
- Neonatal Mortality Rate
- Adolescent Birth Rate (15-19)
- Births <24 months after the preceding birth
- Stunting among children under 5 years of age
- Moderate to severe wasting among children under 5 years of age

The Health Financing Indicators focus on the three core GFF indicators from Global Health Expenditure Database (GHED), in addition to key country-specific indicators from country data sources such as BOOST, NHA, and other budget reports. If data is available, multiple data points are presented for each indicator between 2015 and 2019.

Core GFF health financing indicators

- Domestic General Government Health Expenditure (DGGHE) per capita (US$)
- Domestic General Government Health Expenditure (DGGHE) as share of General Government Expenditure (%)
- Out-of-pocket spending on health, per capita (US$)

Country-specific indicators

- Share of government budget allocated to health (%)
- Health budget execution (%)
- Share of health expenditure going to frontline providers (%)

Monitoring the Country-Led Process provides details on country progress across the key process indicators in the GFF approach. Each country receives a score between 1-5 for each indicator. This score is not meant for cross-country comparisons since each country is at a different stage in the process and has different priorities.

THE GFF'S CATALYTIC ROLE

1 **Reduce fragmentation of external resources and increase coordination and harmonization of current budget investments.** The GFF provides analytical support to map out off-budget and on-budget investments at subnational level that complement the basic package of health services (BPHS) and the essential package of health services (EPHS) contracts to increase alignment, coordination, and mutual accountability.

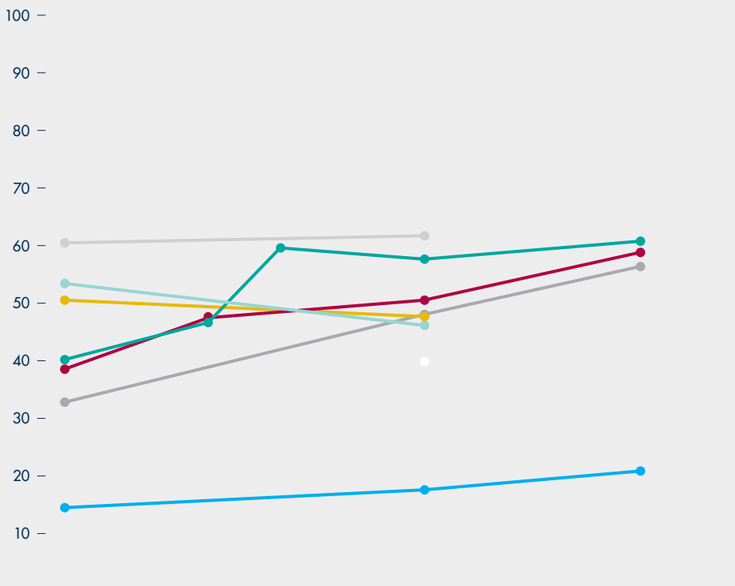
2 **Improve healthcare efficiency gains by better managing contracts with NGOs.** The GFF and World Bank support the Ministry of Public Health (i) to institutionalize the shift to performance management of health service providers, (ii) to support the development of a monitoring and evaluation framework that covers on- and off-budget programs and (iii) to better measure quality of care delivered under service-delivery contracts.

3 **Adopt evidence-based innovations to reduce maternal mortality and stunting and increase access to and quality health and nutrition services such as family planning.** The GFF supported analyses to identify existing innovations that have increased quality and uptake of these services and develop a roadmap for bringing these interventions into the on-budget program. Interventions include an intervention to prevent post-partum hemorrhage and neonatal sepsis at community level and the scale-up of new family planning methods.

4 **Strengthen coordination and engagement among different stakeholders including the private sector and civil society organization with a collective response towards RMNCAH-N impacts.** The GFF is providing support to the country platform (High-Level Oversight Committee) which serves as the governance mechanism for the implementation of BPHS/EPHS contracts and a forum for donor coordination. The GFF finances a liaison officer based in Kabul who supports the Ministry of Public Health and the High-Level Oversight Committee in its efforts to align partners behind national priorities and facilitate communication between stakeholders.

RMNCAH-N COVERAGE INDICATORS

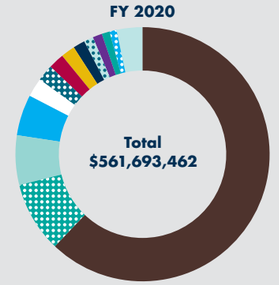
Data on immunization are presented from the WHO/UNICEF joint reporting process and recent population-based surveys. All other RMNCAH-N coverage indicators are presented from the most recent available population-based surveys.



Afghanistan

RESOURCE MAPPING

In Afghanistan, a resource mapping exercise was commissioned to support health budget alignment and harmonization and take stock of both on- and off-budget health resources at national and sub-national levels. A critical takeaway of the resource mapping is that a significant portion of funding for health is on-budget (62%), with the government contributing approximately 5% of the overall funding. The key findings of this exercise will help the Ministry of Public Health (MoPH) and its international partners make informed decisions in ongoing and future planning and budgeting process, support with updating the Investment Case (IC) for Afghanistan, and promote alignment, coordination and efficiency in the use of scarce resources. Mapping for the government and development partners captured actual health resources available for the period of 2018-2019 and forward-looking budgets for the period of 2020-2021. The MoPH is currently finalizing costing of the IC, which will allow calculation of the funding gap for the overall health sector, as well as by specific IC priority.



- GOVERNMENT/ ON-BUDGET*
- CANADIAN AID
- USAID
- GAVI
- UNICEF
- GF
- ROTARY INTERNATIONAL
- EUROPEAN UNION
- WHO
- JICA
- BMGF
- GERMANY
- CERF
- OTHER DONORS

*Includes World Bank/GFF contributions as well as funds from other donors pulling resources in the Afghanistan Reconstruction Trust Fund (ARTF).

CORE RMNCAH-N IMPACT INDICATORS

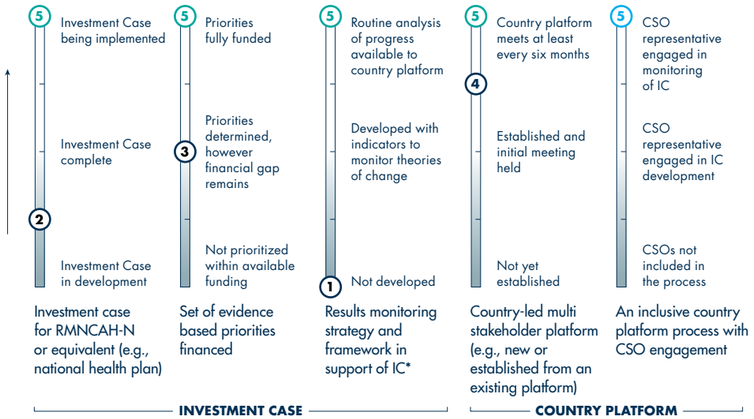
	Previous		Recent	
Maternal mortality ratio (per 100,000 live births)	**701**	2015	**638**	2017
Under 5 mortality rate (per 1,000 live births)	**76.8**	2015	**49.6**	2018
Neonatal mortality rate (per 1,000 live births)	**34.9**	2015	**23**	2018
Adolescent birth rate – 15-19 (per 1,000 women)	**28**	2015	**62**	2018
Births <24 months after the preceding birth (%)	**32.4**	2015	**–**	–
Stunting among children under 5 years of age (%)	**40.4**	2013	**36.6**	2018
Moderate to severe wasting among children under 5 years of age (%)	**9.5**	2013	**5**	2018

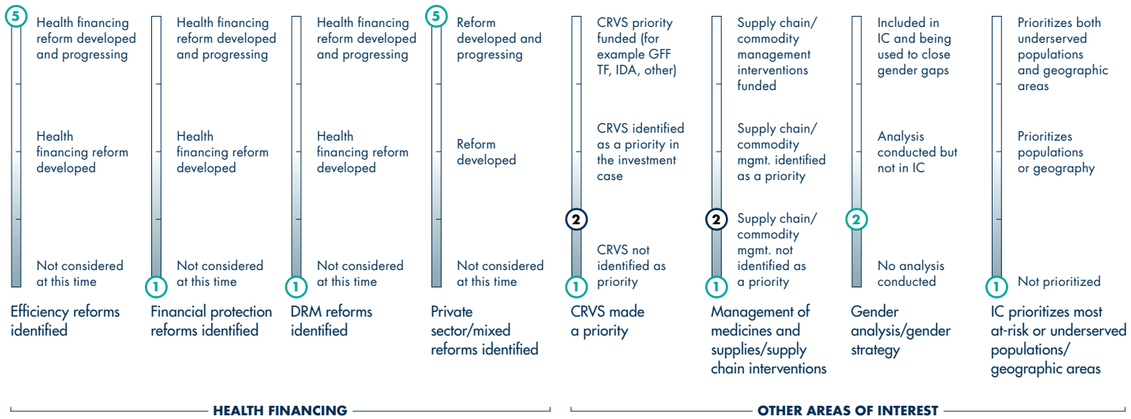
HEALTH FINANCING

Core Indicators	2015	2016	2017
Domestic General Government Health Expenditure (DGGHE), per capita (US$)	**3**	**3.2**	**3.4**
Domestic General Government Health Expenditure (DGGHE) as share of general government expenditure (%)	**2**	**2.1**	**2.3**
Out-of-pocket spending on health, per capita (US$)	**45.3**	**47.4**	**50.7**

Country-Specific Indicators	2016	2017	2018	2019
Share of government budget allocated to health (%)	**4.5**	**4.9**	**4.2**	**–**
Health budget execution (%)	**78**	**89**	**142**	**–**
Share of health expenditure going to frontline providers (%)	**56**	**55**	**55**	**–**

MONITORING THE COUNTRY-LED PROCESS





○ Annual report 2019/2020 score ○ Annual report 2018/2019 score ○ No change between last year and this year

* Both included in the IC document or a separate document

Bangladesh

THE GFF'S CATALYTIC ROLE

1 **Contribute to: (i) strengthening fiduciary systems; (ii) improving RMNCAH-N services in lagging divisions; and (iii) improving adolescent health through a cross-sectoral interventions in health and education.** The Health Sector Support Project (HSSP), co-financed by the GFF supports development of health system governance, implementation of an Essential Services Package that includes key RMNCAH-N services, a focus on lagging regions, particularly Sylhet and Chattogram Divisions; as well as the development and implementation of a school-based adolescent health program.

2 **Build capacity in health financing to support evidence generation and advocacy on the need to increase domestic resources allocated to health and improve resource use.** The Health Sector Support Project includes several disbursement-linked indicators for improved budget planning, execution and monitoring, as well as increased budget allocation and execution for frontline service delivery. The GFF has supported an assessment of public financial management arrangements and their impact on service delivery and implementation of the health financing strategy. In addition, the GFF supports advocacy around domestic resource mobilization.

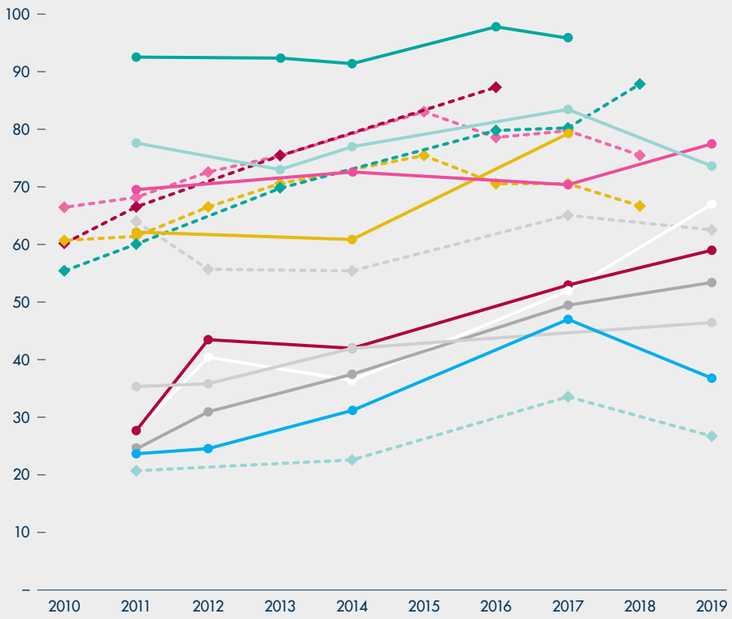
3 **Support analysis and dialogue on health equity and financial protection.** The analysis focused on household consumption survey and an in-depth assessment of different pathways to reduce household out of pocket payments.

4 **Strengthen private sector engagement and collaboration in the delivery of health services.** A high reliance on private sector providers has resulted in high out-of-pocket expenses (66 percent of households' total health spending). The GFF supports an initial development and dialogue on strategies to engage private sector providers, building on data from the private health sector assessments and capacity assessments conducted by GFF-World Bank, and from ongoing experiences with public-private collaboration.

5 **Support a multisectoral approach to improve adolescent health.** The GFF supported the preparation of school-level adolescent health programs and training-of-trainers in Sylhet and Chattogram divisions to particularly address adolescent pregnancy rates, by keeping girls in school and increasing access to adolescent health and nutrition services.

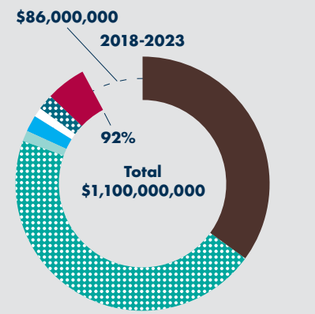
RMNCAH-N COVERAGE INDICATORS

Data on immunization are presented from the WHO/UNICEF joint reporting process and recent population-based surveys. Education indicators are presented from the World Development Indicators. All other RMNCAH-N coverage indicators are presented from the most recent available population-based surveys.



RESOURCE MAPPING

Bangladesh has a well-established donor coordination platform to align partners around shared priorities through a sector-wide approach, which has helped the government direct domestic and international funding to support key health goals. As such, elements of resource mapping and expenditure tracking are inherent to the SWAp mechanisms of joint planning, resource allocation, and implementation monitoring. Through the SWAp, the Government of Bangladesh has aligned more than US$1.1 billion in domestic and international public financing in support of its Fourth Health, Nutrition, and Population Sector Program for 2017-2022; the GFF contributes to and is an integral part of the partnership.



GOVERNMENT · WORLD BANK · GFF TRUST FUND · SIDA · NETHERLANDS · CANADA · DFID · GAP

CORE RMNCAH-N IMPACT INDICATORS

	Previous		Recent	
Maternal mortality ratio (per 100,000 live births)	**169**	2018	**165**	2019
Under 5 mortality rate (per 1,000 live births)	**46**	2014	**45**	2017
Neonatal mortality rate (per 1,000 live births)	**28**	2014	**30**	2017
Adolescent birth rate – 15-19 (per 1,000 women)	**113**	2014	**108**	2017
Births <24 months after the preceding birth (%)	**11.3**	2014	**–**	–
Stunting among children under 5 years of age (%)	**36**	2014	**30.8**	2017
Moderate to severe wasting among children under 5 years of age (%)	**14**	2014	**8.4**	2017

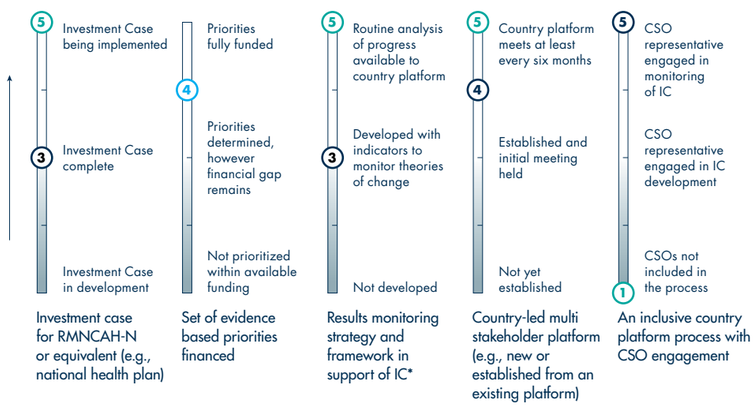
HEALTH FINANCING

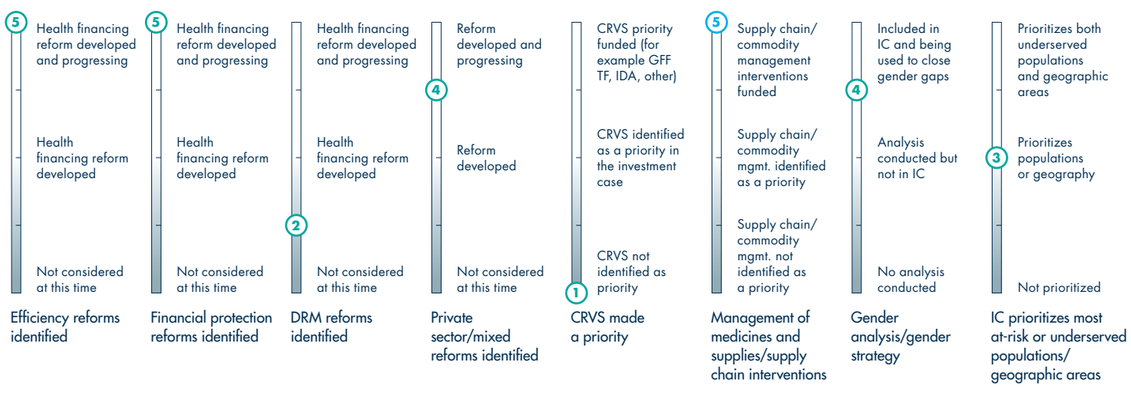
Core Indicators	2015	2016	2017
Domestic General Government Health Expenditure (DGGHE), per capita (US$)	**6.1**	**5.7**	**6.1**
Domestic General Government Health Expenditure (DGGHE) as share of general government expenditure (%)	**3.4**	**3**	**3**
Out-of-pocket spending on health, per capita (US$)	**25**	**25.3**	**26.8**

Country-Specific Indicators	2016	2017	2018	2019
Share of government budget allocated to health (%)	**4.7**	**5.2**	**5.2**	**5**
Health budget execution (%)	**–**	**84**	**85**	**85**
Share of health expenditure going to frontline providers (%)	**–**	**19**	**33***	**31***
Budget planning and allocation are improved: Operational plans approved including activities and budgets for achievement of DLIs	**–**	**0**	**13**	**13**
Procurement process is improved using IT: Percentage of National Competitive Tenders (NCTs) using electronic government procurement (e-GP) system issued by MOHFW	**–**	**0**	**0**	**18**

*33% and 31% refer to budget only

MONITORING THE COUNTRY-LED PROCESS





Annual report 2019/2020 score · Annual report 2018/2019 score · No change between last year and this year

* Both included in the IC document or a separate document

Burkina Faso

THE GFF'S CATALYTIC ROLE

1 **Improve equitable access, coverage, and utilization of an integrated package of high-impact RMNCAH-N interventions especially in rural/remote geographic areas.** The GFF supports the availability of functional basic and comprehensive emergency obstetric and newborn care health facilities, and scale-up of the community health services to additional villages to encourage more women to seek services.

2 **Strengthen human resources availability, infrastructure, equipment, and commodities.** The GFF has contributed funding to organize two learning events to ensure the availability of operational, competent, motivated and fairly distributed staff.

3 **Support efforts to improve data availability and analysis through health information systems, including CRVS.** The GFF supports the development of digital CRVS systems to enhance birth/death registrations. To improve data availability, the GFF is supporting the rollout of the population census to facilitate all coverage data, and an evaluation of the National health information system and support to the MOH for 2019 data recovery.

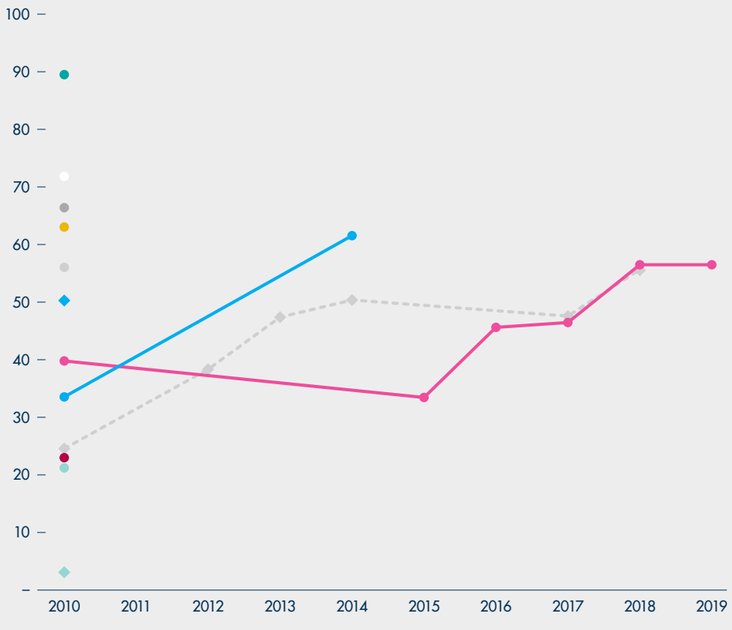
4 **Support key health financing reforms.** The GFF provided technical assistance and stakeholders coordination to develop and prioritize health financing reforms: (i) rollout of free healthcare for pregnant women and children under five; (ii) expansion of health insurance with the CNAMU; and (iii) implementation of PBF.

5 **Strengthen strategic efficiency and quality of care.** The GFF has helped improve performance contracting and funded a study on family planning quality of care. Five core partners to the IC, including GFF will increase their support for the implementation of strategic purchasing.

6 **Strengthen Civil Society Organizations (CSOs).** The GFF empowers CSOs to monitor progress under the investment case and engage in dialogue for updating it.

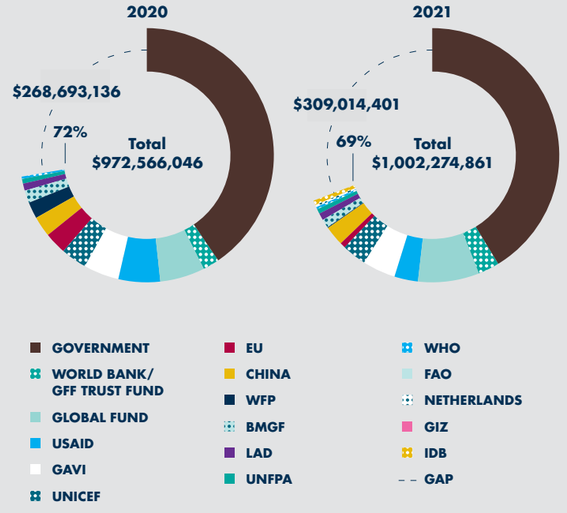
RMNCAH-N COVERAGE INDICATORS

Data on family planning are presented from the PMA2020 database and recent population-based surveys.
All other RMNCAH-N coverage indicators are presented from the most recent available population-based surveys.



RESOURCE MAPPING

A resource mapping of the UHC strategy (2020-2024) was conducted in 2020. The GFF investment Case is an essential element of the UHC strategy since it was revised with the purpose of becoming the central document for the upcoming High level UHC financing forum. The resource mapping focuses on RMNCAH and health system strengthening priorities for 2020 and 2021. The analysis shows that the government of Burkina Faso is maintaining its engagement in funding the UHC strategy and remains the main source of funding in 2020 and 2021. 16 donors are aligned to the UHC strategy in 2020 and 2021. The funding gap slightly increased between 2020 and 2021 due to an increase in cost of the UHC strategy from 2020 to 2021. Funding gap analysis by priority area highlights that nutrition, malaria, child health and community health are particularly underfunded while the health system strengthening component appears to be slightly over-funded underlining room for improving allocative efficiency. Further analysis needs to be conducted by the Ministry of Health to better understand reasons behind under-funding of key priorities to reach UHC targets and define strategies to make existing resources more efficient.



CORE RMNCAH-N IMPACT INDICATORS

	Previous		Recent	
Maternal mortality ratio (per 100,000 live births)	**341**	2010	**330**	2015
Under 5 mortality rate (per 1,000 live births)	**129**	2010	**82**	2015
Neonatal mortality rate (per 1,000 live births)	**28**	2010	**23**	2015
Adolescent birth rate – 15-19 (per 1,000 women)	**132**	2014	**132.3**	2018
Births <24 months after the preceding birth (%)	**17.4**	2014	**16.1**	2018
Stunting among children under 5 years of age (%)	**24.9**	2017	**21.1**	2018
Moderate to severe wasting among children under 5 years of age (%)	**8.4**	2017	**8.6**	2018

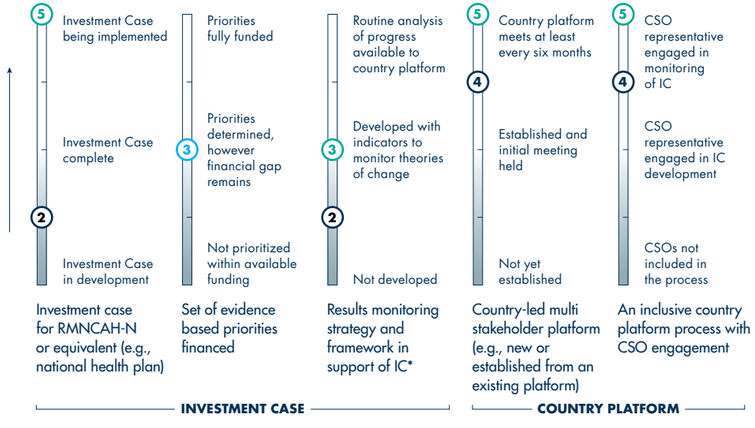
HEALTH FINANCING

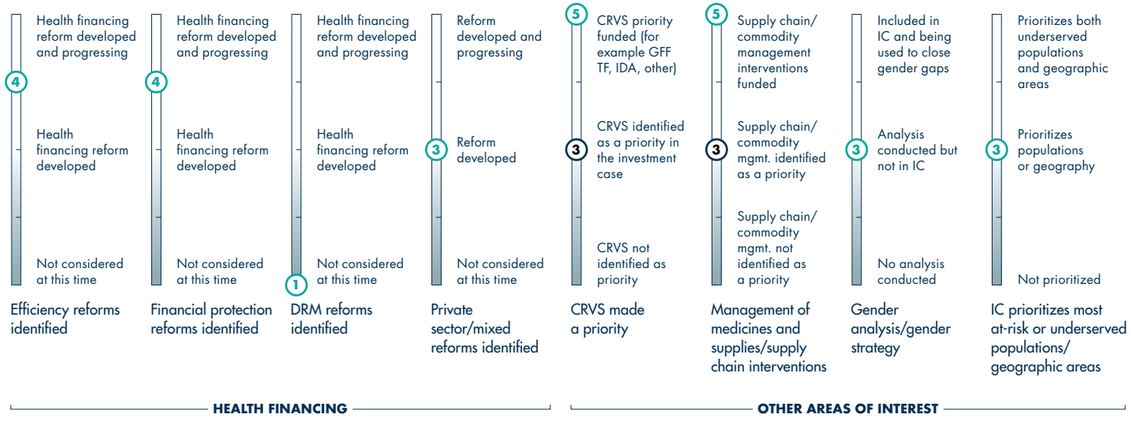
Core Indicators	2015	2016	2017
Domestic General Government Health Expenditure (DGGHE), per capita (US$)	**10**	**16**	**16**
Domestic General Government Health Expenditure (DGGHE) as share of general government expenditure (%)	**12**	**13**	**14**
Out-of-pocket spending on health, per capita (US$)	**7.2**	**11**	**10**

Country-Specific Indicators	2016	2017	2018	2019
Share of government budget allocated to health (%)	–	**12**	**11**	**11**
Health budget execution (%)	–	**93**	**100**	**100**
Share of health expenditure going to frontline providers (%)*	–	–	–	–

*This is a new indicator that is still being defined at the country-level

MONITORING THE COUNTRY-LED PROCESS





Annual report 2019/2020 score
Annual report 2018/2019 score
No change between last year and this year

* Both included in the IC document or a separate document

Cambodia

THE GFF'S CATALYTIC ROLE

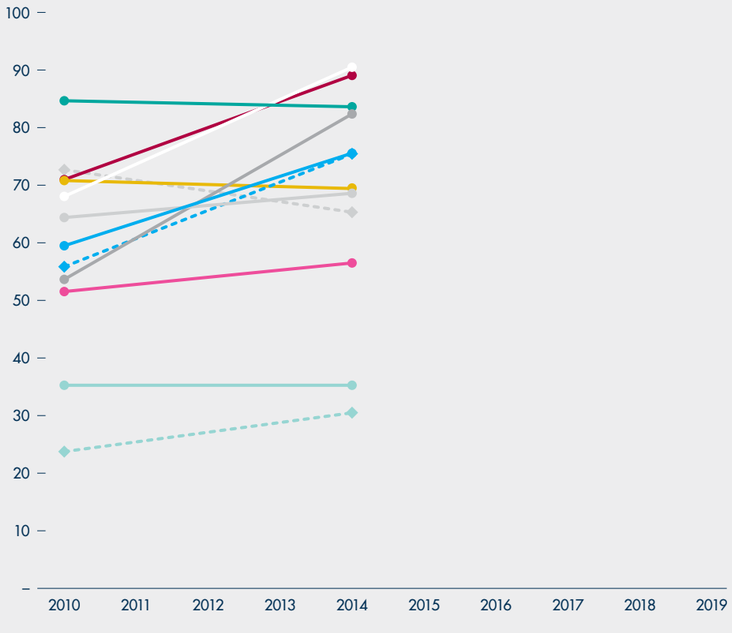
1 **Support the health financing agenda which includes domestic resource mobilization (DRM) for RMNCAH-N, enhancing efficiency, and providing financial protection for the poor.** GFF will provide technical assistance for analytics and capacity building for ongoing support to Cambodia's health financing reform agenda. The reforms will build on the success of the health equity fund (HEF) and service delivery grant systems. HEF provides financial protection for the poor seeking care at public health facilities, while SDGs channel flexible funds to public health facilities. The technical assistance will focus on (i) strengthening and institutionalizing the systems and processes; and (ii) supporting equitable access to quality health services as the country moves toward decentralization/de-concentration of public services to authorities at the local and subnational levels.

2 **Defragment RMNCAH-N financing and integrate service delivery within mainstream government systems and reforms to improve the coordination, quality, effectiveness, and sustainability of RMNCAH-N interventions.** In collaboration with other partners and NGOs, the GFF is financing TA to strengthen the health system, enhance nutrition service delivery, and improve maternal, infant and young child nutrition (MICYN) behaviors. TA is supporting the development of quality assessment tools for public facilities through a quarterly assessment process. Competency-based training and coaching packages are also under development; they will align content, materials, and messages with an improved multi-channel MICYN social and behavior change communication strategy and campaign.

3 **Support evidence generation and evidence-informed policy making.** The GFF supports the integration of RMNCAH-N priorities into the policy dialogue for HF and service delivery reforms. This includes nutrition and immunization drill-downs for the health financing strategy assessment to develop options for sustainable financing of the Investment Case priorities; assessments and TA for the design and financing of a community health and nutrition platform; a knowledge exchange; and support for evaluation and research, including the project's impact evaluation and implementation research.

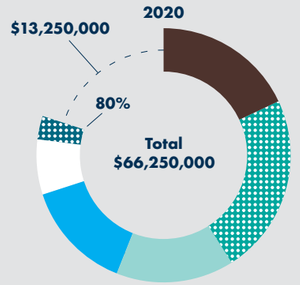
RMNCAH-N COVERAGE INDICATORS

All RMNCAH-N coverage indicators are presented from the most recent available population-based surveys.



RESOURCE MAPPING

Cambodia's Investment Case is focused on three key issues: reducing newborn mortality, reducing child undernutrition, and decreasing adolescent fertility. The Cambodia Nutrition Project (2019-2024), a US$53 million investment lending operation, will fund an estimated 80% of the activities included in the Investment Case and is closely aligned with its strategic priorities. The CNP harmonizes financing from IDA, GFF, German KfW, Australian DFAT, and the Health Equity and Quality Improvement Project MDTF (pooling financing from Australian Aid, German KfW and KOICA) and includes 23% of domestic resources from the Royal Government of Cambodia. A detailed resource mapping exercise of the Investment Case was planned in early 2020 but has been delayed due to the covid-19 pandemic and will resume in fiscal year 2021. The resource mapping will identify funding gaps by priority and will show trends in domestic resource mobilisation and donor alignment around the Investment Case.



CORE RMNCAH-N IMPACT INDICATORS

	Previous		Recent	
Maternal mortality ratio (per 100,000 live births)	–	–	170	2014
Under 5 mortality rate (per 1,000 live births)	54	2010	35	2014
Neonatal mortality rate (per 1,000 live births)	27	2010	18	2014
Adolescent birth rate – 15-19 (per 1,000 women)	46	2010	57	2014
Births <24 months after the preceding birth (%)	16.1	2010	13.3	2014
Stunting among children under 5 years of age (%)	39.8	2010	32.4	2014
Moderate to severe wasting among children under 5 years of age (%)	11	2010	9.7	2014

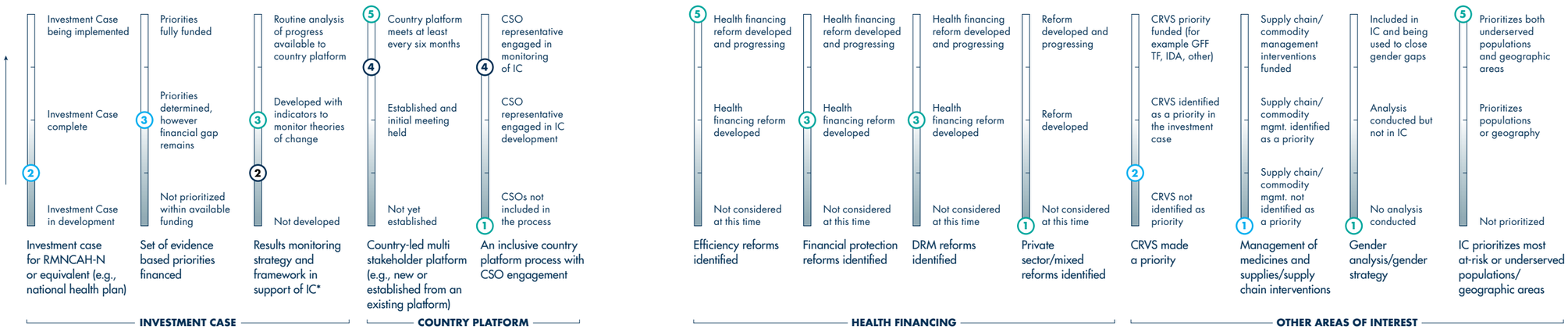
HEALTH FINANCING

Core Indicators	2015	2016	2017
Domestic General Government Health Expenditure (DGGHE), per capita (US$)	16.8	17.6	19.5
Domestic General Government Health Expenditure (DGGHE) as share of general government expenditure (%)	6.4	6	6.1
Out-of-pocket spending on health, per capita (US$)	44.4	47.1	49.6

Country-Specific Indicators	2016	2017	2018	2019
Share of government budget allocated to health (%)	14.2	12.9	13	11.7
Health budget execution (%)	–	–	–	–
Share of health expenditure going to frontline providers (%)*	–	–	–	–
Amount of outpatient Health Equity Fund services in target areas (number of services in millions)	–	–	2.5	2.6

*This is a new indicator that is still being defined at the country-level

MONITORING THE COUNTRY-LED PROCESS



Annual report 2019/2020 score Annual report 2018/2019 score No change between last year and this year

* Both included in the IC document or a separate document

Cameroon

THE GFF'S CATALYTIC ROLE

1 **Increase domestic resources going to frontline health providers as well as allocative efficiency.** The GFF supports the review of financial rules to push funding to the frontlines.

2 **Scale up results-based financing in disadvantaged regions, in order to improve equity in spending.** With GFF support, the coverage in performance-based financing (PBF) has substantially increased: out of 189 districts it has risen from 78 districts in 2017 to 148 districts in 2018 to 172 districts in 2019.

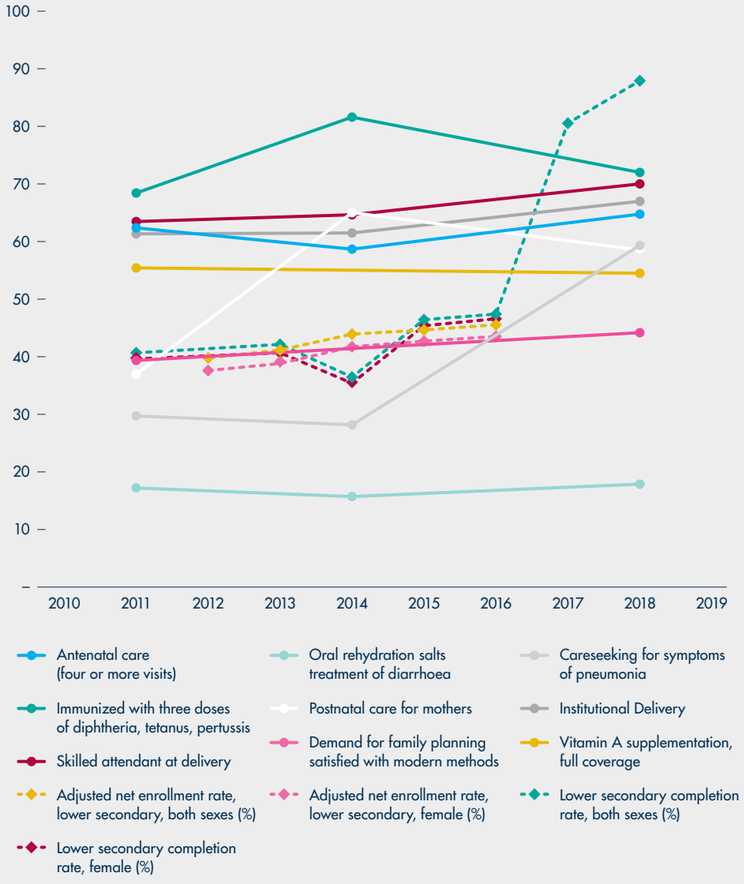
3 **Strengthen Kangaroo Mother Care and neonatal health care through a development impact bond, in order to reduce neonatal mortality and the number of low-birthweight and preterm infants.** Mobilization of the Development Impact Bond for Kangaroo Mother Care started in January 2019. Six out of 10 hospitals are now delivering Kangaroo Mother Care services, collecting data and building the capacity of their staff to deliver the highest quality of care, and more than 380 babies were enrolled in this program across these 6 hospitals. In addition, with support from the GFF, emphasis was laid on capacity building of service providers (in service training, mentoring) and proper equipment for both basic and comprehensive emergency obstetric and newborn care in more than 100 health facilities at the primary level (integrated health centers and district hospitals) in the priority regions.

4 **Enhance the focus on adolescent reproductive health,** which aims to reduce high rates of adolescent fertility and mistimed pregnancies, increase adolescent access to social services, and improve educational opportunities, especially for girls. The GFF supports the availability of adolescent and youth services in district and regional hospitals in priority regions.

5 **Incentivize birth registration through performance-based financing,** adopt international standards for the registration of events, improve the interoperability of systems, and increase registration centers and the number of civil registration officials.

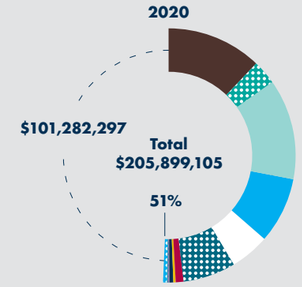
RMNCAH-N COVERAGE INDICATORS

Education indicators are presented from the World Development Indicators. All other RMNCAH-N coverage indicators are presented from the most recent available population-based surveys.



RESOURCE MAPPING

A detailed resource mapping and expenditure tracking exercise was conducted in Cameroon, based on the four RMNCH priorities identified in the 2018-2022 Investment Case. The objective was to analyze the evolution of the resources committed by the Cameroonian Government and its partners to these health priorities, and to determine the funding gap to be filled through better alignment of external aid and increased mobilization of domestic funding. The resource mapping shows gaps by priority but also sub-national region. Despite a fairly large number of 25 partners funding the IC priorities, there remains a financing gap of 57% of the total cost over four years (the gap is 49% in 2020). Mobilization of both domestic and external funding towards RMNCH priorities is critical particularly in light of the high out of pocket spending, which accounts for over 70% of current health expenditure in Cameroon.



- GOVERNMENT
- WORLD BANK/ GFF TRUST FUND
- USAID
- AFD
- KFW
- CDC
- BID
- LAD
- UNICEF
- SUPPLIES
- CERF
- GFATM
- OTHER DONORS
- GAP

CORE RMNCAH-N IMPACT INDICATORS

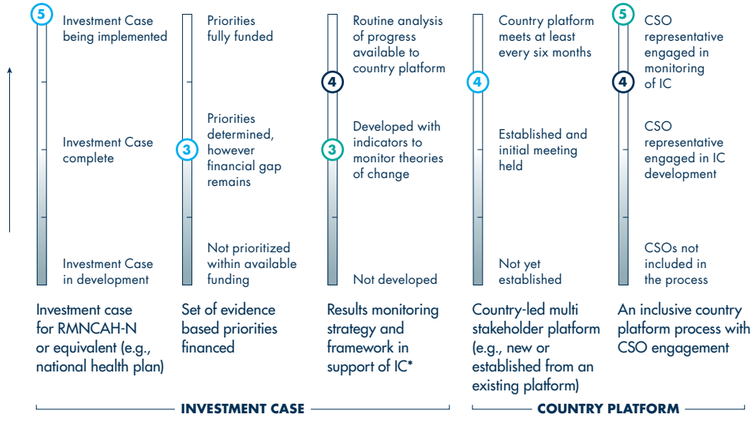
	Previous		Recent	
Maternal mortality ratio (per 100,000 live births)	**782**	2011	**406**	2018
Under 5 mortality rate (per 1,000 live births)	**103**	2014	**80**	2018
Neonatal mortality rate (per 1,000 live births)	**28**	2014	**28**	2018
Adolescent birth rate – 15-19 (per 1,000 women)	**119**	2014	**122**	2018
Births <24 months after the preceding birth (%)	**21.3**	2011	**25.3**	2018
Stunting among children under 5 years of age (%)	**31.7**	2014	**28.9**	2018
Moderate to severe wasting among children under 5 years of age (%)	**5.2**	2014	**4.3**	2018

HEALTH FINANCING

Core Indicators	2015	2016	2017
Domestic General Government Health Expenditure (DGGHE), per capita (US$)	**9.6**	**8.9**	**9**
Domestic General Government Health Expenditure (DGGHE) as share of general government expenditure (%)	**3.3**	**3**	**3.1**
Out-of-pocket spending on health, per capita (US$)	**46.3**	**46.9**	**48.1**

Country-Specific Indicators	2016	2017	2018	2019
Share of government budget allocated to health (%)	**5.6**	**5.7**	**4.8**	**4**
Health budget execution (%)	**–**	**95**	**97**	**98**
Share of health expenditure going to frontline providers (%)	**–**	**1**	**3**	**–**

MONITORING THE COUNTRY-LED PROCESS



Annual report 2019/2020 score Annual report 2018/2019 score No change between last year and this year

* Both included in the IC document or a separate document

THE GFF'S CATALYTIC ROLE

1 **Reduce fragmentation by integrating humanitarian and development financing.** The GFF supports the transition from an emergency to recovery for the health sector by aligning development and humanitarian health-focused actors to pursue a common goal of improving maternal and child health and nutrition.

2 **Increase domestic and external financial resources for the health sector.** The GFF assisted the government in undertaking and finalizing a fiscal space analysis. It will also help explore ways to develop public-private partnerships to make the private sector involved in health delivery and health financing activities. The GFF also provides a great opportunity to mobilize more external resources, facilitated by increasing the credibility of public institutions and by improving the planning, budgeting, and delivery of high-impact health interventions. The GFF's emphasis on tracking and demonstrating results will encourage partners to further finance and support the sector.

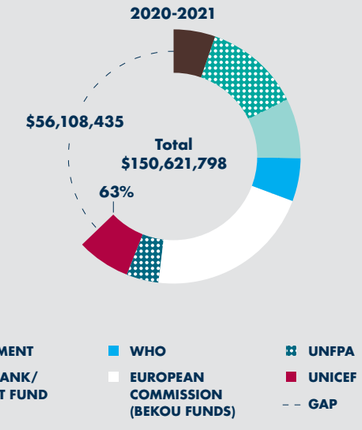
3 **Increase allocative and technical efficiency in the health sector in delivering essential healthcare services to the population.** With respect to allocative efficiency, the GFF, through the IC, will help policy makers channel funds into: (i) high-impact interventions, (ii) promotion and development of care provision at the community level; and (iii) investment in marginalized areas. For technical efficiency, the IC will guide the health system to optimize the use of existing resources. For this, the GFF supports the scale-up of performance-based financing to all districts nationally.

4 **Support health system strengthening initiatives, including (i) strengthening of health information systems by aligning the IC results framework with ongoing health information systems' reforms, and (ii) strengthening the human resources for health.** The GFF provides TA to strengthen the country's health management information system (HMIS) and supports the recruitment and incentivization of health workers through support to the performance-based financing scheme.

Central African Republic

RESOURCE MAPPING

A resource mapping of the Investment Case was conducted in 2019, presented here. The Investment Case was completed and launched in April 2020. In light of the COVID pandemic, the GFF will support an update to the resource mapping to measure the extent to which financial inputs that were committed and are reflected in the 2019 resource mapping are still available to finance the implementation of the Investment Case for maintaining access and delivery of essential RMNCAH-N services. This resource mapping will be conducted in the summer and early fall of 2020.



CORE RMNCAH-N IMPACT AND COVERAGE INDICATORS

Due to the recurrent and ongoing military, political, and security challenges, there is a dearth of recent household survey or HMIS data available for CAR. The most recent MICS for which there is publicly available data was conducted in 2010, before the civil war. Available, modeled global estimates for key indicators such as mortality are also considered to be unreliable as they do not account for the challenging socio-political environment the country faced in the last decade. The GFF is supporting initiatives to address these gaps in evidence through technical and financial assistance for RMNCAH-N service continuity surveys and providing HMIS expertise for major new investments in a DHIS2-based HMIS re-design. Furthermore, results from the 2019 MICS survey are expected later this year, and together with the initiatives outlined above, should ensure that a much deeper evidence base is available for planning and monitoring in 2021.

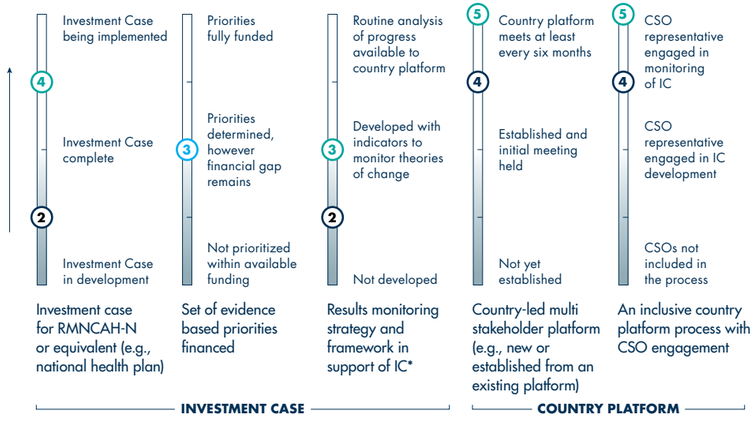
HEALTH FINANCING

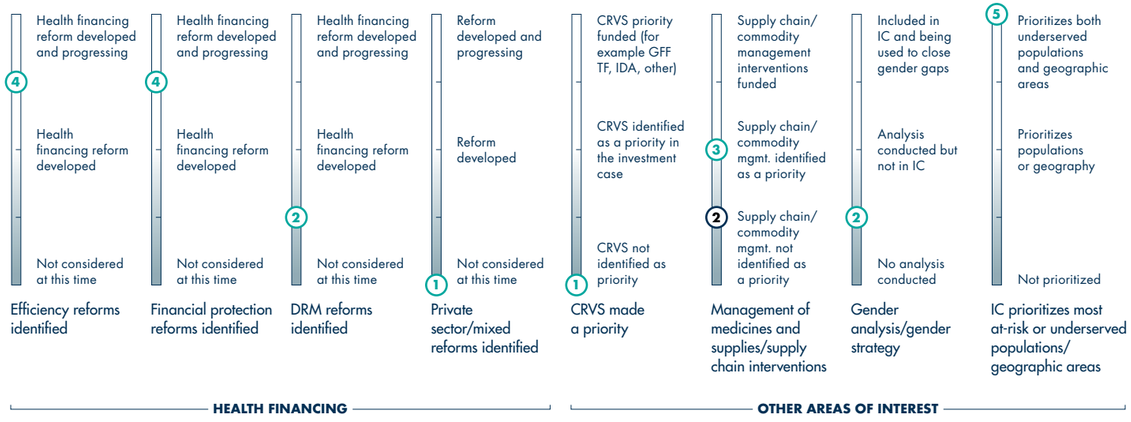
Core Indicators	2015	2016	2017
Domestic General Government Health Expenditure (DGGHE), per capita (US$)	2	2.5	3.1
Domestic General Government Health Expenditure (DGGHE) as share of general government expenditure (%)	3.5	5	5
Out-of-pocket spending on health, per capita (US$)	7.4	7.4	7.5

Country-Specific Indicators	2016	2017	2018	2019
Share of government budget allocated to health (%)	5.1	7.8	7.8	10.3
Health budget execution (%)	–	27	103	–
Share of health expenditure going to frontline providers (%)*	–	–	–	–
Proportion of health facilities covered by PBF (%)	–	–	38.7	49.6

*This is a new indicator that is still being defined at the country-level

MONITORING THE COUNTRY-LED PROCESS





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* Both included in the IC document or a separate document

Chad

THE GFF'S CATALYTIC ROLE

1 **Chad joined the GFF in 2019 and is in the process of developing a prioritized investment case.** Chad has already established a country-led multi-stakeholder platform that is meeting regularly.

2 **Prioritize and coordinate investments in RMNCAH service delivery through Investment case development.** The GFF provided technical assistance to initiate the GFF process, put in place the country platform and task force for IC development, designed a roadmap for the IC development, and held workshops for the situation analysis based on which the investment case will be built.

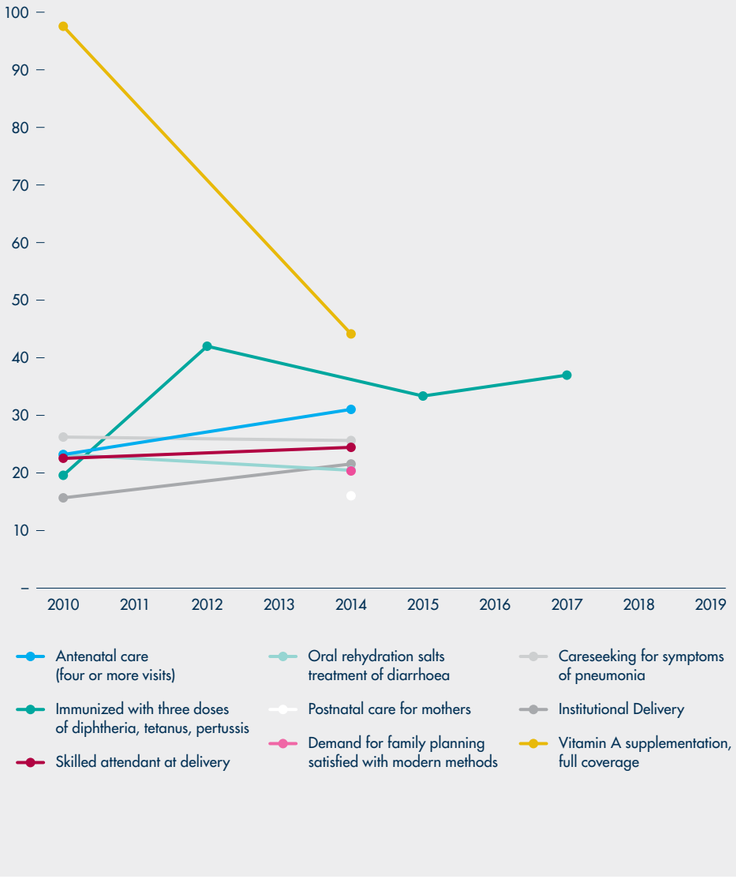
3 **Provide technical assistance for results-based financing (RBF) design.** Experts from the GFF assisted the country team in reflecting on the design of the upcoming RBF program under preparation as part of the World Bank/GFF co-financed project, including early dialogue on institutionalizing the RBF as a national strategic purchasing instrument.

4 **Support resource mapping for improved efficiency.** The GFF provides technical assistance for the resource mapping exercise that aims to rapidly capture both a forward-looking budget and high-level past budget data from government and/or external partners. In Chad, resource mapping pertains to mapping external and government budget linked to IC priorities of the RMNCH-A strategy from which the IC will be drawn. The resource mapping exercise is in an early stage of data collection.

5 **Strengthen civil society organizations (CSOs).** CSOs are benefitting from capacity building provided by the GFF CSO Hub, with the aim of being equipped for effective involvement in the GFF process in general and in IC development and implementation in particular. Consultations are at an advanced stage to fine-tune needs identification to ensure that the support is as well coordinated and effective as possible.

RMNCAH-N COVERAGE INDICATORS

Data on immunization are presented from the WHO/UNICEF joint reporting process and recent population-based surveys. All other RMNCAH-N coverage indicators are presented from the most recent available population-based surveys.



RESOURCE MAPPING

The first round of resource mapping in Chad has been initiated and will focus initially on the National Health Development Plan (Plan National de Développement Sanitaire or PNDS 2018-2021) in order to support the development and inform prioritization of the investment case. Data on government and development partners' budgetary commitments will provide a common and clear understanding of the domestic and external financing available for the health sector and the funding gaps. The RM process in Chad is in its initial phase and activities so far have focused on coordination and alignment with other initiatives such as resource mapping of the Covid-19 response plan and National Health Accounts led by WHO. The government team dedicated to the resource mapping has been formally appointed and the data collection phase is due to start soon. Resource mapping of both the PNDS and IC will be completed by the end of year 2020.

CORE RMNCAH-N IMPACT INDICATORS

	Previous		Recent	
Maternal mortality ratio (per 100,000 live births)	–	–	**860**	2014
Under 5 mortality rate (per 1,000 live births)	**175**	2010	**133**	2014
Neonatal mortality rate (per 1,000 live births)	–	–	**34**	2014
Adolescent birth rate – 15-19 (per 1,000 women)	**203.4**	2010	**179**	2014
Births <24 months after the preceding birth (%)	–	–	**30.2**	2014
Stunting among children under 5 years of age (%)	**31.9**	2018	**32**	2019
Moderate to severe wasting among children under 5 years of age (%)	**13.5**	2018	**12.9**	2019

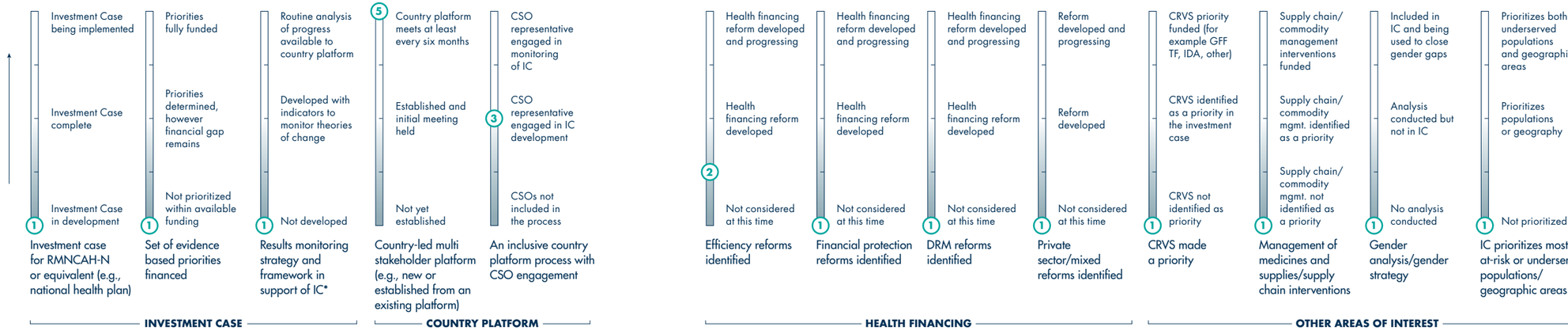
HEALTH FINANCING

Core Indicators	2015	2016	2017
Domestic General Government Health Expenditure (DGGHE), per capita (US$)	**7.5**	**5.9**	**4.7**
Domestic General Government Health Expenditure (DGGHE) as share of general government expenditure (%)	**5.3**	**5.7**	**4.7**
Out-of-pocket spending on health, per capita (US$)	**20**	**20**	**17.3**

Country-Specific Indicators	2016	2017	2018	2019
Share of government budget allocated to health (%)	**9**	**6.3**	**4.6**	**6.9**
Health budget execution (%)	**98.3**	**91.3**	**92.9**	**98.6**
Share of health expenditure going to frontline providers (%)*	–	–	–	–

*This is a new indicator that is still being defined at the country-level

MONITORING THE COUNTRY-LED PROCESS



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* Both included in the IC document or a separate document

Cote d'Ivoire

THE GFF'S CATALYTIC ROLE

1 **Strengthen donor coordination.** The GFF supports the resource mapping that has allowed evidence of over- and underfunded areas and provides a tool for improved prioritization.

2 **Support domestic resource utilization and mobilization (DRUM) by advocating for increased domestic budget allocated to health and its share for primary health care (PHC).** The GFF will fund analytical support to identify solutions to optimize public financial management and effective roll-out of budget programming.

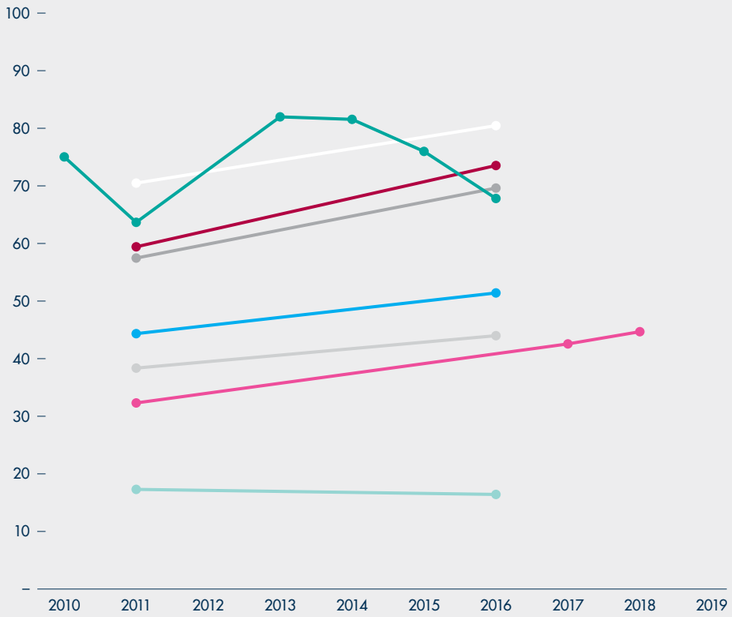
3 **Improve efficiency by prioritizing and coordinating investments in primary health care, including community health services, through decentralization and nationwide scale-up of strategic purchasing.** The GFF, through the Investment Case and the co-financed World Bank project supports the scale-up of performance-based financing nationally as well as development and implementation of program-based budgeting. These initiatives contribute to the prioritization of PHC in the budget.

4 **Strengthen private-sector service providers in strategic purchasing reforms through regulation, accreditation, and contracting mechanisms.** A private-sector assessment done in 2019 identified key gaps in regulations and systems, which will be addressed with GFF support. Through the GFF process, additional options, such as generating resources from the private sector (e.g. for paying social health insurance premiums of the informal sector); using mobile technologies; options for supply chains; and others will be explored to enhance the private sector possibility to contribute to improved health outcomes.

5 **Support capacity building on health care financing and linking to the universal health insurance scheme.** The GFF supports the Health Insurance Agency (CNAM) to develop the capacity to function as a purchaser, moving it toward a true separation of functions in the sector. The GFF supports bringing together the main financiers of technical assistance together with (regional) experts into an advisory board to CNAM that can provide guidance on technical workplans.

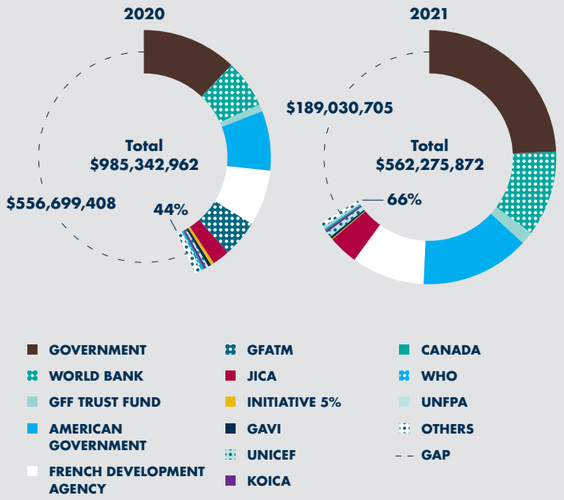
RMNCAH-N COVERAGE INDICATORS

Data on immunization are presented from the WHO/UNICEF joint reporting process and recent population-based surveys. Family planning indicators are presented from the PMA2020 database and recent population-based surveys. All other RMNCAH-N coverage indicators are presented from the most recent available population-based surveys.



RESOURCE MAPPING

In CIV, the investment case has been a vehicle to foster domestic resources over a set of prioritized health interventions. The budget from the Ministry of Health and Public Hygiene increased by 16,6% between 2019 and 2020 translating the strong engagement from the government to increase its yearly health budget by 15%. Based on the government budget increase and resource mapping data collected among donors, the funding gap of the investment was reduced by 50% between 2020 and 2021 from 57% in 2020 to 34% in 2021. The 2020 and 2021 resource mapping by priority areas also shows that funding gaps for key areas has gone down. Nevertheless, several priority areas remain unfunded such as quality of PHC and supply chain while community health approach continues to be over-funded, pointing to limited allocative efficiency . The result of the resource mapping exercise can support the government of CIV to request donors to shift funding from over-funded areas to under-funded areas. While the resource mapping exercises capture disaggregated finance data by region, it is not possible to provide acute data on each donor and gov contribution by region. Almost 80% of funding pertains to a category called: Multi-regions. The rest goes to the autonomous district of Abidjan (15%) and the central level, which suggest that funding is allocated in an equitable way, since 80% goes to the decentralized level which usually drives health results of the country.



CORE RMNCAH-N IMPACT INDICATORS

	Previous		Recent	
Maternal mortality ratio (per 100,000 live births)	**614**	2011	**–**	–
Under 5 mortality rate (per 1,000 live births)	**108**	2011	**96**	2016
Neonatal mortality rate (per 1,000 live births)	**38**	2011	**33**	2016
Adolescent birth rate – 15-19 (per 1,000 women)	**129**	2011	**124**	2016
Births <24 months after the preceding birth (%)	**14.9**	2011	**–**	–
Stunting among children under 5 years of age (%)	**29.8**	2011	**21.6**	2016
Moderate to severe wasting among children under 5 years of age (%)	**7.5**	2011	**6**	2016

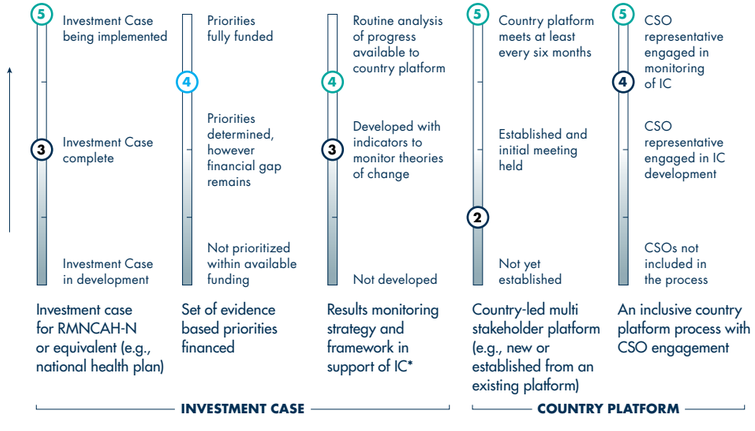
HEALTH FINANCING

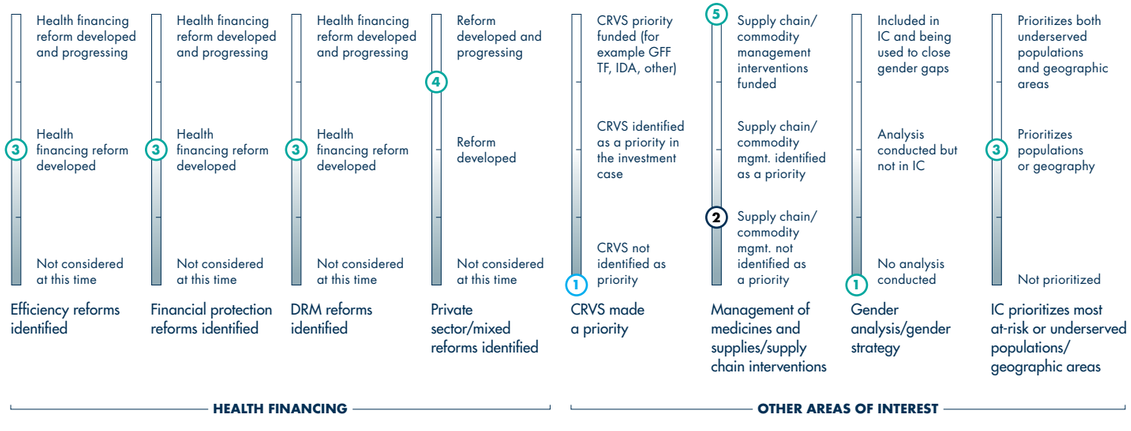
Core Indicators	2015	2016	2017
Domestic General Government Health Expenditure (DGGHE), per capita (US$)	**15.3**	**17.2**	**19.9**
Domestic General Government Health Expenditure (DGGHE) as share of general government expenditure (%)	**4.8**	**4.8**	**5.1**
Out-of-pocket spending on health, per capita (US$)	**26.8**	**27.2**	**27.5**

Country-Specific Indicators	2016	2017	2018	2019
Share of government budget allocated to health (%)	**6**	**6.1**	**5.4**	**5.3**
Health budget execution (%)	**90**	**90**	**87**	**93**
Share of health expenditure going to frontline providers (%)*	**–**	**–**	**–**	**–**
Number of PBF covered districts	**4**	**17**	**17**	**19**
Number of people covered by the CMU (*couverture maladie universelle*) (in thousands)	**–**	**–**	**–**	**1.9**
Number of poor and vulnerable covered by CMU (*couverture maladie universelle*) (in thousands)	**–**	**–**	**–**	**190.5**

*This is a new indicator that is still being defined at the country-level

MONITORING THE COUNTRY-LED PROCESS





Annual report 2019/2020 score Annual report 2018/2019 score No change between last year and this year

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Democratic Republic of Congo

THE GFF'S CATALYTIC ROLE

1 **Support the implementation of Program-based budgeting (PBB) to align government and donor investment to the National Health Development Plan (NHDP).** The GFF supports the MOH in the implementation of PBB to monitor increases in domestic and external spending on priority areas of the National Health Development Plan (e.g., RMNCAH, health system strengthening).

2 **Improve DRM and provide technical assistance on public financial management** to address the low budget execution rate. The GFF and the World Bank with funding from GAVI and Japan conducted several analytics on DRM and on the bottlenecks of low budget execution at central and decentralized level leading to recommendations such as the set-up of a ministerial committee between ministries of budget, finance and health to monitor budget execution regularly.

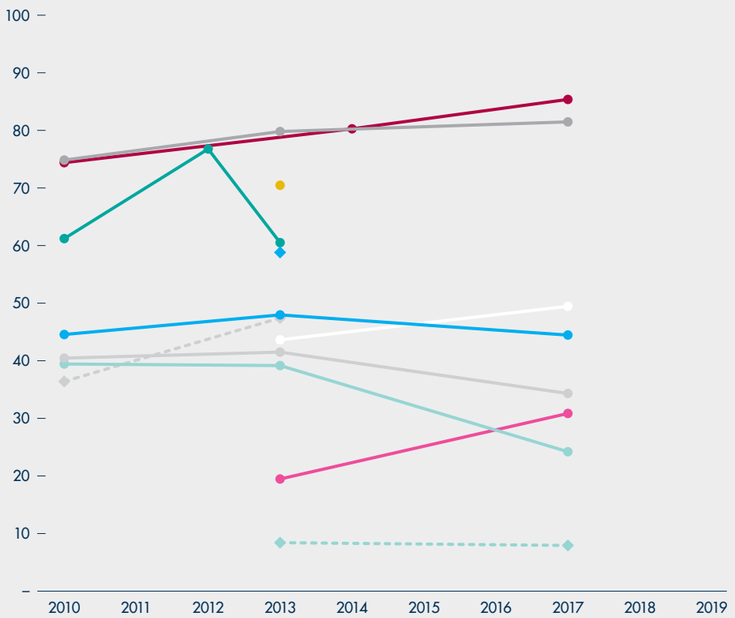
3 **Reduce the fragmentation of donor support through single contracts and regular resource mapping.** The 'contrat unique' is a virtual pooling of all financial resources supporting one integrated action plan to ensure proper supervision and monitoring of the RMNCAH-N package of services in the health zones under this mechanism. Regular resource mapping of the health sector, including RMNCAH-N will address duplication and contribute to more informed planning and lower transaction costs.

4 **Provide a package of RMNCAH services through RBF and implementation of equity fund to subsidize the poor.** The GFF supports the scale-up of PBF to improve the governance and management of the health system as well as deliver an integrated essential package of health services.

5 **Leverage the private sector to improve effective coverage and efficiency.** The World Bank and GFF supported discussions with the private sector on pharmaceuticals to ensure local manufacturers get certified to procure essential drugs.

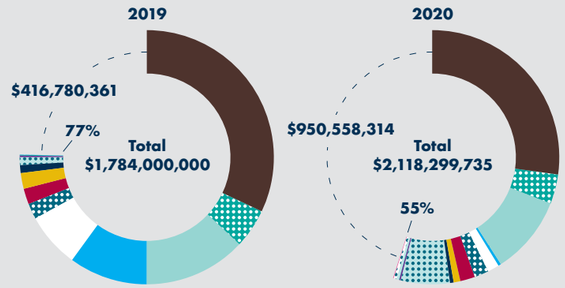
RMNCAH-N COVERAGE INDICATORS

Data on immunization are presented from the WHO/UNICEF joint reporting process and recent population-based surveys. All other RMNCAH-N coverage indicators are presented from the most recent available population-based surveys.



RESOURCE MAPPING

The resource mapping has been completed for the Plan National de Développement Sanitaire (PNDS) 2019-22, which serves as DRC's prioritized national health strategy and IC. The resource mapping (RM) shows trend analysis between FY2019 and FY2020. Data for this assessment was provided by the Ministry of Health (MOH) through the program-based budgeting (PBB) process consolidating both domestic and international budget and expenditure data with respect to the PNDS. The health donor's coordination group, known as Groupe Inter-Bailleurs de la Santé (GIBS) also provided feedback. The MOH highlighted these estimates are still in the process of being updated by the GIBS and may change. First, the funding gap of the IC doubled between 2019 and 2020. This is due to a cost increase of the PNDS between 2019 and 2020 and a decreased contribution from donors to the IC. Because of COVID-19, not all donors could maintain same level of engagement in 2020 as to 2019 as several had to re-prioritize funding committed to the PNDS to the COVID-19 response. Nevertheless, there seems to be more donors aligned to the IC in 2020 compared to 2019. Third, domestic resource has slightly increased in absolute terms but has decreased in relative terms of covering the cost of the IC.



CORE RMNCAH-N IMPACT INDICATORS

	Previous		Recent	
Maternal mortality ratio (per 100,000 live births)	**846**	2014	**–**	–
Under 5 mortality rate (per 1,000 live births)	**104**	2014	**70**	2017
Neonatal mortality rate (per 1,000 live births)	**28**	2014	**14**	2017
Adolescent birth rate – 15-19 (per 1,000 women)	**138.1**	2014	**109**	2017
Births <24 months after the preceding birth (%)	**27.1**	2014	**–**	–
Stunting among children under 5 years of age (%)	**42.7**	2014	**41.8**	2017
Moderate to severe wasting among children under 5 years of age (%)	**7.9**	2014	**6.5**	2017

HEALTH FINANCING

Core Indicators	2015	2016	2017
Domestic General Government Health Expenditure (DGGHE), per capita (US$)	**3.2**	**2.4**	**1.9**
Domestic General Government Health Expenditure (DGGHE) as share of general government expenditure (%)	**3.8**	**3.9**	**3.3**
Out-of-pocket spending on health, per capita (US$)	**7.2**	**7.1**	**7.8**

Country-Specific Indicators	2016	2017	2018	2019
Share of government budget allocated to health (%)	**6.9**	**7.8**	**8.5**	**10**
Health budget execution (%)	**97**	**54**	**67**	**57**
Share of health expenditure going to frontline providers (%)	**9**	**9**	**12**	**15**
Number of DPS (*division provinciale de la santé*) implementing single contract	**–**	**9**	**11**	**13**
Domestic health expenditure allocated to RMNCAH (%)	**9**	**9**	**12**	**15**
Domestic budget execution on RMNCAH+ 3 diseases – TB, malaria, HIV/AIDS (%)	**73**	**85**	**74**	**–**

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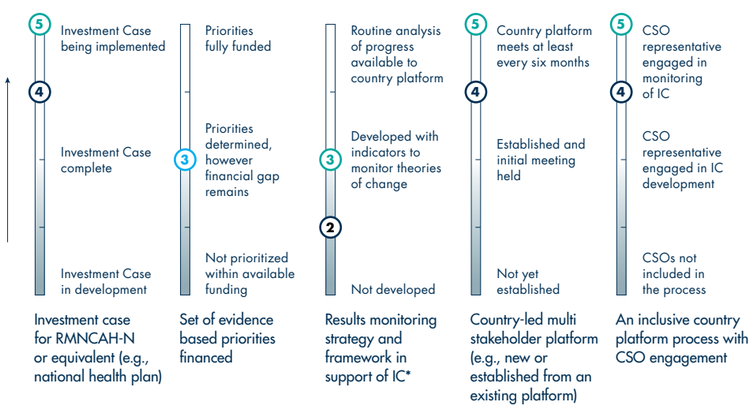

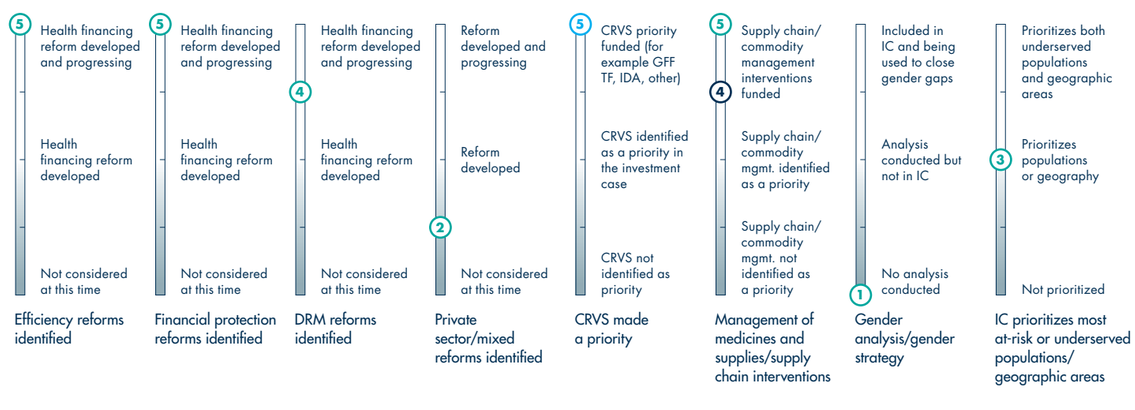

Annual report 2019/2020 score Annual report 2018/2019 score No change between last year and this year

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■ THE GFF'S CATALYTIC ROLE

1 **Incentivize RMNCAH-N and health financing results through disbursement linked indicators (DLIs) linked to the Health Sector Transformation Plan.** The World Bank and GFF provide support through DLIs in which payments are made based on pre-approved targets.

2 **Sharpen prioritization of lagging interventions.** The GFF helped the government focus on two underserved areas: family planning and adolescent health. The GFF/World Bank co-financed operation include DLIs on improving contraceptive prevalence in rural areas and quality of adolescent health services. This led to the development of a national adolescent health policy.

3 **Encourage a stronger focus on equity.** GFF emphasizes narrowing the gap between the national average and certain regions on RMNCAH-N by increasing the proportion of functioning community-based health insurance. In addition, the GFF/WB co-financed operation incentivizes increased skilled birth attendance for the lowest three performing regions (Afar, Oromia and Somali).

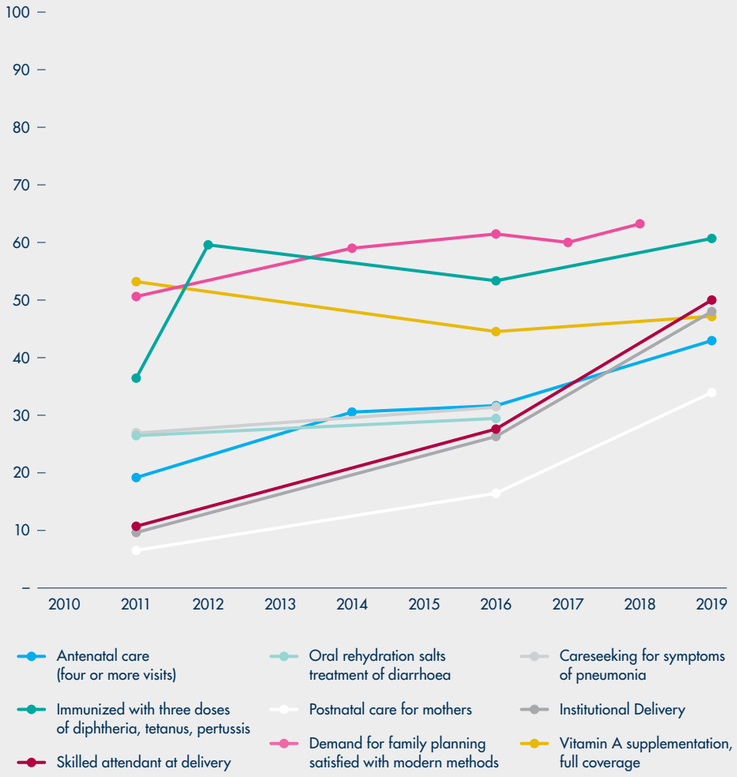
4 **Transform the CRVS system.** The GFF and partners contributed to strengthening the CRVS system by helping the transition from paper-based to electronic registration system and providing training for health workers on recording causes of death and births/deaths registration requirements.

5 **Support public financial management reforms to improve budget execution and support efforts to increase the budget share for health.** The GFF supports a policy dialogue on prioritization of health in the budget, and increased efficiency in the use of existing resources, including through strategic purchasing.

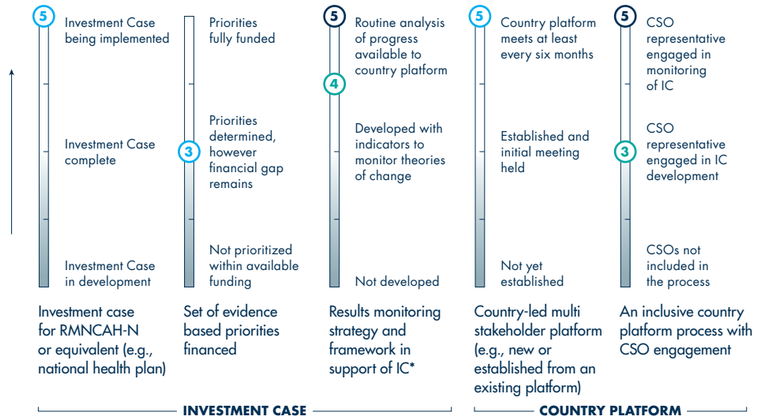
6 **Strengthen private sector engagement.** The GFF supported a private sector health assessment to understand regulations, policies, opportunities and challenges to better leverage private sector for health.

■ RMNCAH-N COVERAGE INDICATORS

Data on immunization are presented from the WHO/UNICEF joint reporting process and recent population-based surveys. Data on family planning are presented from the PMA2020 database and recent population-based surveys. All other RMNCAH-N coverage indicators are presented from the most recent available population-based surveys.



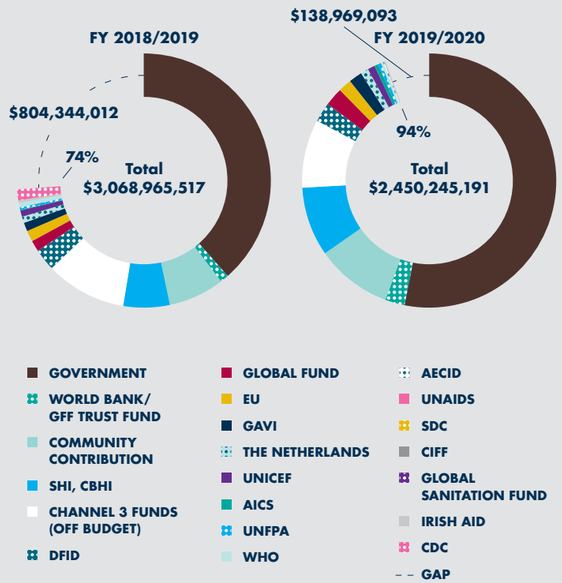
■ MONITORING THE COUNTRY-LED PROCESS



Ethiopia

■ RESOURCE MAPPING

The resource mapping (RM) shows trend analysis between FY 2018/19 and FY 2019/20. Resource mapping in Ethiopia is based on the Health Sector Transformation Plan (HSTP). The HSTP is the national health strategy and the Investment Case (IC). The HSTP is the national health strategy and the Investment Case (IC). The consolidated data for this assessment was based on HSTP actual annual budget and annual HSTP resource mapping provided by the Ministry of Health (MOH). The RM trend analysis indicated major findings in terms of the government's improved commitment to the health sector which resulted in a significant decline in the HSTP financing gap. Government finance to the health sector showed a significant increase from 38.5% in 2018/19 to 53.1% in 2019/20. Accordingly, the HSTP financing gap has declined from 26% in 2018/19 to 5.7% in 2019/20. On the other hand, donors contribution both on and off -budget and alignment to the IC more or less are similar in both fiscal years. In addition, community contribution entailing both society's in cash and in-kind contribution to the sector indicated similar contribution levels in both years.



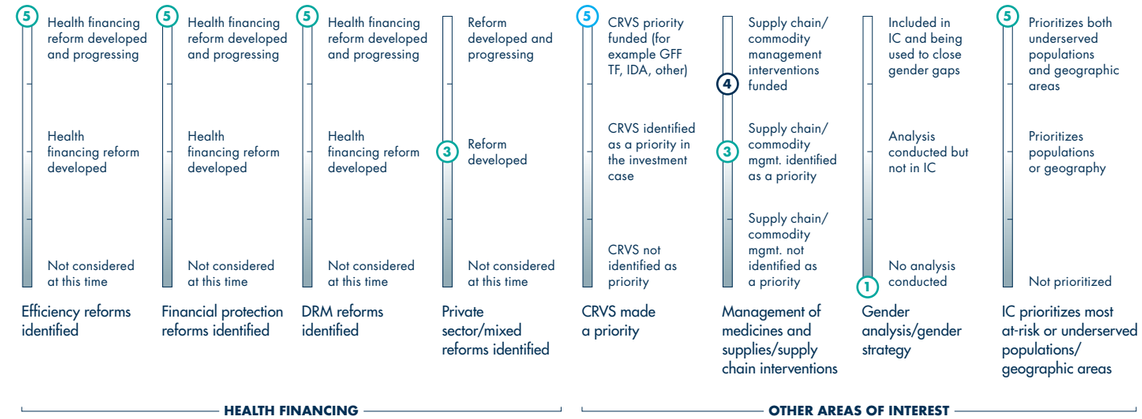
■ CORE RMNCAH-N IMPACT INDICATORS

	Previous		Recent	
Maternal mortality ratio (per 100,000 live births)	**412**	2016	**–**	–
Under 5 mortality rate (per 1,000 live births)	**67**	2016	**55**	2019
Neonatal mortality rate (per 1,000 live births)	**29**	2016	**30**	2019
Adolescent birth rate – 15-19 (per 1,000 women)	**80**	2016	**–**	–
Births <24 months after the preceding birth (%)	**21.7**	2016	**–**	–
Stunting among children under 5 years of age (%)	**38.4**	2016	**36.8**	2019
Moderate to severe wasting among children under 5 years of age (%)	**9.8**	2016	**7.2**	2019

■ HEALTH FINANCING

Core Indicators	2015	2016	2017
Domestic General Government Health Expenditure (DGGHE), per capita (US$)	**6.2**	**6.2**	**6.3**
Domestic General Government Health Expenditure (DGGHE) as share of general government expenditure (%)	**5.6**	**5**	**4.8**
Out-of-pocket spending on health, per capita (US$)	**9**	**8.7**	**8.7**

Country-Specific Indicators	2016	2017	2018	2019
Share of government budget allocated to health (%)	**8.6**	**8.1**	**8.9**	**–**
Health budget execution (%)	**80**	**77**	**83**	**–**
Share of health expenditure going to frontline providers (%)	**36**	**41**	**37**	**–**
Percent of PHC facilities having all drugs from the MoH list of essential drugs available	**42**	**–**	**48**	**–**
CBHI coverage: percent of districts with functional community-based health insurance (CBHI) schemes	**–**	**30**	**51**	**63.5**



Annual report 2019/2020 score Annual report 2018/2019 score No change between last year and this year

* Both included in the IC document or a separate document

Ghana

THE GFF'S CATALYTIC ROLE

1 **Ghana joined the GFF in 2019 and is in the process of developing a prioritized investment case.** Ghana has already established a country-led multi-stakeholder platform that is meeting regularly and includes CSO representation already engaged in the IC development process.

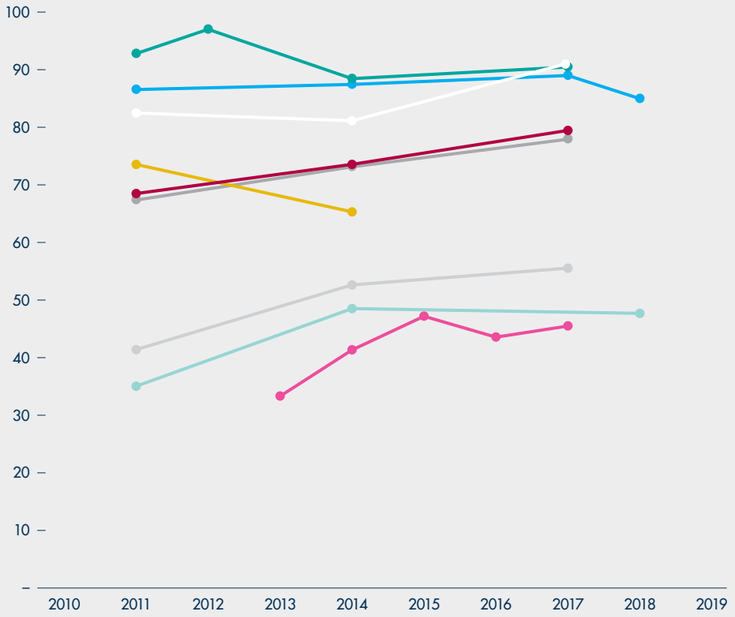
2 **Accelerate the progress toward better human capital and universal health coverage by ensuring effective implementation of multi-sectoral interventions that affect health and the universal health coverage (UHC) roadmap.** To achieve the human capital goal, GFF will support the government to develop a prioritized and costed operational plan (POP-C) to operationalize the UHC Roadmap, with clear targets and a monitoring and financing strategy. The specific impacts to be achieved are: (i) reducing preventable maternal, adolescent and child deaths and disabilities; (ii) improved access to better and efficiently managed quality health services; (iii) improved access to key multisectoral interventions in education, water sanitation and hygiene (WASH), and nutrition; and (iv) increased access to and quality of responsive clinical and public health emergency services.

3 **Support the government in implementing selected health and financing reforms** in the area of reorganization of the service delivery model, quality of care, domestic resource utilization and mobilization (DRUM), public financial and procurement management, governance, and strategic use of health intelligence, which includes surveys, artificial intelligence, and the use of data for decision making.

4 **Support the resource mapping for the POP-C, which commenced in June 2020 and captures funding commitments across the health sector that will finance the plan's implementation.** Together with costed scenarios for scale-up, resource mapping data will be used to prioritize interventions and to find allocative and technical efficiencies.

RMNCAH-N COVERAGE INDICATORS

Data on immunization are presented from the WHO/UNICEF joint reporting process and recent population-based surveys. Data on family planning are presented from the PMA2020 database and recent population-based surveys. All other RMNCAH-N coverage indicators are presented from the most recent available population-based surveys.



RESOURCE MAPPING

In 2020, Ghana began developing its IC, the Prioritized Operational Plan (POP) for Universal Health Coverage, which outlines priority interventions to achieve UHC over the next decade. Resource mapping for the POP commenced in June 2020 and captures funding commitments across the health sector that will finance the plan's implementation. Together with costed scenarios for scale up, resource mapping data will be used to prioritize interventions and to find allocative and technical efficiencies. In addition, the exercise is intended to harmonize previous resource mapping exercises, including mappings of health systems strengthening investments and COVID-19 resource mapping.

CORE RMNCAH-N IMPACT INDICATORS

	Previous		Recent	
Maternal mortality ratio (per 100,000 live births)	–	–	**310**	2017
Under 5 mortality rate (per 1,000 live births)	**60**	2014	**56**	2017
Neonatal mortality rate (per 1,000 live births)	**29**	2014	**27**	2017
Adolescent birth rate – 15-19 (per 1,000 women)	**76**	2014	**75**	2017
Births <24 months after the preceding birth (%)	**13.1**	2014	–	–
Stunting among children under 5 years of age (%)	**18.8**	2014	**17.5**	2017
Moderate to severe wasting among children under 5 years of age (%)	**4.7**	2014	**6.8**	2017

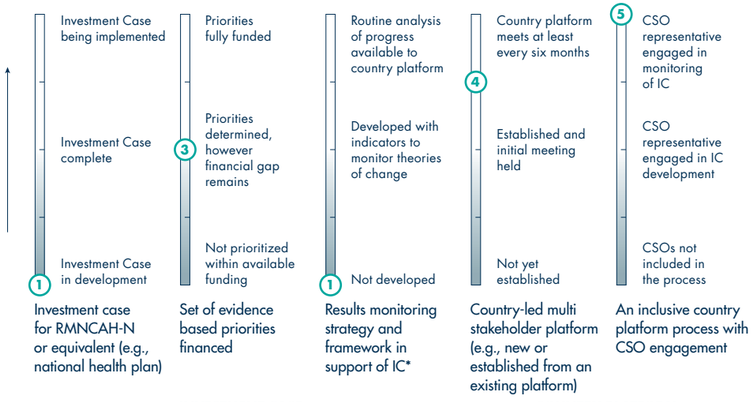
HEALTH FINANCING

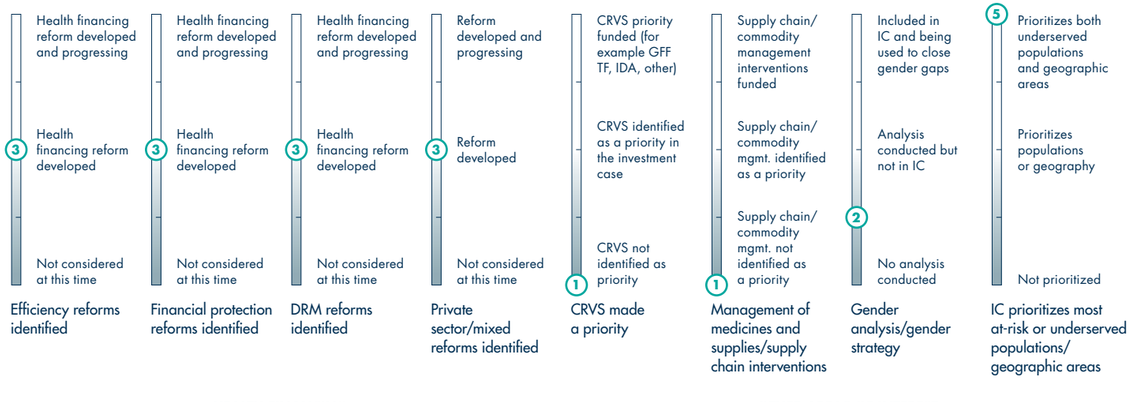
Core Indicators	2015	2016	2017
Domestic General Government Health Expenditure (DGGHE), per capita (US$)	**31**	**25.7**	**22.3**
Domestic General Government Health Expenditure (DGGHE) as share of general government expenditure (%)	**8.6**	**6.5**	**6.1**
Out-of-pocket spending on health, per capita (US$)	**31.6**	**25.3**	**26.9**

Country-Specific Indicators	2016	2017	2018	2019
Share of government budget allocated to health (%)	**13.8**	**14.6**	**13.1**	**14.3**
Health budget execution (%)	**124.8**	**72.8**	**102.9**	**109**
Share of health expenditure going to frontline providers (%)*	–	–	–	–

*This is a new indicator that is still being defined at the country-level

MONITORING THE COUNTRY-LED PROCESS





Annual report 2019/2020 score

* Both included in the IC document or a separate document

Guatemala

THE GFF'S CATALYTIC ROLE

1 **Free up domestic resources from debt payments through the GFF buy-down to reduce malnutrition in indigenous communities using a multisectoral approach and results-based mechanisms.** The buy-down is conditional on the Ministry of Finance (MoF) guaranteeing double the amount of the buy-down (US$18 million) for the national conditional cash transfer (CCT) program. This program's cash transfers are conditional upon use of health and nutrition services that Crecer Sano provides.

2 **Contribute to stunting reduction, focusing on increasing the quality of and demand for health and nutrition services, social safety nets, and sanitation.** The GFF supports technical assistance to strengthen the governance of water and sanitation, including the development of an action plan to enhance a water supply and sanitation (WSS) policy to clarify and strengthen the water and sanitation institutional arrangements within the MOH.

3 **Improve the efficiency and transparency of public spending by providing technical assistance on strategic planning and public financial management.** The GFF has supported the capacity building for staff in the MOH in strategic planning, financial management, procurement and budget execution to increase efficiency and overall budget execution.

4 **Improve data and evidence-based policy making for health and nutrition and increase focus on results for marginalized indigenous populations and quality of care.** The GFF has contributed to financing a service delivery indicators (SDI) and household survey to improve data availability, and to the development of the digitalized information system of the Ministry of Social Affairs (MIDES), as well as improvements to the country's health management information system (HMIS).

5 **Play a catalytic role in convening partners and government to strengthen integrated service delivery networks (ISDN).** The GFF supported the engagement of an ISDN expert who participated in the revision and strengthening of the ISDN National Strategy in collaboration with the MOH and the Pan American Health Organization (PAHO).

RMNCAH-N COVERAGE INDICATORS

The last population-based survey in Guatemala was conducted in 2014-15 (DHS). Although discussions for another DHS had been initiated prior to the COVID-19 pandemic, results were not anticipated for another 1-2 years. To improve data availability in Guatemala, the GFF is supporting three streams of work in this area; they include: (1) the first ever Service Delivery Indicator (SDI) survey that will shed light on the quality and basic performance of service provision at the primary care level; (2) a household survey to measure household-level health and nutrition practices in seven of the ten districts that are prioritized in the National Strategy for Nutrition; and (3) support to strengthen the national health management information system, SIGSA, to improve data capture, data transformation, and data use.

RESOURCE MAPPING

Guatemala is not dependent on external financing, with less than 2 percent of total financing for the health sector from external sources. The GFF is supporting efforts to improve the planning, financial flow, and utilization of resources from the central Ministry of Health to departments within the ministry through improved alignment of annual purchasing and operating plans. The National Secretariat for Food Security and Nutrition (SESAN) which developed the Investment Case and will oversee its implementation, plans to conduct a costing and resource mapping exercise for the new investment case, to support planning, potential re-prioritization and resource mobilization for any activities included and demonstrated as being unfunded. The GFF will support SESAN in this exercise in any way that is requested or needed.

CORE RMNCAH-N IMPACT INDICATORS

	Recent	
Maternal mortality ratio (per 100,000 live births)	**140**	2014
Under 5 mortality rate (per 1,000 live births)	**35**	2014
Neonatal mortality rate (per 1,000 live births)	**17**	2014
Adolescent birth rate – 15-19 (per 1,000 women)	**92**	2014
Births <24 months after the preceding birth (%)	**18.8**	2014
Stunting among children under 5 years of age (%)	**46.5**	2014
Moderate to severe wasting among children under 5 years of age (%)	**0.7**	2014

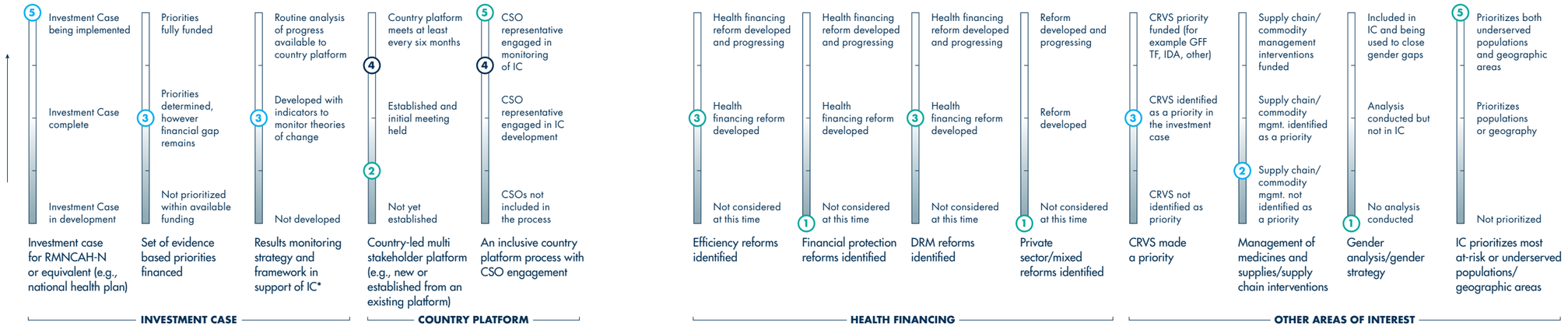
HEALTH FINANCING

Core Indicators	2015	2016	2017
Domestic General Government Health Expenditure (DGGHE), per capita (US$)	**97.3**	**97.1**	**93.2**
Domestic General Government Health Expenditure (DGGHE) as share of general government expenditure (%)	**18.1**	**18.1**	**17.2**
Out-of-pocket spending on health, per capita (US$)	**144.1**	**142**	**140.7**

Country-Specific Indicators	2016	2017	2018	2019
Share of government budget allocated to health (%)	–	**9**	**9**	**9**
Health budget execution (%)	–	–	–	–
Share of health expenditure going to frontline providers (%)*	–	–	–	–

*This is a new indicator that is still being defined at the country-level

MONITORING THE COUNTRY-LED PROCESS



Annual report 2019/2020 score Annual report 2018/2019 score No change between last year and this year

* Both included in the IC document or a separate document

Guinea

THE GFF'S CATALYTIC ROLE

1 **Improve spending efficiency and support delivery of health services.** Continued support is being given to World Bank/GFF project implementation, including results-based financing and pro-poor financing strategies to enhance the quality and quantity of reproductive, maternal, child and nutrition services for recipients in selected regions.

2 **Strengthen the capacity of MOH in public financial management, in health financing, and in development of long-term reform strategies.** The World Bank and the GFF both supported an assessment of the *Bureau de Stratégie et de Développement* (BSD) in 2019 which brought to light weaknesses that need immediate attention. The support will consist of: training on new tools needed to strengthen health financing planning, management, and monitoring of health financing, and helping to lay the groundwork for systematic, long-term financing for health (focused on decentralized financing, decision-making authority, and accountability systems), and the establishment of the *Unité Economique de la Santé*. In addition, the the World Bank and the GFF support the design and implementation of various health financing initiatives (e.g., medium-term expenditure framework, national health accounts, and fiscal space analysis).

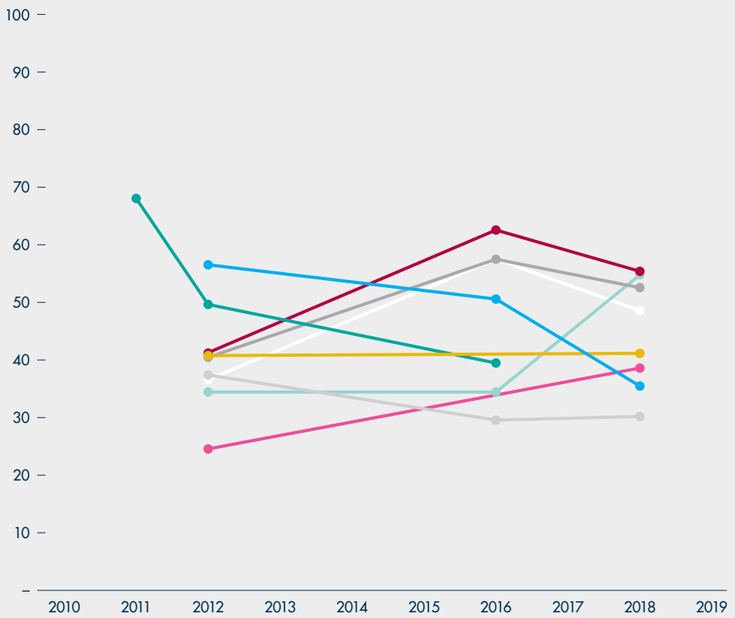
3 **Support financial protection interventions targeting of the poor.** The GFF will support the implementation of the strategy targeting the poor.

4 **Support health system strengthening initiatives, including civil registration and vital statistics (CRVS) and health management information system (HMIS).** The GFF and the World Bank supported improving stakeholder engagement in CRVS, in collaboration with the Centre of Excellence (CoE), the European Union, UNICEF, Enabel, and UNFPA.

5 **Improve availability and quality of health financing data.** The GFF provides technical assistance in conducting a resource mapping exercise that aims to rapidly capture retrospective, actual, and forward-looking budget data from government and external partners. In Guinea, the resource mapping exercise is being finalized and includes both external and government budget linked to IC priorities.

RMNCAH-N COVERAGE INDICATORS

All RMNCAH-N coverage indicators are presented from the most recent available population-based surveys.



RESOURCE MAPPING

Guinea is currently finalizing a prioritized Investment Case that is aligned with the National RMNCAH-N Strategy and features a high impact RMNCAH-N package and selected health system and health financing reforms. Guinea has completed the first phase of the resource mapping exercise which covers five years (2020-2024) with partners' funding aligned to the seven strategic priorities of the Investment Case (IC). Data from government and development partners' budgetary commitments was obtained to estimate the total resources available for Investment Case implementation. The costing of the IC is currently ongoing and results for the resource mapping including the financing gap analysis will be available by September 2020. There are currently 10 external partners in Guinea who are aligned with and committed to contributing to the Investment Case.

CORE RMNCAH-N IMPACT INDICATORS

	Previous		Recent	
Maternal mortality ratio (per 100,000 live births)	**724**	2012	**550**	2016
Under 5 mortality rate (per 1,000 live births)	**123**	2012	**111**	2018
Neonatal mortality rate (per 1,000 live births)	**33**	2012	**32**	2018
Adolescent birth rate – 15-19 (per 1,000 women)	**146**	2012	**120**	2018
Births <24 months after the preceding birth (%)	**12.8**	2012	**16.4**	2018
Stunting among children under 5 years of age (%)	**31.2**	2012	**30.3**	2018
Moderate to severe wasting among children under 5 years of age (%)	**9.6**	2012	**9.2**	2018

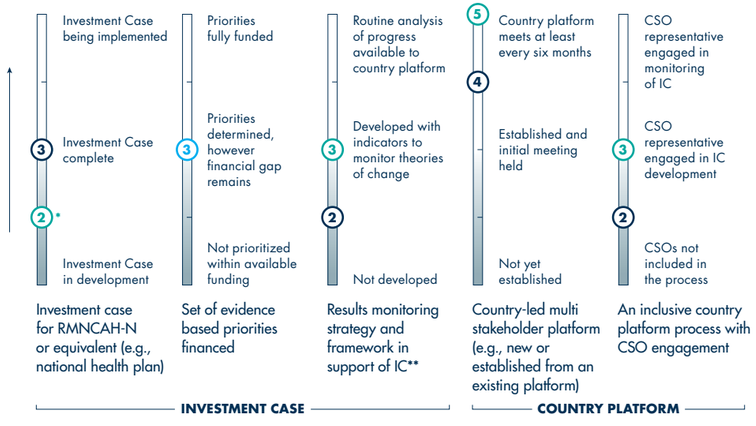
HEALTH FINANCING

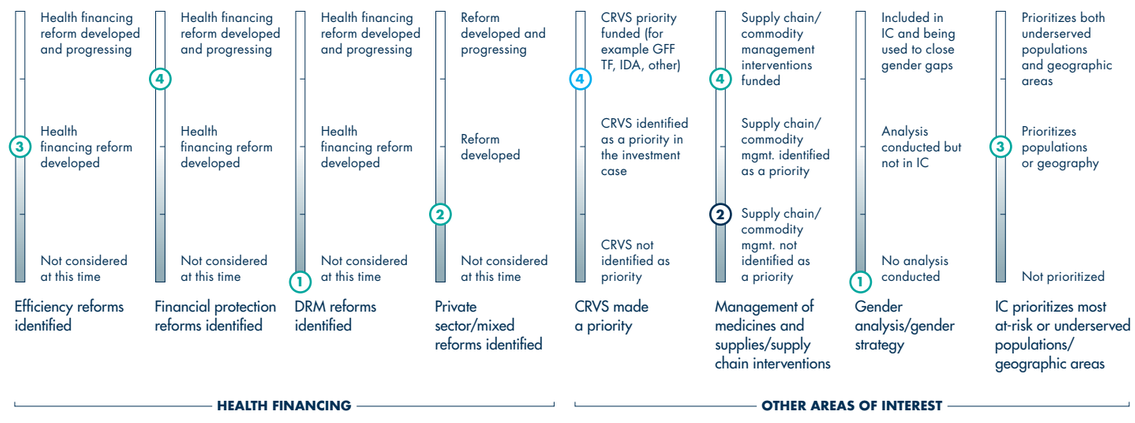
Core Indicators	2015	2016	2017
Domestic General Government Health Expenditure (DGGHE), per capita (US$)	**3**	**5**	**5.8**
Domestic General Government Health Expenditure (DGGHE) as share of general government expenditure (%)	**2**	**4.1**	**4.1**
Out-of-pocket spending on health, per capita (US$)	**20.9**	**18.6**	**19.1**

Country-Specific Indicators	2016	2017	2018	2019
Share of government budget allocated to health (%)	**5**	**6**	**7.1**	**8**
Health budget execution (%)	**89**	**73**	**40**	**61.5**
Share of health expenditure going to frontline providers (%)*	–	–	–	–

*This is a new indicator that is still being defined at the country-level

MONITORING THE COUNTRY-LED PROCESS





Annual report 2019/2020 score ◯ Annual report 2018/2019 score ◯ No change between last year and this year

* A new prioritized Guinea IC is being developed

** Both included in the IC document or a separate document

Haiti

THE GFF'S CATALYTIC ROLE

1 **Improve donor coordination to enhance foreign aid effectiveness and improve utilization and impact of available resources.** The GFF will support an upcoming resource mapping exercise which will map and track external resources for health, which have shrunk. The resource mapping tool has been finalized.

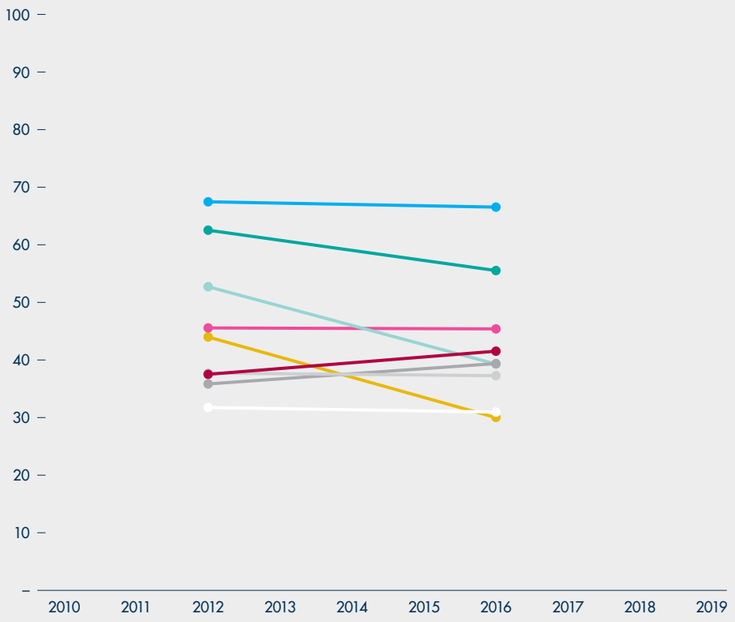
2 **Support an increase in domestic resource use and mobilization (DRUM), with a strong emphasis on improving the efficiency of available resources in the health sector.** The GFF will support the development of a strategic plan (2020-2030) for rationalizing human resources with a particular focus on achieving a more effective distribution and mix of human resource categories throughout the country.

3 **Increase access to and quality of primary care.** GFF support includes (i) improving the national supply and distribution system for medical commodities (SNADI) to guarantee an ongoing availability and accessibility to essential medicines at all levels and (ii) using results-based payments for the delivery of a package of PHC services, with a special focus on RMNCAH-N services.

4 **Support to the revision of the national Community Health Strategy to increase the efficiency and scale of service delivery and use.** The GFF has supported ongoing work by a set of key partners to finalize the national community health workers (CHW) strategy, which clearly details protocols, task allocation, and other operational modalities of CHWs. The GFF is also supporting parallel activities that have fed into the strategy revision, such as the use of a risk-stratification approach, a systematic tracking mechanism for CHWs, and modeling work to determine CHW allocation and reallocation needs across the country.

RMNCAH-N COVERAGE INDICATORS

All RMNCAH-N coverage indicators are presented from the most recent available population-based surveys.



RESOURCE MAPPING

In July 2019, the External Cooperation division within the planning unit of Haiti's Ministry of Public Health and Population launched a resource mapping of funding—both national budget and external financing—in the health sector. Among the objectives of this resource mapping exercise is an assessment of how available financing maps to budgetary requirements outlined in sectoral strategies and plans. These strategies and plans include the country-led investment case that is under development, key reforms in the health sector, and geographic distribution of funds. Haiti initially planned to complete its resource mapping by May 2020. However, the COVID-19 outbreak interrupted the resource mapping exercise in January 2020.

CORE RMNCAH-N IMPACT INDICATORS

	Previous		Recent	
Maternal mortality ratio (per 100,000 live births)	–	–	529	2016
Under 5 mortality rate (per 1,000 live births)	88	2012	81	2016
Neonatal mortality rate (per 1,000 live births)	31	2012	32	2016
Adolescent birth rate – 15-19 (per 1,000 women)	66	2012	55	2016
Births <24 months after the preceding birth (%)	19.4	2012	17.8	2016
Stunting among children under 5 years of age (%)	21.9	2012	21.9	2016
Moderate to severe wasting among children under 5 years of age (%)	5.1	2012	3.6	2016

HEALTH FINANCING

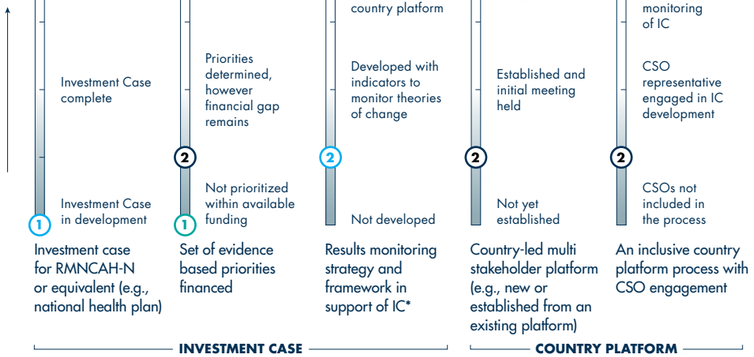
Core Indicators	2015	2016	2017
Domestic General Government Health Expenditure (DGGHE), per capita (US$)	7.4	7.2	7.4
Domestic General Government Health Expenditure (DGGHE) as share of general government expenditure (%)	4.4	5	5.2
Out-of-pocket spending on health, per capita (US$)	22.7	23.1	25.1

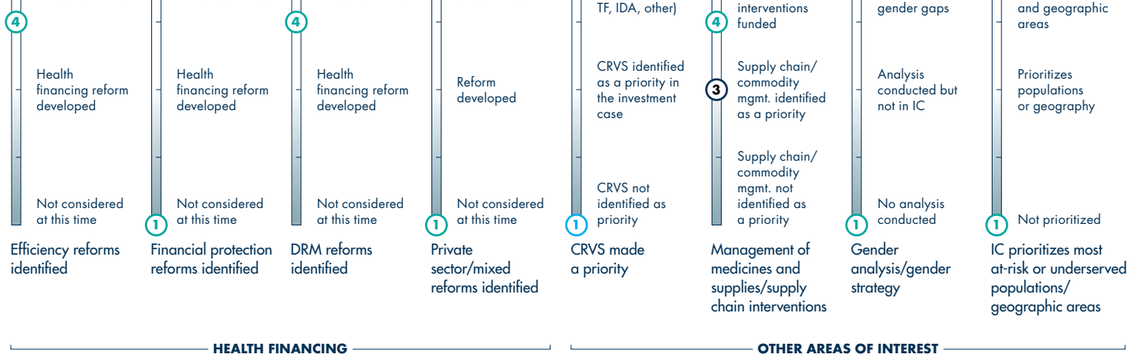
Country-Specific Indicators	2016	2017	2018	2019
Share of government budget allocated to health (%)	4.4	3.9	3.9	10.9
Health budget execution (%)*	76	–	–	–
Share of health expenditure going to frontline providers (%)**	–	–	–	–

*Data on budget execution has not been officially published by the Ministry of Finance for the years 2017-2019

**This is a new indicator that is still being defined at the country-level

MONITORING THE COUNTRY-LED PROCESS





Annual report 2019/2020 score Annual report 2018/2019 score No change between last year and this year

* Both included in the IC document or a separate document

Indonesia

THE GFF'S CATALYTIC ROLE

1 **Strengthen management and accountability system to implement the National Strategy to Accelerate Stunting Prevention (StraNas Stunting) through a multisectoral convergence approach.** At the national level, GFF supported strengthening leadership and oversight capacity of the Office of Vice President through Stunting Summit to secure political commitment at all levels and establishment of data-driven performance monitoring system. At the district level, GFF supported districts to implement the convergence action plan and enhance alignment of planning and budgeting process with StraNas Stunting priorities.

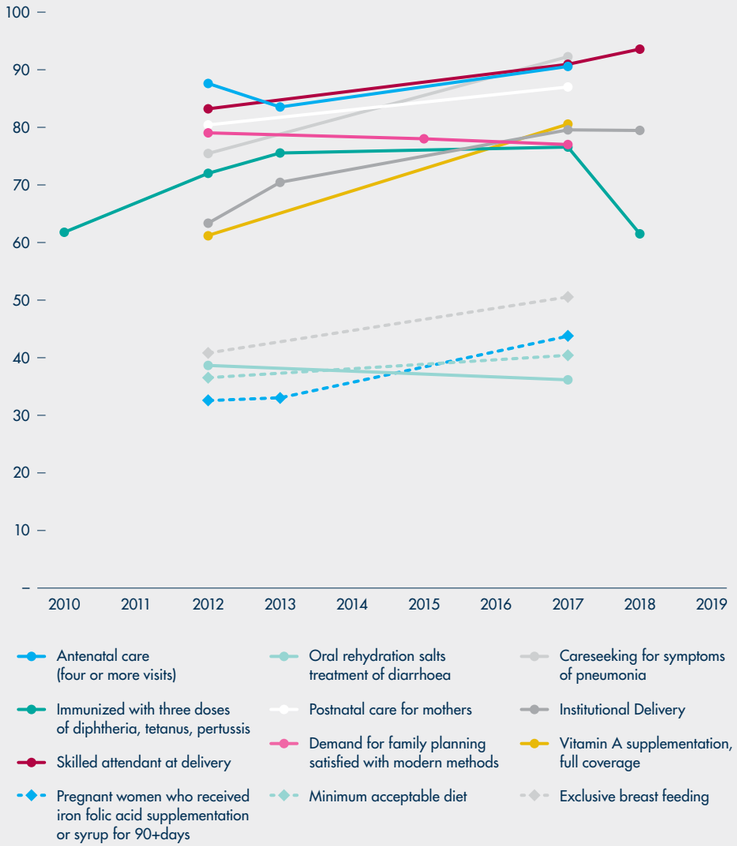
2 **Promote reforms to improve efficiency and increase public resources.** The GFF helped improving the performance assessment of fiscal transfers to districts and villages to enhance accountability for results and introduction of new financing instrument to incentivize coordination and implementation of convergence program. Furthermore, GFF supports the development of system for tracking government expenditures on priority nutrition interventions and institutionalizing comprehensive nutrition budget review linking spending to performance.

3 **Roll-out of innovations to deliver services and improve citizen engagement at scale.** The GFF contributed to the scaling up of a village convergence scorecard, the child-length mat, and mobilization of health development workers (HDWs) to empower 70,000+ villages to converge services and leverage village budget for stunting reduction. Moreover, GFF supports the rollout of innovative technology solutions (e.g. e-HDW application) to enable real-time monitoring from 75,000 villages and improve HDWs capacity to manage convergence program at village level.

4 **Scale up of high impact interventions to address critical service delivery gaps.** The GFF supported the scale-up of the three interventions to close service gaps to accelerate stunting reduction: early childhood development (ECD) services for parents and children under two, nutrition-sensitive food assistance and behavior change communication (BCC) efforts. More specifically, GFF supported districts to implement locally-adapted BCC activities, capacity building for ECD teachers and introduction of nutrition-rich food in the food assistance program.

RMNCAH-N COVERAGE INDICATORS

Family planning indicators are presented from the PMA2020 database and recent population-based surveys.
All other RMNCAH-N coverage indicators are presented from the most recent available population-based surveys.



RESOURCE MAPPING

Since Indonesia's investment case is focused on nutrition, the country's resource mapping covers multiple sectors. Indonesia's National Planning Agency and Ministry of Finance are leading a budget tagging and tracking exercise that will help institutionalizing multisectoral expenditure tracking system and comprehensive budget evaluation with support from the World Bank and GFF. This exercise also includes multisectoral resource mapping for domestic resources through budget tagging. The multisectoral nutrition budget tagging, tracking and evaluation is included in the disbursement-linked indicators in the GFF co-financed project (INEY PforR). Results for budget tagging and tracking were completed in 2019 and 2020. GFF supports ongoing technical assistance to strengthen the use of budget tagging and tracking to inform resources allocation and course correct the program implementation.

CORE RMNCAH-N IMPACT INDICATORS

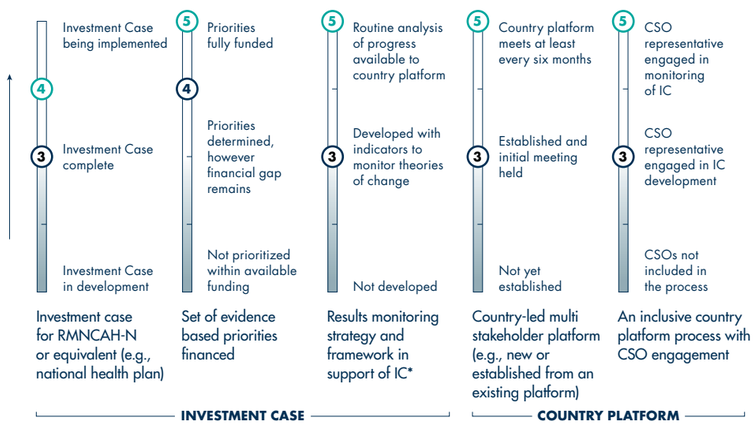
	Previous		Recent	
Maternal mortality ratio (per 100,000 live births)	**359**	2012	**305**	2015
Under 5 mortality rate (per 1,000 live births)	**40**	2012	**32**	2017
Neonatal mortality rate (per 1,000 live births)	**19**	2012	**15**	2017
Adolescent birth rate – 15-19 (per 1,000 women)	**48**	2012	**36**	2017
Births <24 months after the preceding birth (%)	**10.5**	2012	**9**	2017
Stunting among children under 5 years of age (%)	**30.5**	2018	**27.7**	2019
Moderate to severe wasting among children under 5 years of age (%)	**10.2**	2018	**7.4**	2019

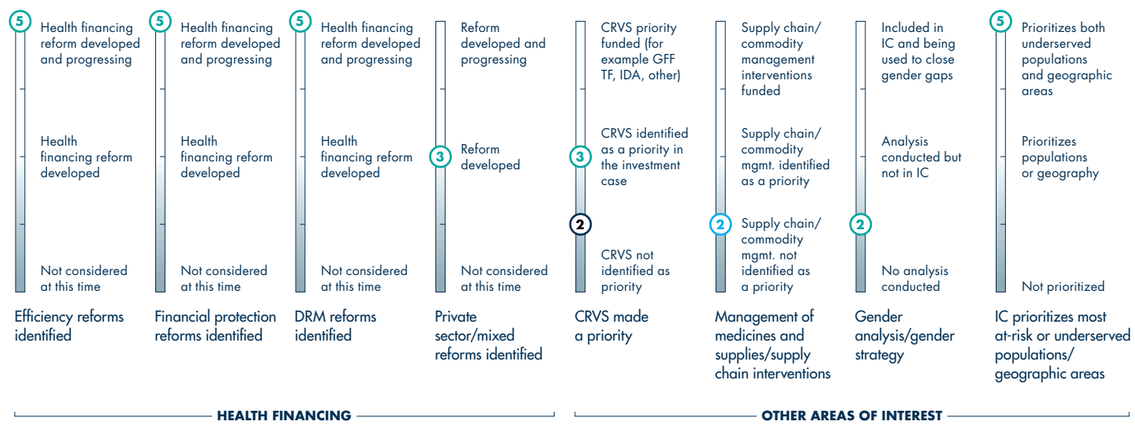
HEALTH FINANCING

Core Indicators	2015	2016	2017
Domestic General Government Health Expenditure (DGGHE), per capita (US$)	**43.2**	**51.8**	**55.6**
Domestic General Government Health Expenditure (DGGHE) as share of general government expenditure (%)	**6.9**	**8.3**	**8.7**
Out-of-pocket spending on health, per capita (US$)	**44.4**	**43.5**	**39.8**

Country-Specific Indicators	2016	2017	2018	2019
Share of government budget allocated to health (%)	**8.4**	**8.8**	**8.3**	–
Health budget execution (%)	**89**	–	–	–
Share of health expenditure going to frontline providers (%)	**17.4**	**25.5**	–	–

MONITORING THE COUNTRY-LED PROCESS





Annual report 2019/2020 score Annual report 2018/2019 score No change between last year and this year

* Both included in the IC document or a separate document

■ THE GFF'S CATALYTIC ROLE

1 **Provide financial incentives for counties to increase budget allocation for health and to improve coverage of RMNCAH interventions.** Counties receive their annual allocations if they allocate at least 20 percent of their overall county budget to health, increase their allocation each year if it was less than 30%; and if they improve results of a composite of key RMNCAH indicators (antenatal care services, skilled birth attendance, child immunization and use of modern contraceptives). Based on set public financial management conditions, counties are also incentivized to transfer their allocations timely and fully to implement RMNCAH priorities.

2 **Reduce fragmentation and improve the efficiency of spending at the county level.** Through the Technical Assistance Multi Donor Trust Fund as part of the budget and planning process, more counties are working towards including funding from other development partners in their annual work plans, which improves coordination and efficiency.

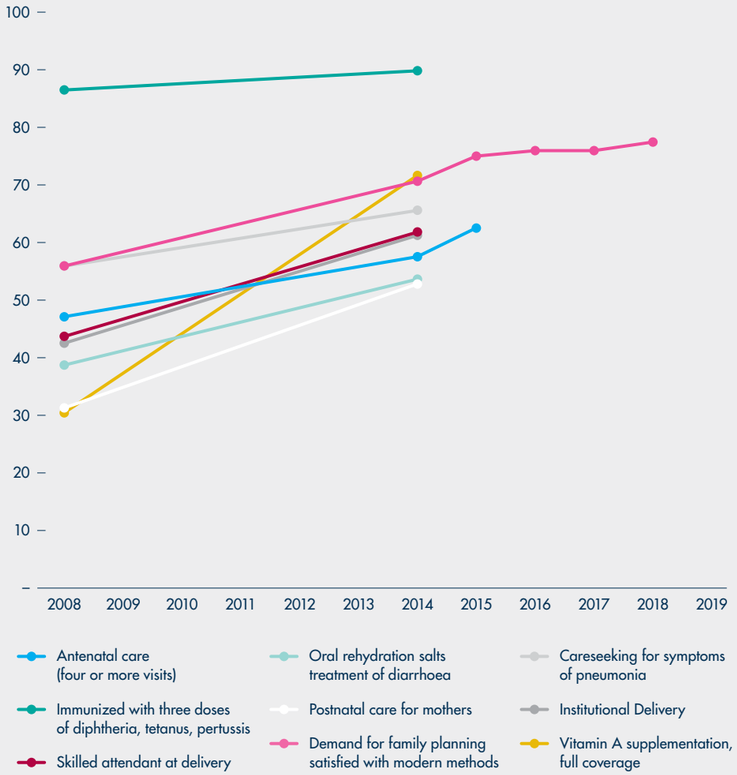
3 **Support platforms for strategic private-sector dialogue and engagement.** The GFF is supporting multiple private sector engagement activities in Kenya including: (i) analytics for mapping of global, regional, and country-level public–private partnership engagement models that are innovative and appropriate for delivery of primary health care in the Kenya context; and (ii) review of existing policy and regulatory frameworks for public-private partnerships, as well as the tools and guidelines required for different modes of contracting at the primary care level for RMNCAH.

4 **Scale up birth registration through maternal and child health services and incentivizing birth registration.** The GFF also supports capacity building among registration officials in monitoring and supervision; and among health officials in cause-of-death certification and coding. It will also provide support for the piloting of a mobile civil registration unit for hard-to-reach areas.

5 **Strengthen Universal Health Coverage (UHC).** As the government focus has shifted to UHC support, the GFF will provide support for advisory and analytical services to inform and support the design and implementation of UHC reforms.

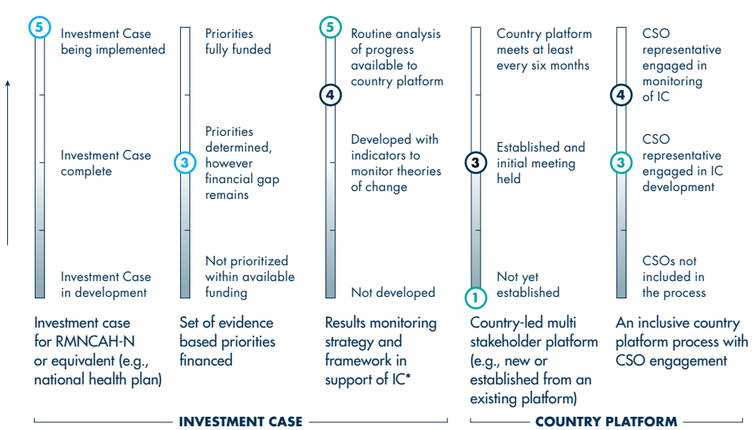
■ RMNCAH-N COVERAGE INDICATORS

Family planning indicators are presented from the PMA2020 database and recent population-based surveys. All other RMNCAH-N coverage indicators are presented from the most recent available population-based surveys.



Kenya has been undertaking demographic and health surveys (DHS) consistently since 1989, from which data for RMNCAH-N core impact and coverage indicators are derived. However, the upcoming DHS originally planned for 2019-2020 has been postponed to 2021 due to COVID-19, thus limiting availability of comparable data for 2019.

■ MONITORING THE COUNTRY-LED PROCESS



Kenya

■ RESOURCE MAPPING

Resource mapping informs and supports the implementation of the RMNCAH investment framework. The financial requirement for RMNCAH investments for the 20 priority counties was estimated at US$989 million from 2017-18 to 2019-20 (source: RMNCAH investment framework). Although detailed information is not currently available, Kenya's Ministry of Health estimates that the government contributes 40 percent of all health expenditures, households (through out of pocket payments) 31 percent, donors 23 percent, and other private sources 6 percent (source: NHA); representing a progressive trend toward an increased government share of funding and a decreased share from external partners. External contributing health partners include the Bill & Melinda Gates Foundation, the Clinton Health Access Initiative, Global Fund, Gavi, the governments of Denmark, Japan (JICA), United Kingdom (DFID), and United States (PEPFAR, USAID, CDC), the UN H6 partners, and the World Bank.

■ CORE RMNCAH-N IMPACT INDICATORS

	Previous		Recent	
Maternal mortality ratio (per 100,000 live births)	**488**	2008	**362**	2014
Under 5 mortality rate (per 1,000 live births)	**74**	2008	**52**	2014
Neonatal mortality rate (per 1,000 live births)	**31**	2008	**22**	2014
Adolescent birth rate – 15-19 (per 1,000 women)	**103**	2008	**96.3**	2014
Births <24 months after the preceding birth (%)	**22.6**	2008	**17.9**	2014
Stunting among children under 5 years of age (%)	**35.3**	2008	**26.2**	2014
Moderate to severe wasting among children under 5 years of age (%)	**6.7**	2008	**4**	2014

■ HEALTH FINANCING

Core Indicators	2015	2016	2017
Domestic General Government Health Expenditure (DGGHE), per capita (US$)	**31.9**	**33.5**	**32.7**
Domestic General Government Health Expenditure (DGGHE) as share of general government expenditure (%)	**7.8**	**8**	**8**
Out-of-pocket spending on health, per capita (US$)	**21.2**	**19.6**	**18.4**

Country-Specific Indicators	2016	2017	2018	2019
Share of government budget allocated to health (%)	**6.5**	**6.8**	**7.4**	–
Health budget execution (%)	**72**	**77**	**78**	–
Share of health expenditure going to frontline providers (%)	**34**	**34**	**37**	–
Proportion of counties aligning planning and budgeting processes (%)	–	**13**	**75**	–
Proportion of counties allocating at least 30 percent of budget to health (%)	**26**	**39**	**40**	–

Annual report 2019/2020 score Annual report 2018/2019 score No change between last year and this year

* Both included in the IC document or a separate document

Liberia

THE GFF'S CATALYTIC ROLE

1 **Support the improvement of data and analyses for decision making.** The GFF supports improvement of the maternal and neonatal death surveillance and reporting system and CRVS systems as well as the development of a PBF dashboard linked to an RMNCAH score-card to improve data accessibility and clarity. Also, the GFF supported the development of a digital resource mapping platform to improve information availability and sharing.

2 **Improve service delivery quality, and facility / county functionality and efficiency, through primary and hospital level PBF.** GFF supports the design, rollout, and implementation of PBF for primary healthcare service delivery. In addition, GFF supports analytics and capacity management of county health teams to improve facility and county pharmaceutical purchasing from certified pharmacies to fill gaps in essential medicine.

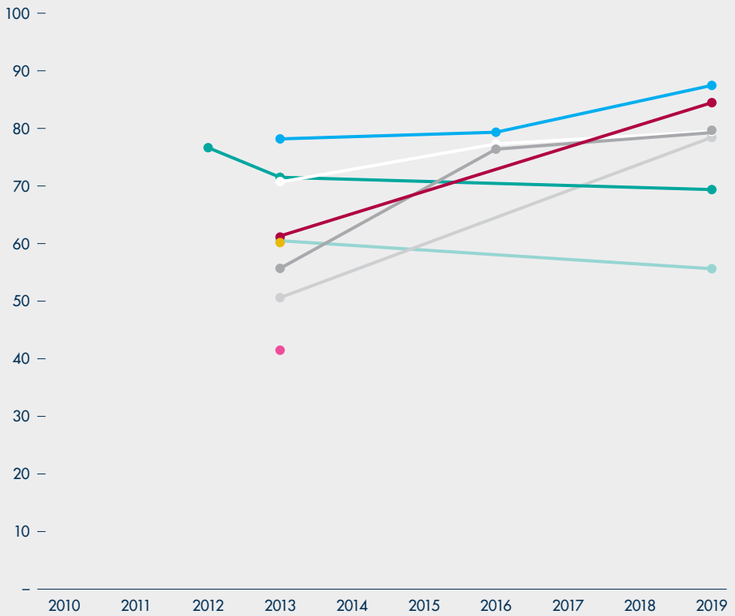
3 **Support the development of adolescent health services.** In Grand Bassa, the GFF supports a pilot adolescent sexual reproductive health service program and helps build links with other sectors for improved adolescent health services. The GFF financed an assessment to identify key barriers to service use for adolescents in one priority county.

4 **Build resilient health systems for emergency preparedness and response.** The GFF supports emergency response strengthening activities including construction of triages to aid early case detection as well as the rollout of Liberia's nationwide community health assistant program and its implementation in seven counties.

5 **Contribute to the roadmap towards UHC.** The GFF provides technical assistance for the development of the Liberian health equity fund roadmap to ensure UHC. The GFF supports an earmarked tax feasibility study to learn more about options for improved domestic resource mobilization.

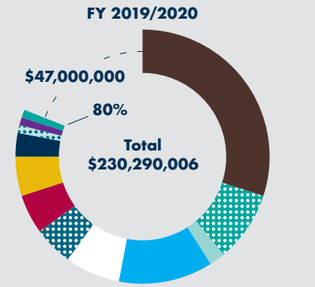
RMNCAH-N COVERAGE INDICATORS

Data on immunization are presented from the WHO/UNICEF joint reporting process and recent population-based surveys. All other RMNCAH-N coverage indicators are presented from the most recent available population-based surveys.



RESOURCE MAPPING

The resource mapping presented here covers FY2019/20 for the entire health sector. Government and donors collectively contribute $183 million, 77% of which is on budget. Domestic government resources account for approximately 37% of total resources available. Within the sector, projected resources for the IC for RMNCAH is US$70 million, with government and development partners contributing $15 million and $55 million, respectively. Liberia is committed to reducing the financing gap for the IC, both through resource mobilization and better use of existing financing. As such, there is an ongoing expenditure analysis focusing on how to improve efficiency of spending and strategic purchasing.



CORE RMNCAH-N IMPACT INDICATORS

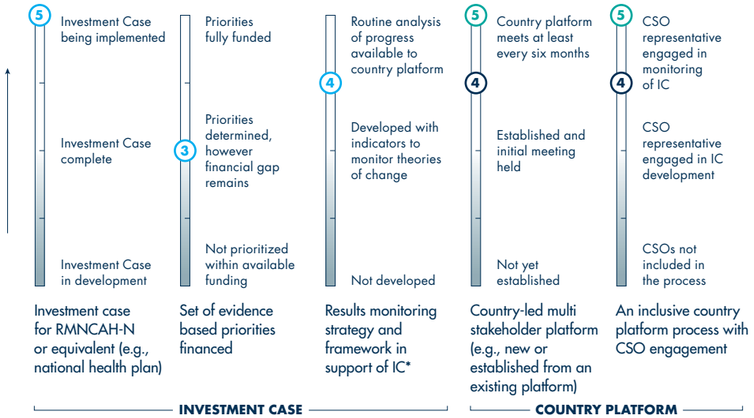
	Previous		Recent	
Maternal mortality ratio (per 100,000 live births)	**1,072**	2013	**–**	–
Under 5 mortality rate (per 1,000 live births)	**94**	2013	**93**	2019
Neonatal mortality rate (per 1,000 live births)	**26**	2013	**37**	2019
Adolescent birth rate – 15-19 (per 1,000 women)	**149**	2013	**128**	2019
Births <24 months after the preceding birth (%)	**15.5**	2013	**–**	–
Stunting among children under 5 years of age (%)	**31.6**	2013	**30**	2019
Moderate to severe wasting among children under 5 years of age (%)	**5.6**	2013	**3**	2019

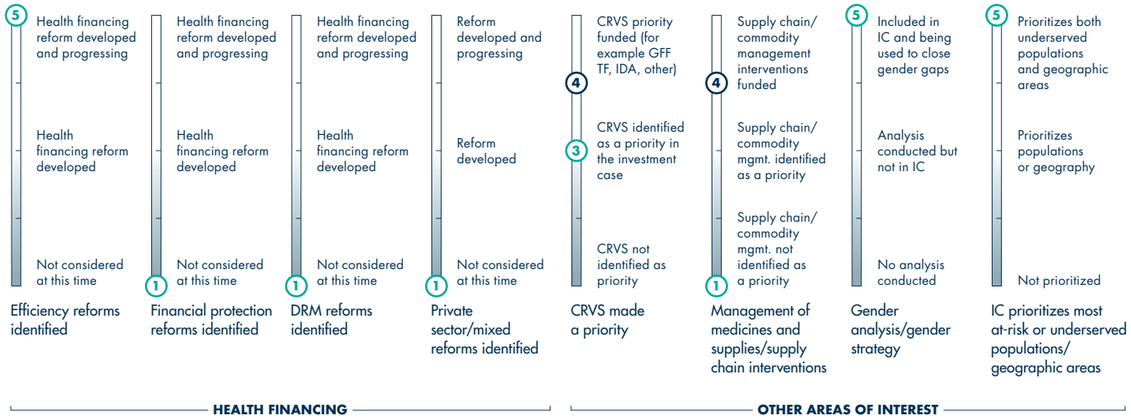
HEALTH FINANCING

Core Indicators	2015	2016	2017
Domestic General Government Health Expenditure (DGGHE), per capita (US$)	**6.5**	**8.1**	**9.7**
Domestic General Government Health Expenditure (DGGHE) as share of general government expenditure (%)	**3.3**	**3.9**	**4.2**
Out-of-pocket spending on health, per capita (US$)	**26.8**	**26.7**	**25.8**

Country-Specific Indicators	2016	2017	2018	2019
Share of government budget allocated to health (%)	**11.7**	**10.5**	**13.2**	**14.1**
Health budget execution (%)	**88.2**	**69.5**	**80.9**	**75**
Share of health expenditure going to frontline providers (%)	**43**	**43**	**32**	**–**

MONITORING THE COUNTRY-LED PROCESS





Annual report 2019/2020 score Annual report 2018/2019 score No change between last year and this year

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■ THE GFF'S CATALYTIC ROLE

1 **Support the coordination of partners around a national plan led by the government.** Through GFF engagement, a national strategy to improve RMNCH-N outcomes is under preparation. As part of this effort, a resource mapping exercise was implemented early on and a new one has started.

2 **Increase the allocation of resources to frontline providers by increasing the decentralization of the health budget.** The World Bank/GFF has supported a change in policy aimed at decentralizing the flow of funds that finance primary health care. These funds are now closer to the frontline providers who will also have decision-making power on the use of these resources.

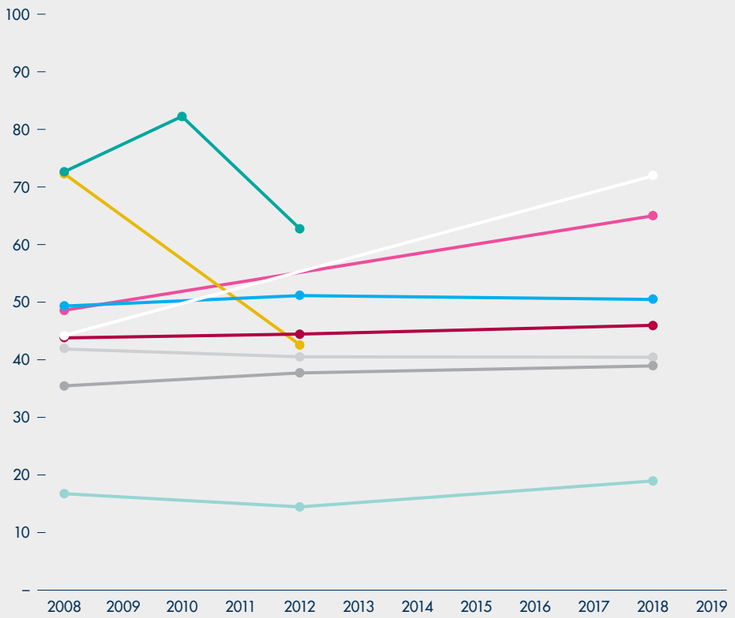
3 **Increase demand for high-impact services for vulnerable populations and support improved access to financial protection mechanisms for those populations.** Currently, the GFF together with all partners, is supporting the government in the development of a health financing strategy that would determine different pathways to increase the demand for essential services while improving financial access and protection.

4 **Contribute to health systems strengthening, in order to ensure the provision of a high-impact RMNCH-N health service package.** This has been one of the areas highlighted in the country's investment case. The specifics around GFF support are still being discussed.

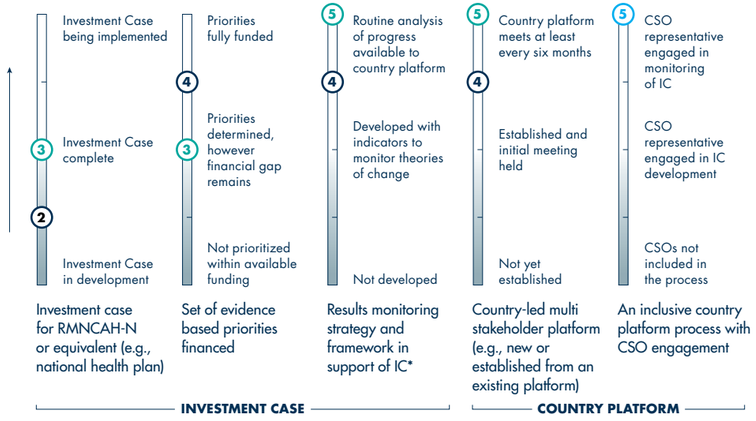
5 **Support implementation of the national CRVS strategic plan, as part of support to strengthening information systems and improving accountability for results.** Through financial support, the GFF is supporting the implementation of this national CRVS strategic plan.

■ RMNCAH-N COVERAGE INDICATORS

Data on immunization are presented from the WHO/UNICEF joint reporting process and recent population-based surveys. All other RMNCAH-N coverage indicators are presented from the most recent available population-based surveys.



■ MONITORING THE COUNTRY-LED PROCESS



Madagascar

■ RESOURCE MAPPING

Madagascar's investment case, which is almost finalized, is aligned with the ongoing preparation of the country's Health Financing Strategy and the new Health Sector Development Strategy (PDSS) 2020-2024. The Investment Case will outline priority regions and interventions requiring specific funding. An initial round of resource mapping was implemented in 2018, arriving at total resources for health of $517 million between 2016 and 2020 (see estimates for 2020 in the graph). This year, the resource mapping exercise was re-launched to update the previous work, assess financing gaps, and collect granual sub-national data. The implementation has been delayed due to the covid-19 outbreak; results are expected by the end of the year. A secondary resource mapping, of the covid-19 national response plan, is currently underway. To support ownership and buy-in of the resource mapping, the Ministry of Health is stewarding the RMET process, and the data collection will be led by a civil society organization (CSO). Results will be used to assess alignment of funding against the eight strategic priorities, and to analyze the sub-national allocation of resources.

■ CORE RMNCAH-N IMPACT INDICATORS

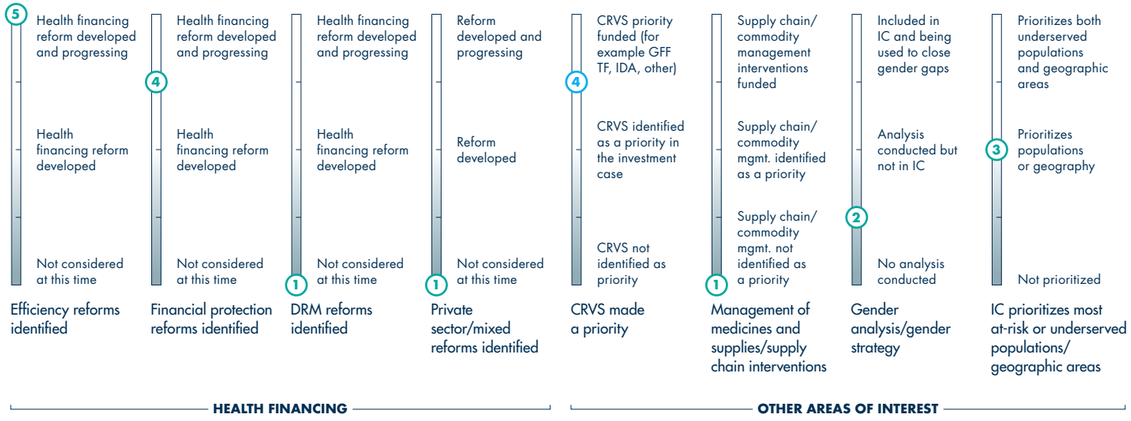
	Previous		Recent	
Maternal mortality ratio (per 100,000 live births)	**498**	2008	**–**	–
Under 5 mortality rate (per 1,000 live births)	**72**	2008	**59**	2018
Neonatal mortality rate (per 1,000 live births)	**24**	2008	**21**	2018
Adolescent birth rate – 15-19 (per 1,000 women)	**148**	2008	**151**	2018
Births <24 months after the preceding birth (%)	**22.9**	2008	**–**	–
Stunting among children under 5 years of age (%)	**48.9**	2012	**41.6**	2018
Moderate to severe wasting among children under 5 years of age (%)	**7.5**	2012	**6.4**	2018

■ HEALTH FINANCING

Core Indicators	2015	2016	2017
Domestic General Government Health Expenditure (DGGHE), per capita (US$)	**10.1**	**12.5**	**11.6**
Domestic General Government Health Expenditure (DGGHE) as share of general government expenditure (%)	**15.3**	**17.5**	**15**
Out-of-pocket spending on health, per capita (US$)	**6.1**	**6**	**6.1**

Country-Specific Indicators	2016	2017	2018	2019
Share of government budget allocated to health (%)	**4.4**	**5**	**5.2**	**6**
Health budget execution (%)	**83.7**	**92.3**	**95.9**	**–**
Share of health expenditure going to frontline providers (%)*	**–**	**–**	**–**	**–**

*This is a new indicator that is still being defined at the country-level



Annual report 2019/2020 score Annual report 2018/2019 score No change between last year and this year

* Both included in the IC document or a separate document

Malawi

THE GFF'S CATALYTIC ROLE

1 **Strengthen the emerging operational plan for the government's Health Sector Strategic Plan (HSSP-II)** with inclusion of RMNCAH-N-relevant priorities identified in the IC, developed in 2019 under MOH leadership. In an interactive process, the priorities were identified down to the subnational level and included $118 million in systems-levels investments aligned with the pillars of the HSSP-II. The bulk of required investments are in improved infrastructure and transport, strengthened human resources, and medical equipment. With the strengthened operational plan, the government is in a stronger position to align donor resources and improve efficiency in a health sector that is still largely funded with external resources.

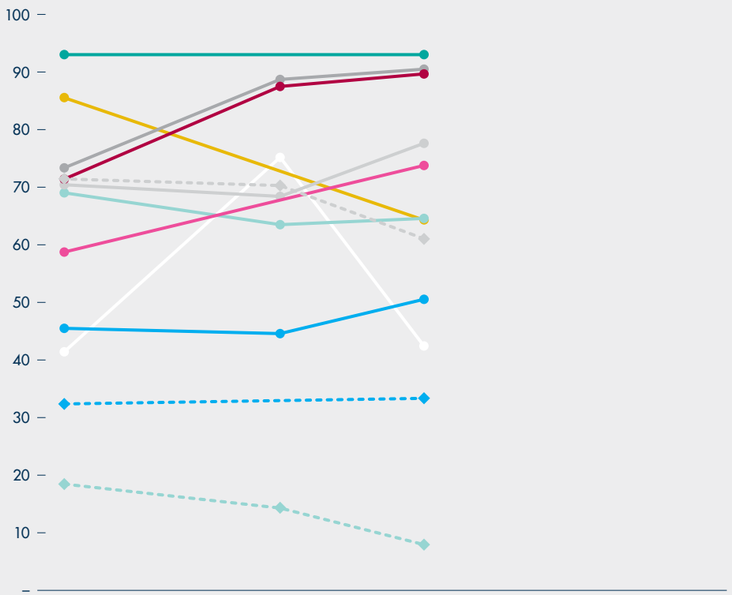
2 **Increase capacity for budget planning and execution at the subnational/district level.** The GFF supports technical assistance to the Department of Planning and Policy Development, which uses this support to work with district health teams to improve district inputs for the national budget planning process; support capacity development to account for all resources being applied to health programming at the district level (including public and private donor resources); and improve efficient budget execution.

3 **Prioritize adolescent health as a contribution to overall human capital formation.** Analytical work supported by the GFF is under way that will inform the new, donor-funded initiatives to be prepared over the next year. This could include a major focus on community-level interventions focused on reducing early marriage and associated adolescent fertility, with important implications for maternal and child health as well as nutritional outcomes.

4 **Support improved efficiency in health financing, building on an already-strong system for resource mapping and expenditure tracking.** As part of the proposed efficiency analysis, the GFF is supporting a detailed analysis of public spending on health that will also look at equity and benefit incidence.

RMNCAH-N COVERAGE INDICATORS

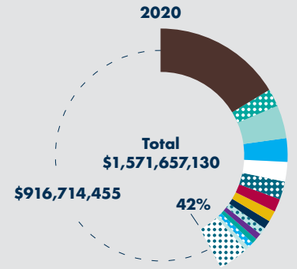
All RMNCAH-N coverage indicators are presented from the most recent available population-based surveys.



- Antenatal care (four or more visits)
- Immunized with three doses of diphtheria, tetanus, pertussis
- Skilled attendant at delivery
- Pregnant women who received iron folic acid supplementation or syrup for 90+days
- Oral rehydration salts treatment of diarrhoea
- Postnatal care for mothers
- Demand for family planning satisfied with modern methods
- Minimum acceptable diet
- Careseeking for symptoms of pneumonia
- Institutional Delivery
- Vitamin A supplementation, full coverage
- Exclusive breast feeding

RESOURCE MAPPING

Malawi has conducted extensive resource mapping and expenditure tracking for the health sector. There are over 180 donors and implementing partners in Malawi who contribute to health financing, with external financing accounting for 75 percent of funding. As such, aid coordination is a key priority in improving the efficiency and effectiveness of health spending. The Ministry of Health consolidated and costed priorities from national and subnational government annual plans and strategies, then analyzed their funding sufficiency and urgency by priority and district. The resulting HSSP II Operational Plan was launched in July 2020 and illustrates the key funding gaps and opportunities for enhancing allocative efficiency and aid effectiveness. Government of Malawi will continue to update the operational tool on an annual basis, with increasing emphasis on data use and tracking implementation.



- GOVERNMENT
- WORLD BANK/GFF
- USG - PEPFAR
- HEALTH SERVICES JOINT FUND
- USAID EXCLUDING PEPFAR
- GFATM
- GERMANY - KFW
- GAVI, THE VACCINE ALLIANCE
- UNITED KINGDOM (DFID)
- EUROPEAN UNION
- UNITED STATES - PMI
- BMGF
- UNICEF
- GERMANY - GIZ
- OTHER†
- GAP

† Approximately $10M of COVID-19 funding from multiple partners is included in "Other"

CORE RMNCAH-N IMPACT INDICATORS

	Previous		Recent	
Maternal mortality ratio (per 100,000 live births)	**675**	2010	**439**	2015
Under 5 mortality rate (per 1,000 live births)	**112**	2010	**63**	2015
Neonatal mortality rate (per 1,000 live births)	**31**	2010	**27**	2015
Adolescent birth rate – 15-19 (per 1,000 women)	**152**	2010	**136**	2015
Births <24 months after the preceding birth (%)	**15**	2010	**11.5**	2015
Stunting among children under 5 years of age (%)	**47.3**	2010	**37**	2015
Moderate to severe wasting among children under 5 years of age (%)	**4**	2010	**3**	2015

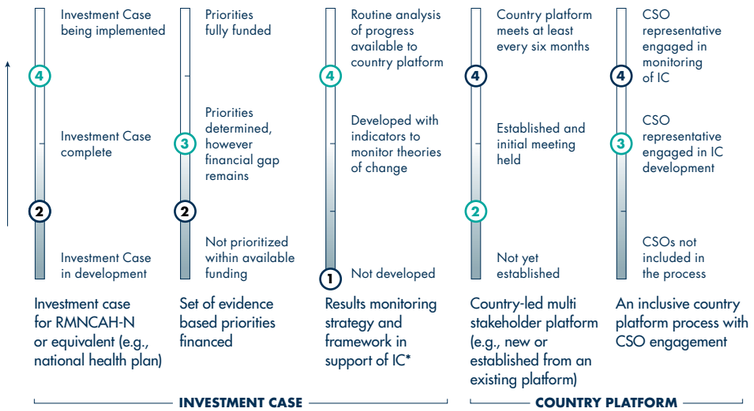
HEALTH FINANCING

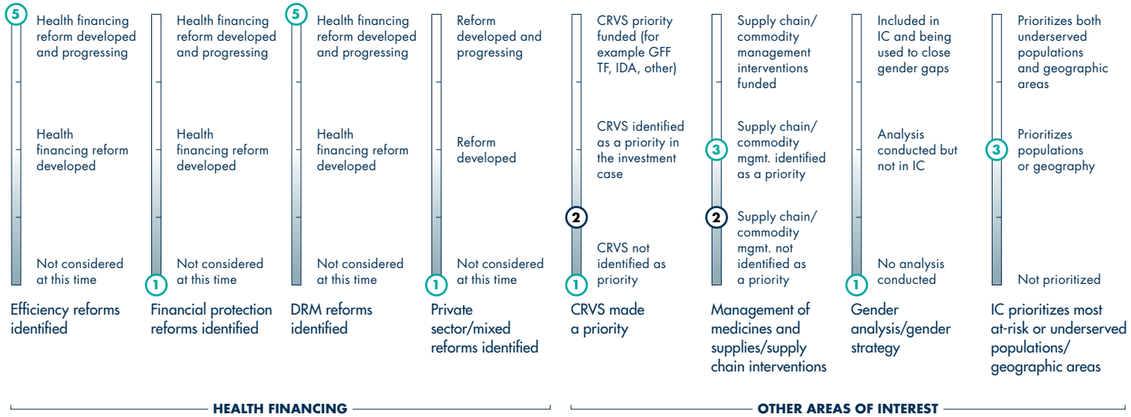
Core Indicators	2015	2016	2017
Domestic General Government Health Expenditure (DGGHE), per capita (US$)	**10**	**8.9**	**9.6**
Domestic General Government Health Expenditure (DGGHE) as share of general government expenditure (%)	**11.9**	**10**	**9.5**
Out-of-pocket spending on health, per capita (US$)	**5.1**	**5**	**5**

Country-Specific Indicators	2016	2017	2018	2019
Share of government budget allocated to health (%)	**10.2**	**9.6**	**9.7**	**9.4**
Health budget execution (%)	**103**	**94**	**98**	–
Share of health expenditure going to frontline providers (%)*	–	–	–	–

*This is a new indicator that is still being defined at the country-level

MONITORING THE COUNTRY-LED PROCESS





○ Annual report 2019/2020 score ○ Annual report 2018/2019 score ○ No change between last year and this year

* Both included in the IC document or a separate document

■ THE GFF'S CATALYTIC ROLE

1 **Support implementation of national health sector plan reforms, which include free care for pregnant women and children under five and the national expansion of the community health worker program.** The World Bank and the GFF are collaborating with the Ministry of Health and Social Affairs to help test different models to scale up a community health worker network nationally.

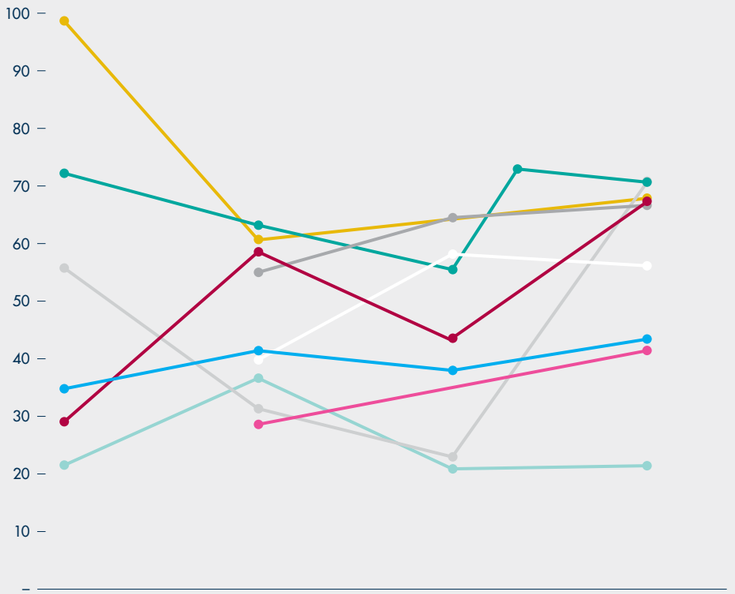
2 **Expand performance-based financing, in order to improve the flow of funds and access to good quality front-line health services.** The GFF is supporting the finalization of the performance-based financing manual, conducting the baseline survey of the impact evaluation, and participating in a ministry-led multi-partner group working on a scale-up plan for the community health model.

3 **Support a landscape analysis of adolescent health services with a view to increase access for adolescents to quality sexual and reproductive health services.** The GFF secretariat will provide technical assistance to assess opportunities inherent in the World Bank's human development portfolio to improve access to services for adolescents, as well as to help the Ministry of Health and Social Affairs test, validate and integrate a tool to routinely measure the quality of family planning services.

4 **Strengthen the CRVS system.** The GFF provides technical assistance to the government of Mali to assess the most strategic use of GFF funds to be invested in the strengthening of the CRVS system.

■ RMNCAH-N COVERAGE INDICATORS

Data on immunization are presented from the WHO/UNICEF joint reporting process and recent population-based surveys. All other RMNCAH-N coverage indicators are presented from the most recent available population-based surveys.



Mali

■ RESOURCE MAPPING

In 2020 Mali conducted the first round of resource mapping of its Investment Case 2019-2023, which targets three priority areas: delivery of quality health services across the continuum of care, support to the health system pillars, and governance. The exercise tracked actual expenditures for 2018 and 2019, and also assessed budget commitments at the subnational level, for all 74 districts. As Mali joined the GFF in mid-2018, it is in the initial stages of institutionalizing resource mapping, having first developed its IC. Data collection for the resource mapping and expenditure tracking exercise was completed in 2020; preliminary findings are currently being validated, with final results expected in fiscal year 2021. The resource mapping will be used to assess alignment with the Mali Action Plan (currently under development), to evaluate subnational resource allocation, and to advocate for additional funding to close the funding gap.

■ CORE RMNCAH-N IMPACT INDICATORS

	Previous		Recent	
Maternal mortality ratio (per 100,000 live births)	**368**	2012	**373**	2018
Under 5 mortality rate (per 1,000 live births)	**108**	2015	**101**	2018
Neonatal mortality rate (per 1,000 live births)	**31**	2015	**33**	2018
Adolescent birth rate – 15-19 (per 1,000 women)	**151**	2015	**164**	2018
Births <24 months after the preceding birth (%)	**21.2**	2012	**22.8**	2018
Stunting among children under 5 years of age (%)	**30.4**	2015	**26.9**	2018
Moderate to severe wasting among children under 5 years of age (%)	**13.5**	2015	**8.8**	2018

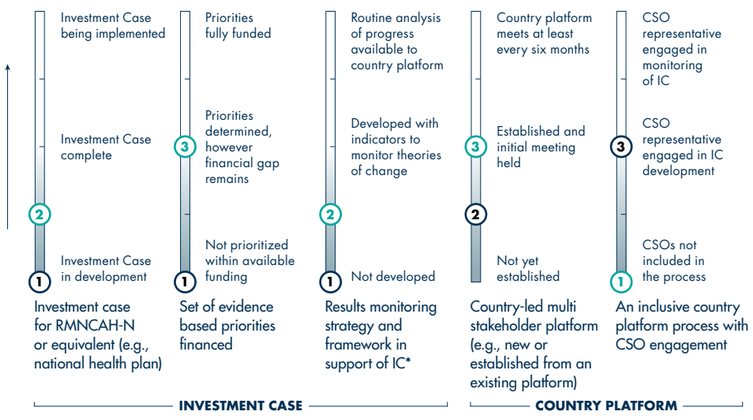
■ HEALTH FINANCING

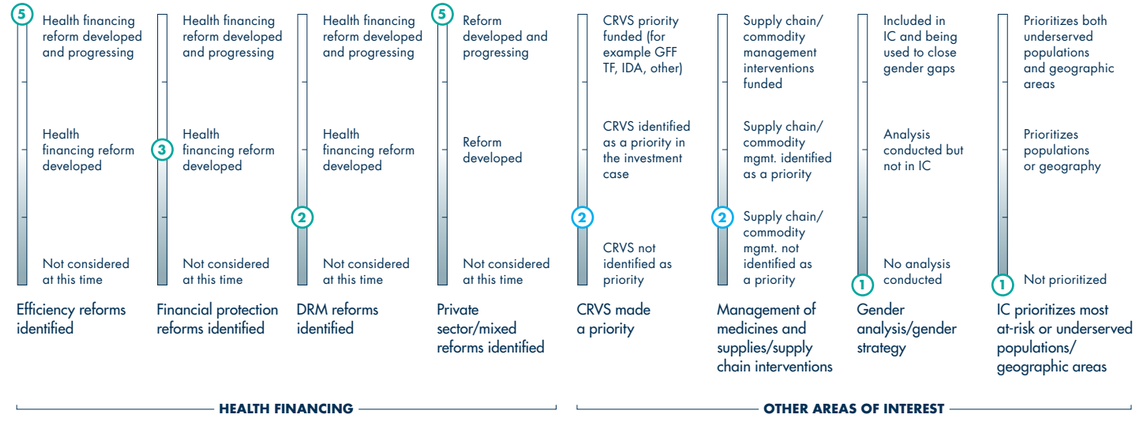
Core Indicators	2015	2016	2017
Domestic General Government Health Expenditure (DGGHE), per capita (US$)	**7.2**	**9.8**	**11**
Domestic General Government Health Expenditure (DGGHE) as share of general government expenditure (%)	**4.4**	**5.4**	**5.8**
Out-of-pocket spending on health, per capita (US$)	**11.1**	**10.9**	**11**

Country-Specific Indicators	2016	2017	2018	2019
Share of government budget allocated to health (%)	**6.3**	**6.7**	**5.6**	**5.5**
Health budget execution (%)	**68**	**79**	**65**	**–**
Share of health expenditure going to frontline providers (%)*	**–**	**–**	**–**	**–**

*This is a new indicator that is still being defined at the country-level

■ MONITORING THE COUNTRY-LED PROCESS





Annual report 2019/2020 score Annual report 2018/2019 score No change between last year and this year

* Both included in the IC document or a separate document

Mauritania

THE GFF'S CATALYTIC ROLE

1 **Mauritania joined the GFF in 2019 and is in the process of developing a prioritized investment case** and establishing a country-led multi-stakeholder platform.

2 **Contribute to the improved health of women, children and adolescents through the development and delivery of a prioritized, quality package of essential services, in particular in the regions with highest inequity.** Through the GFF process, Mauritania is currently developing a prioritized Investment Case aligned with the development of the new National Health Strategy.

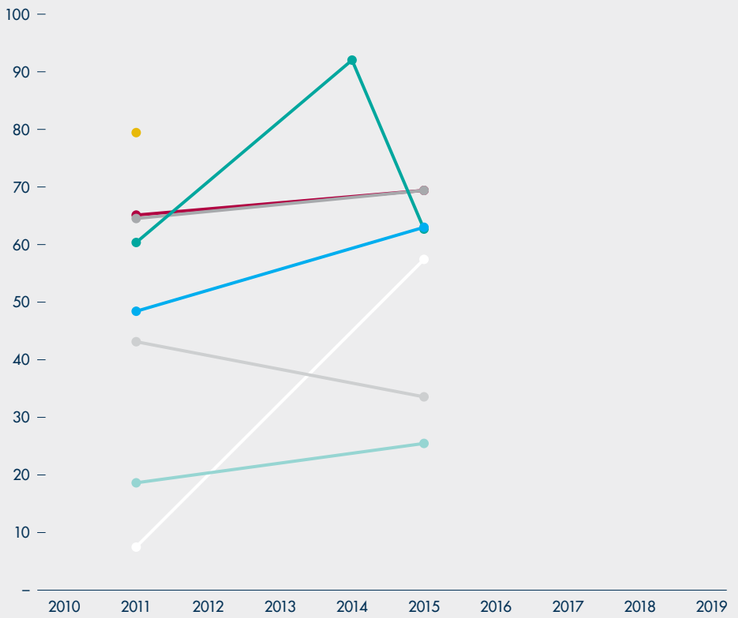
3 **Increase efficiency of domestic and external funding for health through resource mapping and improved partner coordination.** The resource mapping will be launched in September and will be combined with advancing the development of the new health strategy and the Investment Case.

4 **Strengthen equitable access to services through potential support to CRVS.** The specifics around the GFF support are still being discussed.

5 **Strengthen strategic purchasing for increased RMNCAH-N outcomes for women, children and adolescents.** The specifics around the GFF support are being discussed.

RMNCAH-N COVERAGE INDICATORS

Data on immunization are presented from the WHO/UNICEF joint reporting process and recent population-based surveys. All other RMNCAH-N coverage indicators are presented from the most recent available population-based surveys.



RESOURCE MAPPING

Mauritania joined the GFF process in 2019. Mauritania is in the process of developing the new national health strategy this year and evaluating the former health strategy ending in 2020, which will go hand in hand with the development of the IC that should be ready before end of the year. To allow concordance with the pillars of the new strategy, the mapping of resources was therefore stalled till the strategy was developed. The Covid-19 situation hit Mauritania later than its neighbor countries and has further delayed this process. Therefore the resource mapping will only be launched in September when the situation has evolved and can be combined the advancement of the development of the new health strategy and the IC.

CORE RMNCAH-N IMPACT INDICATORS

	Previous		Recent	
Maternal mortality ratio (per 100,000 live births)	**715**	2011	**582**	2015
Under 5 mortality rate (per 1,000 live births)	**118.5**	2011	**54**	2015
Neonatal mortality rate (per 1,000 live births)	**34.3**	2011	**29**	2015
Adolescent birth rate – 15-19 (per 1,000 women)	**–**	–	**–**	–
Births <24 months after the preceding birth (%)	**–**	–	**–**	–
Stunting among children under 5 years of age (%)	**23**	2012	**22.8**	2018
Moderate to severe wasting among children under 5 years of age (%)	**11.7**	2012	**11.5**	2018

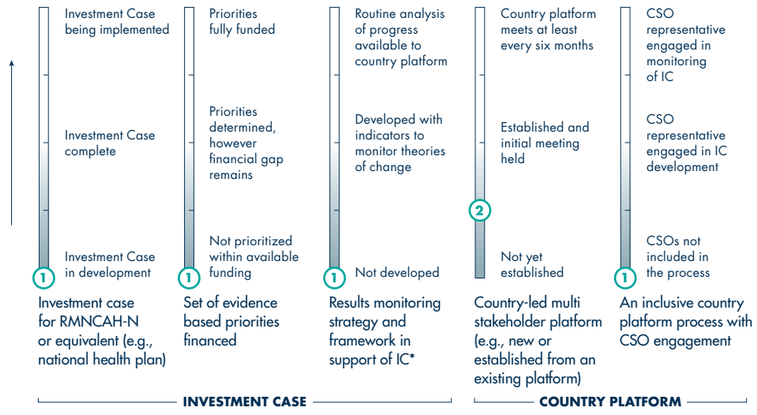
HEALTH FINANCING

Core Indicators	2015	2016	2017
Domestic General Government Health Expenditure (DGGHE), per capita (US$)	**26.5**	**19.8**	**21.1**
Domestic General Government Health Expenditure (DGGHE) as share of general government expenditure (%)	**7.3**	**5.9**	**6**
Out-of-pocket spending on health, per capita (US$)	**29.1**	**29.6**	**30.4**

Country-Specific Indicators	2016	2017	2018	2019
Share of government budget allocated to health (%)	**4.5**	**–**	**4.5**	**5.3**
Health budget execution (%)	**98**	**99**	**97.4**	**102**
Share of health expenditure going to frontline providers (%)*	**–**	**–**	**–**	**–**

*This is a new indicator that is still being defined at the country-level

MONITORING THE COUNTRY-LED PROCESS



◯ Annual report 2019/2020 score

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Mozambique

THE GFF'S CATALYTIC ROLE

1 **Support the government's commitment to keep the share of government health expenditures in total expenditure stable, initially at 7.9 percent and increasing it to 9.5 percent by 2021.**

2 **Support the Government in strengthening Primary Care by increasing number of technical health staff and community health workers at the primary care level.** The GFF supports training, provision of kits, and payment of community health workers. It is also supporting increased spending in undeserved districts and provinces.

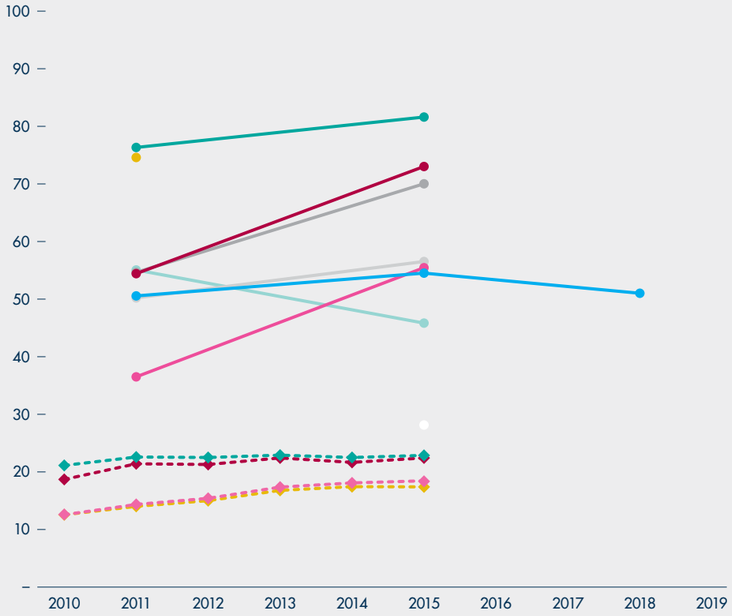
3 **Reduce fragmentation through Multi Donor Trust Fund support of the investment case.**

4 **Incentivize death registration, certification, and coding of the cause of death for deaths in health facilities and incentivize the release of statistical reports.**

5 **Support government to scale up the outsourcing of last-mile distribution of drugs to the private sector to increase the availability of essential drugs in primary care facilities.** The GFF supports the effective supply chain partnership currently in progress and the development of a sub investment case for the implementation of the national pharmaceutical strategy.

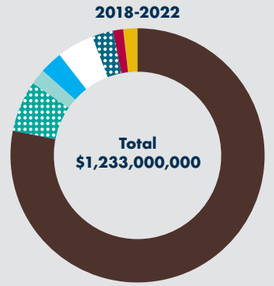
RMNCAH-N COVERAGE INDICATORS

Education indicators are presented from the World Development Indicators. All other RMNCAH-N coverage indicators are presented from the most recent available population-based surveys.



RESOURCE MAPPING

Previously, Mozambique has committed to a fully funded Investment Case with prioritized interventions to ensure there is no funding gap. Contributions from development partners are channeled through government systems, and pooled funds such as the Primary Health Care Strengthening Program and ProSaude are mechanisms through which external donors can finance the health system. As the Investment Case nears the mid-point, there has been a focus on expenditure tracking to assess whether there are shifts in spending to align more closely with identified priorities. A health expenditure review of 2014-2018 found an overall positive trend in domestic resource mobilisation (a 200% increase between 2009 to 2018), but a decrease in budget execution rates (85% of revised budget allocations were executed in 2018). While domestic funds were largely dedicated to operational and personnel costs, off-budget funds, were focused on disease-specific programs, increasingly prioritizing malaria and continuing to fund HIV-AIDS programs. Nutrition, Maternal, Child and Reproductive health programs accounted for approximately 13% of external health spending on vertical programs.



- GOVERNMENT
- WORLD BANK
- GFF TRUST FUND
- NETHERLANDS (MULTI-DONOR TRUST FUND)
- CANADA (MULTI-DONOR TRUST FUND)
- UNITED KINGDOM (MULTI-DONOR TRUST FUND)
- PROSAUDE
- USAID

CORE RMNCAH-N IMPACT INDICATORS

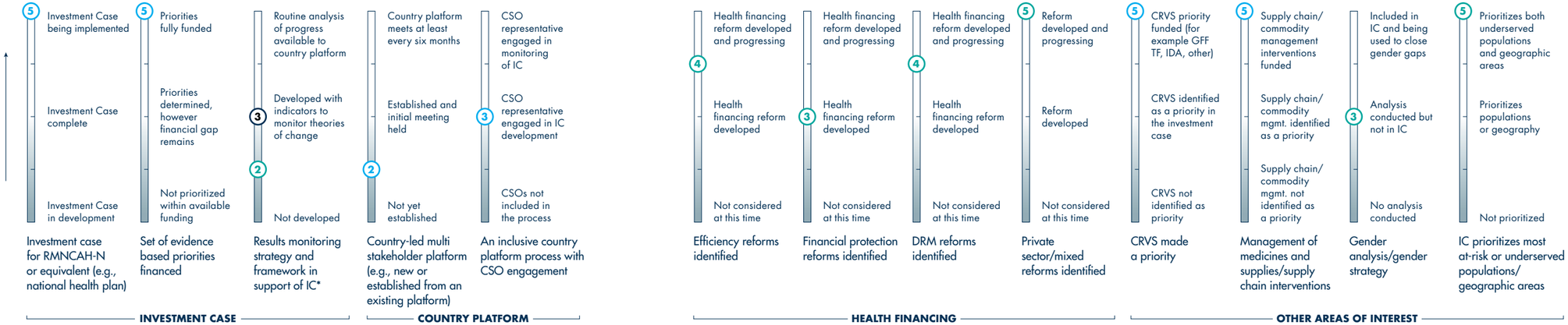
	Previous		Recent	
Maternal mortality ratio (per 100,000 live births)	**408**	2011	**–**	–
Under 5 mortality rate (per 1,000 live births)	**97**	2011	**–**	–
Neonatal mortality rate (per 1,000 live births)	**29.9**	2011	**–**	–
Adolescent birth rate – 15-19 (per 1,000 women)	**167**	2011	**194**	2015
Births <24 months after the preceding birth (%)	**14.4**	2011	**18.8**	2015
Stunting among children under 5 years of age (%)	**42.6**	2011	**41.6**	2019
Moderate to severe wasting among children under 5 years of age (%)	**6.7**	2011	**4.1**	2019

HEALTH FINANCING

Core Indicators	2015	2016	2017
Domestic General Government Health Expenditure (DGGHE), per capita (US$)	**6.9**	**6.4**	**6.3**
Out-of-pocket spending on health, per capita (US$)	**1.6**	**1.6**	**1.6**

Country-Specific Indicators	2016	2017	2018	2019
Share of government budget allocated to health (%)	**9.6**	**8.8**	**9.9**	**–**
Health budget execution (%)	**72**	**80**	**85**	**–**
Share of health expenditure going to frontline providers (%)	**26**	**24**	**26**	**–**
Domestic health expenditures as a percentage of total domestic government expenditures	**8.4**	**7.9**	**8.9**	**7.9**
Number of technical health personnel assigned to primary care (in thousands)	**–**	**12**	**13.8**	**15.3**
Number of trained and active community healthcare workers (CHWs) (in thousands)	**–**	**–**	**3.4**	**5.6**

MONITORING THE COUNTRY-LED PROCESS



◯ Annual report 2019/2020 score ◯ Annual report 2018/2019 score ◯ No change between last year and this year

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Myanmar

THE GFF'S CATALYTIC ROLE

1 **Support the increase in institutional deliveries, in order to reduce maternal and neonatal mortality and create an entry point for broader health system reform.** The GFF is supporting initiatives to address human resources for health bottlenecks including technical assistance, analytics, peer to peer learning, and innovative approaches to training and job aids. Through the GFF co-financed World Bank project, the GFF grant is linked to a health system strengthening component that uses disbursement linked indicators for (i) implementing a quality readiness checklist for maternal and child care; and (ii) extending health resources to the community level that provide integrated outreach and services. The project has a strong peace and inclusion focus on the under-served in Myanmar's conflict-affected states, and the GFF's financing enables targeting of existing inequities in access to essential services for women and children.

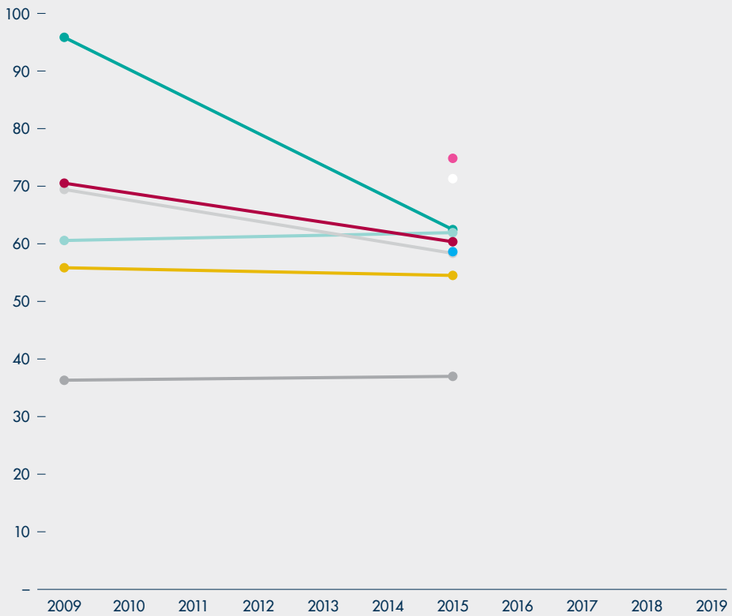
2 **Strengthen private-sector engagement.** The GFF is providing financing and technical assistance to conduct (i) a private-sector assessment of the health sector; (ii) capacity assessment of the MOH private-sector unit; and (iii) public-private dialogue initiatives to bring key stakeholders together to identify priorities and collaboration opportunities.

3 **Use of innovative approaches and technologies to improve access to RMNCAH services.** The GFF is supporting initiatives to explore new ideas, such as the use of smartphones, telemedicine, and public-private partnerships. The GFF is currently supporting a component in the GFF co-financed World Bank project on information and communication technology-based innovation. In addition, the GFF and World Bank are working together to conduct an options analysis of various ways to improve health worker training, performance, and supervision using appropriate technologies.

4 **Strengthen resource mapping and expenditure tracking.** The GFF is providing technical assistance and financing for the planning and implementation of resource mapping and expenditure tracking processes, which will inform resource allocation and donor transition planning in the health sector. This work may include efforts to strengthen the institutionalization and harmonization of different resource tracking exercises in health.

RMNCAH-N COVERAGE INDICATORS

All RMNCAH-N coverage indicators are presented from the most recent available population-based surveys.



RESOURCE MAPPING

Resource mapping of the health sector is under discussion with the Ministry of Health and Sports. With government and development partners supporting health services in many of the 330 townships, there is a need to understand where government and external resources are being allocated and spent, any correlation with health service utilization and outcomes, and whether there is an opportunity to improve targeting of future investments. In some townships, there has been tentative progress towards the development of inclusive Township Investment Plans (those linked to the Additional Financing project of the World Bank). These townships may also benefit from resource mapping and expenditure tracking to understand how different sources of funding are supporting their implementation, where priority funding gaps are, and whether budgets are executed efficiently as planned.

CORE RMNCAH-N IMPACT INDICATORS

	Previous		Recent	
Maternal mortality ratio (per 100,000 live births)	–	–	**227**	2015
Under 5 mortality rate (per 1,000 live births)	**62**	2012	**47**	2020
Neonatal mortality rate (per 1,000 live births)	**30**	2011	**22**	2019
Adolescent birth rate – 15-19 (per 1,000 women)	–	–	**36**	2015
Births <24 months after the preceding birth (%)	–	–	**13.2**	2015
Stunting among children under 5 years of age (%)	**35.1**	2009	**29.4**	2015
Moderate to severe wasting among children under 5 years of age (%)	**7.9**	2009	**6.6**	2015

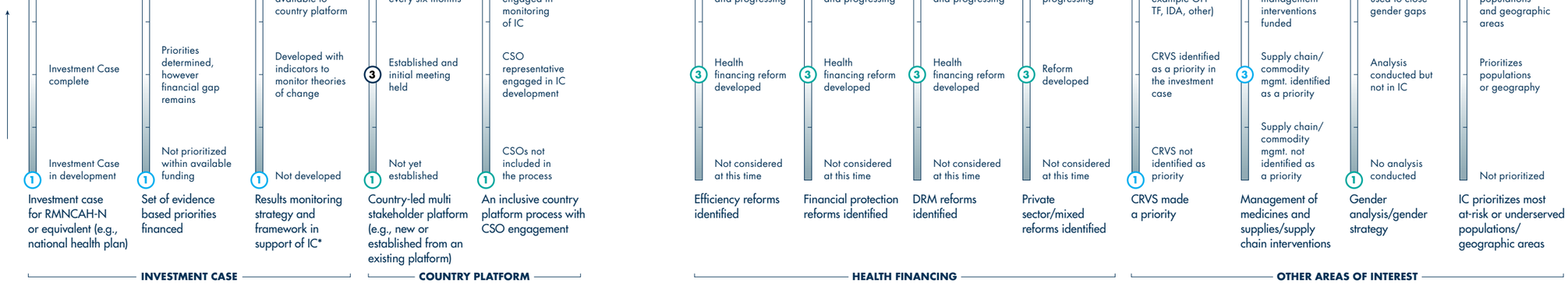
HEALTH FINANCING

Core Indicators	2015	2016	2017
Domestic General Government Health Expenditure (DGGHE), per capita (US$)	**13.6**	**8.3**	**8.6**
Domestic General Government Health Expenditure (DGGHE) as share of general government expenditure (%)	**4.8**	**3**	**3.4**
Out-of-pocket spending on health, per capita (US$)	**43.7**	**44.6**	**43.8**

Country-Specific Indicators	2016	2017	2018	2019
Share of government budget allocated to health (%)	**3**	**3.4**	**3.4**	–
Health budget execution (%)	**110**	**94**	**76**	–
Share of health expenditure going to frontline providers (%)*	–	–	–	–

*This is a new indicator that is still being defined at the country-level

MONITORING THE COUNTRY-LED PROCESS



Annual report 2019/2020 score Annual report 2018/2019 score No change between last year and this year

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Niger

THE GFF'S CATALYTIC ROLE

1 **Niger joined the GFF in 2019 and is in the process of developing a prioritized investment case** and establishing a country-led multi-stakeholder platform with CSO representation already engaged in the IC development process.

2 **Ensure delivery of a prioritized quality package of essential services for women, children and with a particular focus on adolescents, through the IC and the World Bank-MPA and partners.** The specifics around the GFF support are still being discussed.

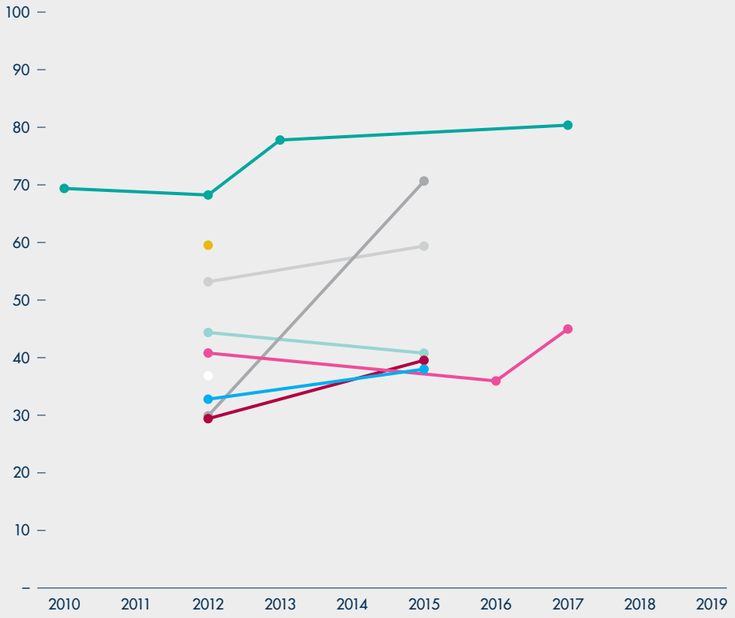
3 **Support increased efficiency of domestic and external funding for health.** The GFF supports the development of resource mapping for improved partner coordination as well as support to public financial management.

4 **Support prioritized health financing reforms, including strategic purchasing.** The GFF supports the development and implementation of the new results-based financing scheme, in line with strengthening of the gratuity policy for women and children under 5 as part of the national universal health coverage strategy

5 **Support interventions that take into account social norms on equity and gender equality for increased RMNCAH-N outcomes.** The specifics around the GFF support are still being discussed.

RMNCAH-N COVERAGE INDICATORS

Data on immunization are presented from the WHO/UNICEF joint reporting process and recent population-based surveys. Family planning indicators are presented from the PMA2020 database and recent population-based surveys. All other RMNCAH-N coverage indicators are presented from the most recent available population-based surveys.



RESOURCE MAPPING

The resource mapping exercise in Niger will focus initially on the Health Development Plan (PDS 2017-2021) in order to support the development of the Investment Case and inform its prioritization process. In addition to budgetary commitments, the exercise is intended to be retrospective by collecting expenditures data for the first three years of HDP implementation. For this purpose, a data collection tool accompanied by its user guide was initially developed and shared with the national counterpart and the main partners involved in the health sector at the end of March 2020 (a total of 25 partners received the data collection tool). Following the COVID-19 outbreak, synergies have been explored with the aim to align with the COVID-19 National Response Plan resource mapping exercise led by the Global Health Security Department at WHO. The decision was taken to redesign the GFF data collection tool to integrate the resource mapping for both the Health Development Plan and the COVID-19 National Response Plan in Niger to decrease data burden and coordination on the government and donors and use that synergy to assess whether essential health services have been protected during the COVID-19 pandemic.

CORE RMNCAH-N IMPACT INDICATORS

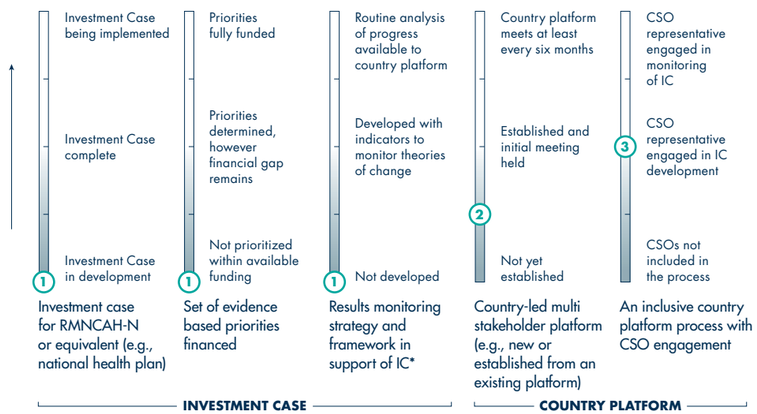
	Previous		Recent	
Maternal mortality ratio (per 100,000 live births)	**535**	2012	**520**	2015
Under 5 mortality rate (per 1,000 live births)	**127**	2012	**126**	2015
Neonatal mortality rate (per 1,000 live births)	**24**	2012	**24**	2015
Adolescent birth rate – 15-19 (per 1,000 women)	**206**	2012	**146**	2015
Births <24 months after the preceding birth (%)	**23**	2012	**–**	–
Stunting among children under 5 years of age (%)	**48.5**	2018	**45.7**	2019
Moderate to severe wasting among children under 5 years of age (%)	**14.1**	2018	**10.2**	2019

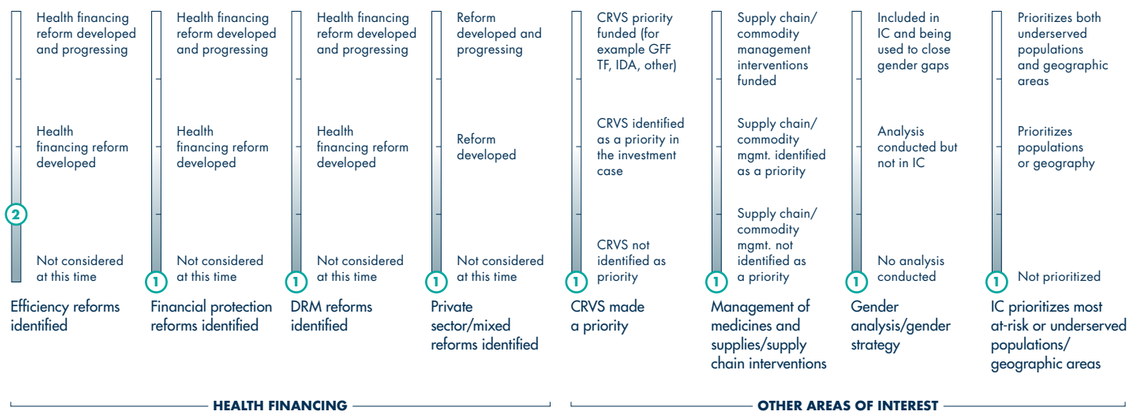
HEALTH FINANCING

Core Indicators	2015	2016	2017
Domestic General Government Health Expenditure (DGGHE), per capita (US$)	**5.5**	**5.6**	**9.8**
Domestic General Government Health Expenditure (DGGHE) as share of general government expenditure (%)	**4.6**	**5.7**	**9.7**
Out-of-pocket spending on health, per capita (US$)	**13.7**	**13.5**	**14**

Country-Specific Indicators	2016	2017	2018	2019
Share of government budget allocated to health (%)	**4.9**	**5.6**	**5.7**	**5.4**
Health budget execution (%)	**68**	**70**	**91**	**79**
Share of health expenditure going to frontline providers (%)	**7.07**	**27.9**	**19.5**	**–**

MONITORING THE COUNTRY-LED PROCESS





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Nigeria

■ THE GFF'S CATALYTIC ROLE

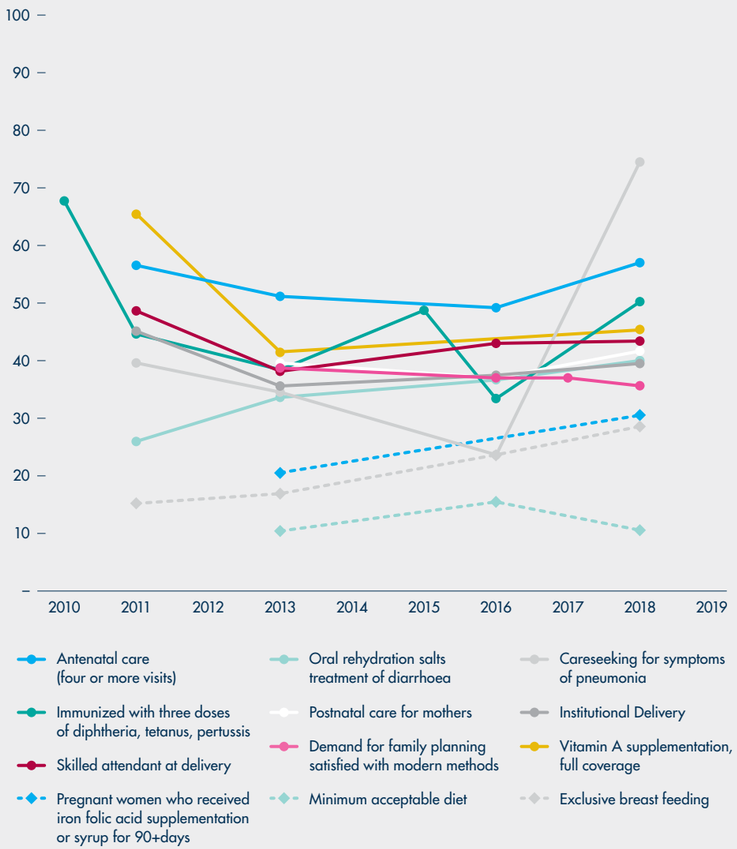
1 **Support the implementation of the National Health Act by triggering the first tranche of the Basic Health Care Provision Fund, US$180 million, as domestic government resources to align with external resources.** The GFF stimulated the federal ministry of health and partners to develop an overarching national RMNCAH-N investment case for operationalization of the Basic Health Care Provision Fund. The fund is a mechanism to channel increased domestic and international financing to strengthen primary health care.

2 **Improve efficiency by defining and delivering a universal, free, minimum package of basic health services through performance-based approaches, including reestablishment of basic health services in the fragile and conflict-affected North East regions and inadequately funded priorities such as chronic malnutrition and adolescent health.** In the conflict-affected North East, the GFF, through the expansion of the Nigeria State Health Investment Project (NSHIP) co-financed by the GFF Trust Fund, is rebuilding the health system, particularly at the primary healthcare level. This is a program that brings new attention to critical issues such as chronic malnutrition. The NSHIP uses a performance-based financing approach that creates incentives to improve maternal and child health outcomes. Financing is provided to preselected public and private primary health care centers directly, based on facilities' achievement of pre-agreed results on health outcomes. Decision-making is also decentralized to the facility level, giving facilities more autonomy and flexibility to innovate.

3 **Improve service delivery for nutrition through a multisectoral approach.** The mechanism at the federal level to facilitate multi-sectoral coordination through the Ministry of Budget and Planning, supported by the GFF, is expected to harness resources and capacity from key sectors (e.g., agriculture, social protection, education, gender) to support implementation of nutrition interventions in 12 priority states. The GFF will support upcoming social and behavioral change communication campaigns to improve infant and young-child feeding behaviors.

■ RMNCAH-N COVERAGE INDICATORS

Data on immunization are presented from the WHO/UNICEF joint reporting process and recent population-based surveys. Family planning indicators are presented from the PMA2020 database and recent population-based surveys. All other RMNCAH-N coverage indicators are presented from the most recent available population-based surveys.



■ RESOURCE MAPPING

Resource Mapping and Expenditure Tracking (RMET) in Nigeria is currently in the initial phase of planning and design. The main focus of the exercise will be on mapping and tracking donor financing, which accounts for three-quarters of domestic spending. Documenting all sources of funds is essential for the Federal Ministry of Health (FMOH) in Nigeria, not only to align and channel resources to sector priorities, but also to address issues relating to the adequacy, sustainability, efficiency, transparency and equity of financing in the implementation of the Basic Health Care Provision Fund (BHCPF). BHCPF is one of three World Bank supported projects co-financed by GFF. GFF's RMET exercise will support FMOH to leverage the Office of the Federal Accountant General's Consolidation Accounts Department (CAD) initiative to collect information on external financing. The RMET process will develop a systematic process for collating DAH expenditure that can be used in budgeting, resource allocation decisions, and preparing consolidated financial statements for the health sector.

■ CORE RMNCAH-N IMPACT INDICATORS

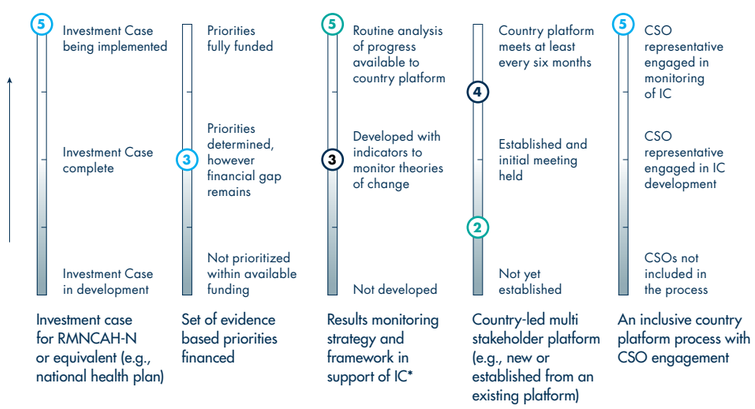
	Previous		Recent	
Maternal mortality ratio (per 100,000 live births)	**576**	2013	**512**	2018
Under 5 mortality rate (per 1,000 live births)	**128**	2013	**132**	2018
Neonatal mortality rate (per 1,000 live births)	**37**	2013	**39**	2018
Adolescent birth rate – 15-19 (per 1,000 women)	**122**	2013	**106**	2018
Births <24 months after the preceding birth (%)	**23.2**	2013	**24.9**	2018
Stunting among children under 5 years of age (%)	**36.8**	2013	**36.8**	2018
Moderate to severe wasting among children under 5 years of age (%)	**18**	2013	**6.7**	2018

■ HEALTH FINANCING

Core Indicators	2015	2016	2017
Domestic General Government Health Expenditure (DGGHE), per capita (US$)	**12.3**	**9.5**	**10.5**
Domestic General Government Health Expenditure (DGGHE) as share of general government expenditure (%)	**5.3**	**5**	**4.6**
Out-of-pocket spending on health, per capita (US$)	**53.9**	**55**	**57.1**

Country-Specific Indicators	2016	2017	2018	2019
Share of government budget allocated to health (%)	**4.2**	**4.1**	**4.1**	**4.9**
Health budget execution (%)	**–**	**–**	**72.7**	**86.2**
Share of health expenditure going to frontline providers (%)	**21**	**–**	**–**	**–**
Number of accredited facilities receiving payments for services financed through the Fee-for-Service (FFS) mechanism (public and private)	**–**	**–**	**–**	**179**
Domestic resource contribution to the Basic Health Care Provision Fund (BHCPF) (US$ in millions)	**–**	**–**	**180**	**167**

■ MONITORING THE COUNTRY-LED PROCESS



Annual report 2019/2020 score Annual report 2018/2019 score No change between last year and this year

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Pakistan

THE GFF'S CATALYTIC ROLE

1. **Pakistan joined the GFF in 2019 and is in the process of developing a prioritized investment case** and establishing a country-led multi-stakeholder platform with CSO representation.

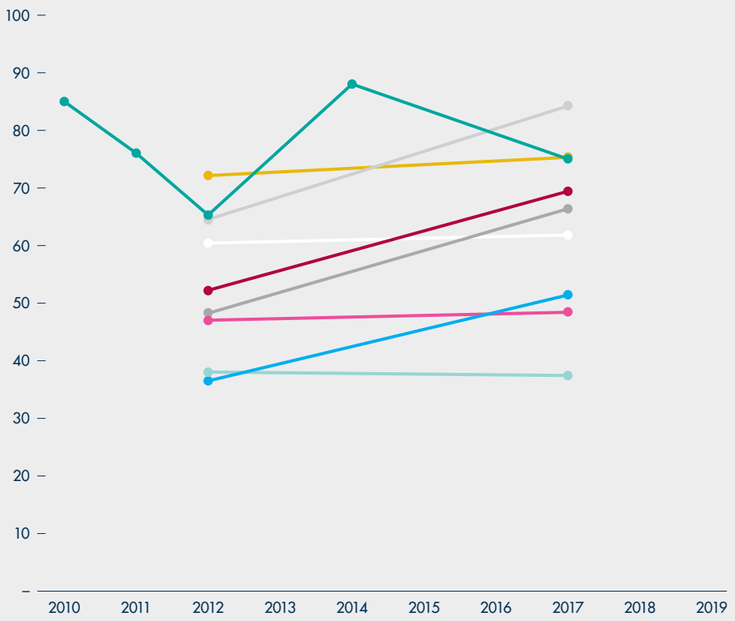
2. **Support health financing and public financial management reforms.** The GFF will support analytical work to help the Government of Pakistan implement the reforms over the next five years.

3. **Strengthen the civil registration and vital statistics (CRVS) system.** The GFF provides technical assistance to the government to develop an operational plan for integrating the now fragmented CRVS system.

4. **Increase access to quality sexual reproductive health and rights (SRHR) services.** The GFF provides technical assistance to conduct an opportunity analysis that will inform the way forward.

RMNCAH-N COVERAGE INDICATORS

Data on immunization are presented from the WHO/UNICEF joint reporting process and recent population-based surveys. All other RMNCAH-N coverage indicators are presented from the most recent available population-based surveys.



RESOURCE MAPPING

Pakistan's investment case corresponds to the Universal Health Coverage (UHC) Essential Package of Health Services (EPHS) which will be finalized by 2020. The GFF is currently supporting the Ministry of National Health Services Regulations and Coordination (MoNHSR&C) in mapping domestic and external resources available for each costed priority of this UHC strategy at national and regional levels. Results are expected in Sept 2020. Those data will inform the prioritization process of the UHC strategy as well as support the MoNHSR&C at federal level and Department of Health (DoH) at regional level in optimizing its planning and budgeting function. The MoNHSR&C and DoH will have a better understanding of potential UHC priorities under-funded at national and regional level, which will inform next round of resources mobilization among the Ministry of Finance/Department of Finance and donors. Pakistan will launch UHC strategy expenditure tracking in 2021 once the UHC-EPHS has started implementation. This exercise will be coordinated with national health account exercises. For now, Ernst and Young is supporting the MoNHSR&C with the resource mapping of the UHC.

CORE RMNCAH-N IMPACT INDICATORS

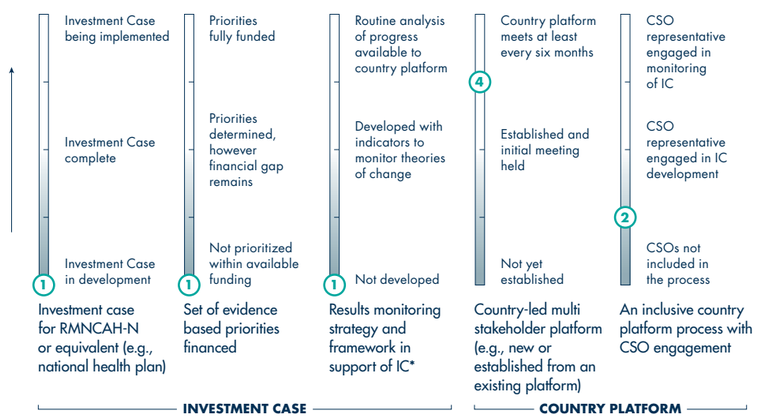
	Previous		Recent	
Maternal mortality ratio (per 100,000 live births)	**178**	2014	**140**	2019
Under 5 mortality rate (per 1,000 live births)	**89**	2012	**74**	2017
Neonatal mortality rate (per 1,000 live births)	**55**	2012	**42**	2017
Adolescent birth rate – 15-19 (per 1,000 women)	**44**	2012	**46**	2017
Births <24 months after the preceding birth (%)	**36.6**	2012	**36.6**	2017
Stunting among children under 5 years of age (%)	**45**	2012	**37.6**	2017
Moderate to severe wasting among children under 5 years of age (%)	**10.5**	2012	**7.1**	2017

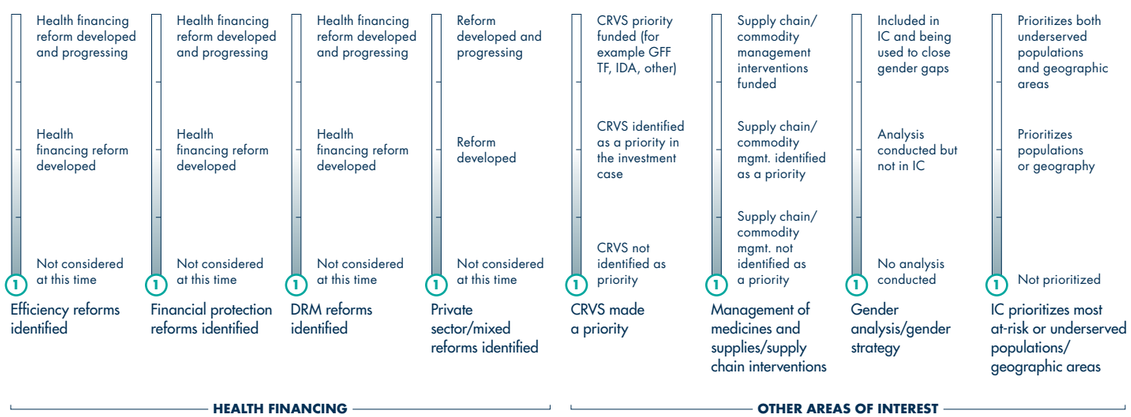
HEALTH FINANCING

Core Indicators	2015	2016	2017
Domestic General Government Health Expenditure (DGGHE), per capita (US$)	**12.7**	**15.3**	–
Domestic General Government Health Expenditure (DGGHE) as share of general government expenditure (%)	**3.7**	**4.1**	**4.3**
Out-of-pocket spending on health, per capita (US$)	**23.8**	**25.9**	**26.9**

Country-Specific Indicators	2016	2017	2018	2019
Share of government budget allocated to health (%)	**3.6**	**4**	**4.6**	–
Health budget execution (%)	**98**	**105**	**90**	–
Share of health expenditure going to frontline providers (%)	–	**7**	**9**	**13**

MONITORING THE COUNTRY-LED PROCESS





Annual report 2019/2020 score

* Both included in the IC document or a separate document

Rwanda

THE GFF'S CATALYTIC ROLE

1 **Strengthen the coordination of the multisectoral nutrition program.** The GFF supports the development of the national early childhood development (ECD) program strategic plan (serves as Investment Case), strengthen the oversight capacity, improve monitoring system to track progress and enhance the use of data for decision making.

2 **Improve the spending efficiency and financing sustainability of priority programs.** GFF supports strengthening of the public financial management with the budget tagging and tracking system to improve nutrition budget oversight and the institutionalizing nutrition budget review linking spending to performance.

3 **Strengthen the community health workers (CHW) program.** The GFF supports new approaches to improve CHWs in delivering critical preventive health and nutrition services. More specifically, GFF helps improve performance through certification and accreditation and enhance incentives system.

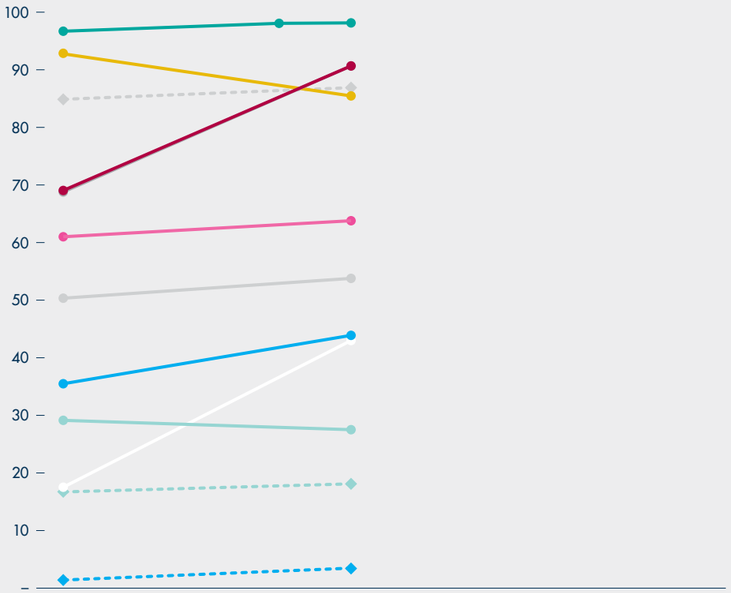
4 **Roll out community-based approaches and strategies for improving behavioral change.** The GFF supports the roll out of innovative tools such as Child Length Mat to raise stunting awareness and trigger actions at community and household., GFF also supports the scaling up of the home-based ECD to enhance feeding practices and early learning and stimulation.

5 **Support innovative social safety net program to incentive the use of health and nutrition services during the first 1000 days.** The GFF contributed to the expansion of nutrition-sensitive direct support (NSDS) — a co-responsibility cash transfer program. GFF also supports strengthening the safety net delivery system through among others promoting interoperability of information systems to effectively administer the NSDS.

6 **Strengthen the functionality of the CRVS system.** The GFF contributed to the regulatory reforms to improve the birth and deaths registration at the health facility level and link the CRVS to the safety net programs to enable better enrollment and monitoring of compliance.

RMNCAH-N COVERAGE INDICATORS

Data on immunization are presented from the WHO/UNICEF joint reporting process and recent population-based surveys. All other RMNCAH-N coverage indicators are presented from the most recent available population-based surveys.



RESOURCE MAPPING

The Ministry of Health has detailed information on external resources through the government's Health Resource Tracking Tool. However, since Rwanda's investment case focuses primarily on nutrition, multisectoral resource mapping is needed. The GFF supports the Nutrition Expenditure and Institutional Review (NEIR) that provides detailed analysis of the level and composition of government and donor spending on multisectoral nutrition program using the National Early Childhood Development Program Strategic Plan (as GFF Investment Case for Rwanda) as reference. Moreover, it identified critical institutional and public financial management arrangements critical to enhance budget oversight and accountability for results. NEIR provides groundwork for policy dialogue with the government on institutionalizing multisectoral expenditure tracking system through IFMIS and comprehensive budget review linking spending and performance. This has been agreed as one of the key reforms in the upcoming Human Capital for Inclusive Growth (HCIG) DPO. The GFF supports ongoing technical assistance in FY21 to support government achieving such objectives.

CORE RMNCAH-N IMPACT INDICATORS

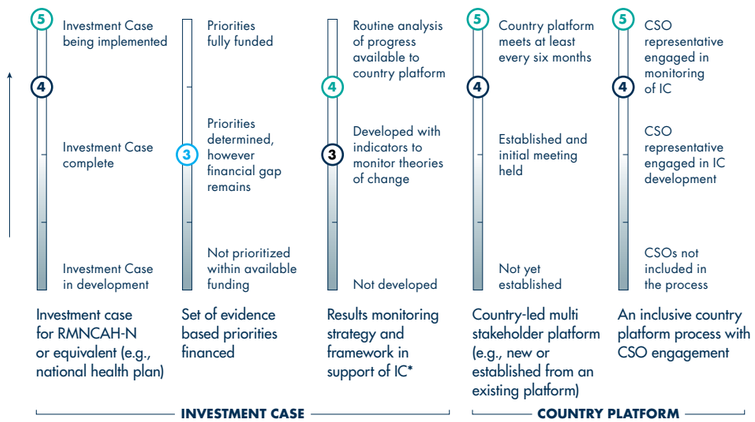
	Previous		Recent	
Maternal mortality ratio (per 100,000 live births)	**476**	2010	**210**	2014
Under 5 mortality rate (per 1,000 live births)	**76**	2010	**50**	2014
Neonatal mortality rate (per 1,000 live births)	**27**	2010	**20**	2014
Adolescent birth rate – 15-19 (per 1,000 women)	**41**	2010	**45**	2014
Births <24 months after the preceding birth (%)	**19.9**	2010	**14**	2014
Stunting among children under 5 years of age (%)	**44.2**	2010	**37.9**	2014
Moderate to severe wasting among children under 5 years of age (%)	**2.8**	2010	**2.2**	2014

HEALTH FINANCING

Core Indicators	2015	2016	2017
Domestic General Government Health Expenditure (DGGHE), per capita (US$)	**15.2**	**16.6**	**16.9**
Domestic General Government Health Expenditure (DGGHE) as share of general government expenditure (%)	**7.9**	**8.9**	**8.9**
Out-of-pocket spending on health, per capita (US$)	**3.5**	**3.1**	**3.1**

Country-Specific Indicators	2016	2017	2018	2019
Share of government budget allocated to health (%)	**11.3**	**9.7**	**9.3**	**9**
Health budget execution (%)	**81**	**94**	**92**	**–**
Share of health expenditure going to frontline providers (%)	**47.1**	**27.6**	**29.1**	**–**

MONITORING THE COUNTRY-LED PROCESS



Annual report 2019/2020 score Annual report 2018/2019 score No change between last year and this year

* Both included in the IC document or a separate document

Senegal

THE GFF'S CATALYTIC ROLE

1 **Enhance efficiency by strengthening PFM, to better track resources going to health, improve budget planning, and increase budget execution.** The GFF supports (i) the implementation of program-based budgeting: development of program-based budgeting tools, training sessions and recruitment of accountants at regional level; (ii) the ongoing public expenditure review in health; (iii) analytical work on costing and fiscal space; and (iii) the development of a fiduciary unit in the MOH to manage external resources.

2 **Support the implementation of the universal health insurance (UHI) scheme by consolidating the community-based health insurance schemes while effectively exempting the poor.** The GFF supports the UHI program through the World Bank co-financed project to ensure the scale-up of the integrated *Gratuité* and CBHI scheme as well as the cash transfer program to pregnant women in 6 priority regions. In addition, the GFF finances a Providing for Health (P4H) coordinator supporting the MOH in overseeing health financing reforms.

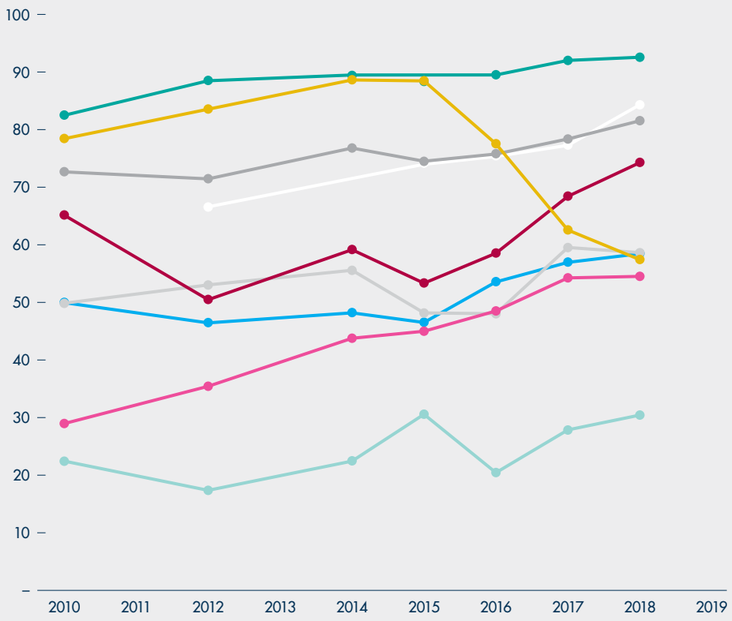
3 **Strengthen quality of care at the community and PHC levels.** The GFF contributes to (i) in-service training of healthcare professionals; (ii) strengthening the capacity of medical regions to manage and organize integrated networks of quality health services; (iii) the development and piloting of an accreditation process in two regions; and (iv) strengthening local accountability for better quality of care through the release of local quality scorecards.

4 **Support efforts for data availability and analysis.** The GFF collaborates with Countdown to 2030 to strengthen the country's analytical capacity. GFF also supports the improvement of CRVS systems and financing processes, allowing interoperability between the District Health Information System 2 (DHIS2) and the CRVS system.

5 **Strengthen civil society organizations (CSOs).** The GFF supports the functionality of the CSO platform, the implementation of a community scorecard, the development and implementation of watch and alert tools as well as the communication plan.

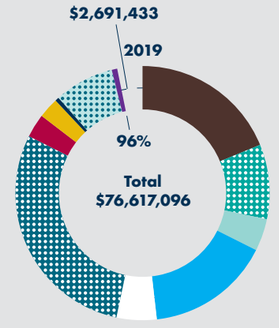
RMNCAH-N COVERAGE INDICATORS

All RMNCAH-N coverage indicators are presented from the most recent available population-based surveys.



RESOURCE MAPPING

Senegal previously conducted resource mapping for the Investment Case (IC), which identified more than 12 partners aligned to and financing the five IC priorities and estimated a 32.5% financial gap over a period of 5 years (2017-2021). The subsequent round of RMET is in its early stage. It is seen as a tool which will allow the Ministry of Health and Social Action to better orient the limited resources of the various stakeholders on the priorities of the health sector in general and of the IC in particular. Preliminary results are expected by the end of October 2020. Meanwhile, a recent rapid data collection underscored that donors are strongly aligned to the IC in 2019, funding 78% of its costs. By comparison, the previous resource mapping indicated that donors funded only 33% of the IC. In contrast, the share of IC cost covered by the government seems to have declined since the previous resource mapping. In 2019, the government contribution to the IC was $14M, representing 19% of costs; in the previous mapping, the government committed funding towards approximately 33% of the IC costs.



CORE RMNCAH-N IMPACT INDICATORS

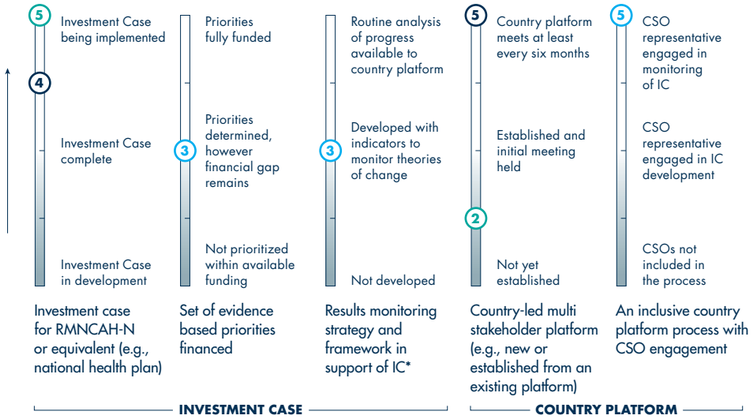
	Previous		Recent	
Maternal mortality ratio (per 100,000 live births)	**236**	2017	**–**	–
Under 5 mortality rate (per 1,000 live births)	**51**	2018	**37**	2019
Neonatal mortality rate (per 1,000 live births)	**23**	2018	**21**	2019
Adolescent birth rate – 15-19 (per 1,000 women)	**68**	2018	**71**	2019
Births <24 months after the preceding birth (%)	**15.8**	2017	**14.2**	2018
Stunting among children under 5 years of age (%)	**18.8**	2018	**17.9**	2019
Moderate to severe wasting among children under 5 years of age (%)	**7.8**	2018	**8.1**	2019

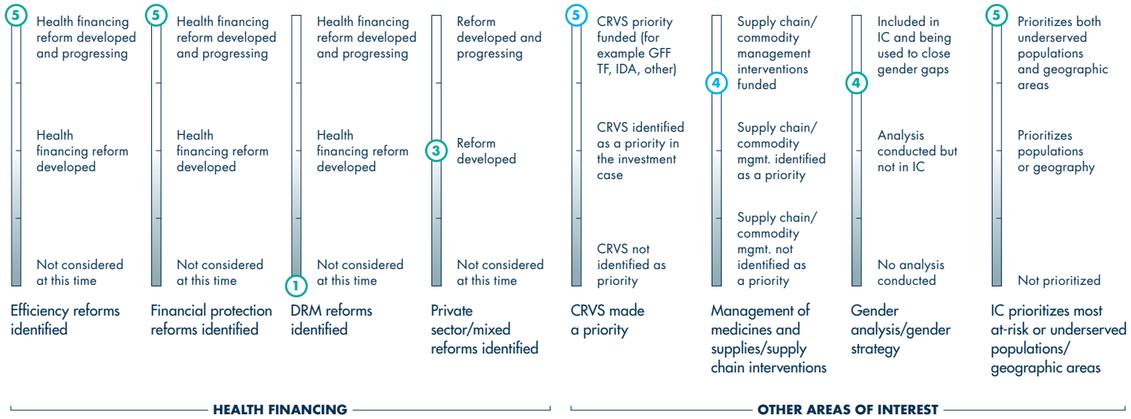
HEALTH FINANCING

Core Indicators	2015	2016	2017
Domestic General Government Health Expenditure (DGGHE), per capita (US$)	**13.3**	**13.7**	**11.5**
Domestic General Government Health Expenditure (DGGHE) as share of general government expenditure (%)	**4.7**	**4.5**	**3.9**
Out-of-pocket spending on health, per capita (US$)	**27.5**	**27.9**	**28.8**

Country-Specific Indicators	2016	2017	2018	2019
Share of government budget allocated to health (%)	**5.2**	**4.7**	**4.2**	**5**
Health budget execution (%)	**92**	**81**	**89**	**93**
Share of health expenditure going to frontline providers (%)	**7**	**10**	**9**	–
Number of children under 5 enrolled in the free health care policy (in millions)	–	**2.6**	**1.8**	**2**

MONITORING THE COUNTRY-LED PROCESS





Annual report 2019/2020 score ◯ Annual report 2018/2019 score ◯ No change between last year and this year

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Sierra Leone

THE GFF'S CATALYTIC ROLE

1 **Increase efficiency through resource mapping and expenditure tracking; strengthen health finance systems and capacity; and strengthen PFM.** The GFF has supported the development of the health financing system assessment in 2019 and public expenditure review for 2020.

2 **Improve efficiency in the sector through performance-based financing (PBF) approach to increase the proportion of funding to the primary health care and district health management levels,** thus promoting fiscal decentralization and semi-autonomy at peripheral levels. The changes will be driven by the World Bank/GFF co-financed project. More specifically, the GFF supports the development of facility mapping, a PBF manual, a quality checklist, and a PBF portal/module in the District Health Information System 2 (DHIS2).

3 **Strengthen routine MOH systems with a focus on health information systems, monitoring and evaluation (M&E), and human resource management.** The GFF will support (i) the mapping of current HMIS capacity and support in the country at all levels; (ii) the development of an health management information system strengthening plan; and (iii) production of a scorecard for monitoring IC implementation; (iv) the training of district health management teams; and (v) the development of health facility surveys.

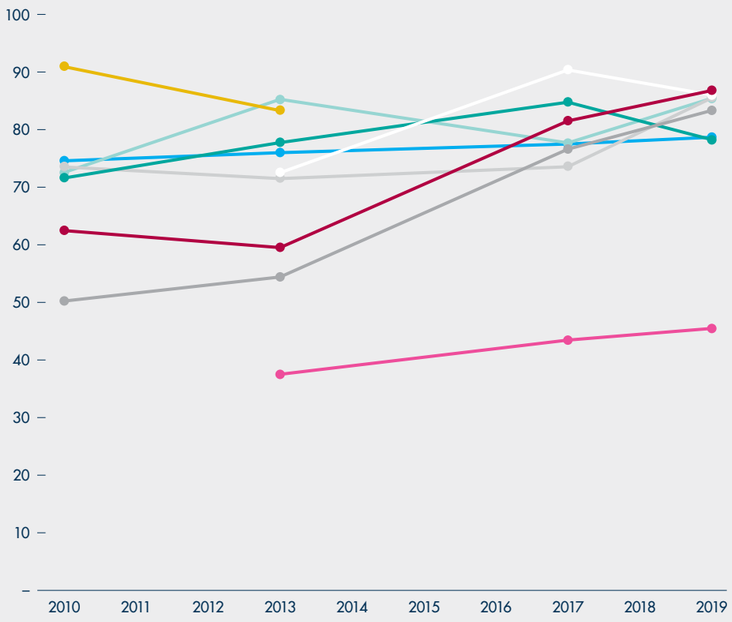
4 **Strengthen the prioritization and monitoring system of the RMNCAH strategy, including the focus on adolescent health.** The GFF will support the midterm review of the IC and reprioritize the activities to include greater focus on quality of care, neonatal health, and adolescent sexual and reproductive health.

5 **Improve partner coordination through the country platform.** The GFF will support the expansion of the country platform to include more stakeholders and will strengthen the platform in implementing and monitoring the investment case.

6 **Strengthen the civil registration and vital statistics system.** The GFF will strengthen the capacity of the civil registration agency and support the scale-up of birth and death registration services.

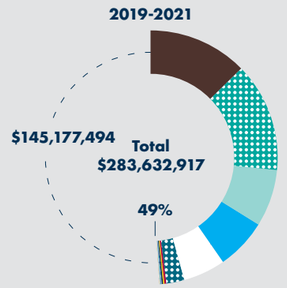
RMNCAH-N COVERAGE INDICATORS

All RMNCAH-N coverage indicators are presented from the most recent available population-based surveys.



RESOURCE MAPPING

Sierra Leone previously conducted resource mapping for the IC, which identified more than 15 partners aligned to and financing the RMNCAH Strategy 2017-2021. The country is currently conducting its first sector-wide resource mapping and expenditure tracking exercise in health, which will be undertaken as part of a national health sector public expenditure review. Specifically, analysis will include levels and composition of domestic health expenditures, document all sources of health sector funding (including donor financing), and evaluate budget execution. The main objective of the exercise is to inform policymakers of the effectiveness, efficiency, and equity of health expenditures in Sierra Leone. The resource mapping presented here showcases previously projected funding for the IC during FY2019-FY2021.



- GOVERNMENT
- WORLD BANK
- GAVI
- DFID
- GFATM
- UNFPA
- UNICEF
- USAID/PEPFAR
- PRIVATE DONOR
- MULTI PARTNER TRUST FUND (MPTF)
- IRISH AID
- EBOLA RESPONSE MULTI TRANSFER FUND (ERMTF)
- BMGF
- WHO AFRO
- WAHO
- ADB
- GOVERNMENT OF ITALY
- GAP

CORE RMNCAH-N IMPACT INDICATORS

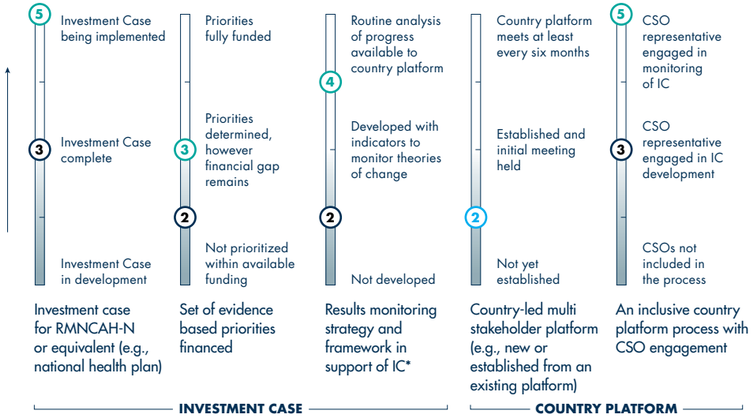
	Previous		Recent	
Maternal mortality ratio (per 100,000 live births)	**1,165**	2013	**717**	2019
Under 5 mortality rate (per 1,000 live births)	**156**	2013	**122**	2019
Neonatal mortality rate (per 1,000 live births)	**39**	2013	**31**	2019
Adolescent birth rate – 15-19 (per 1,000 women)	**125**	2013	**102**	2019
Births <24 months after the preceding birth (%)	**16.1**	2013	**15**	2019
Stunting among children under 5 years of age (%)	**37.9**	2013	**30**	2019
Moderate to severe wasting among children under 5 years of age (%)	**9.3**	2013	**5.4**	2019

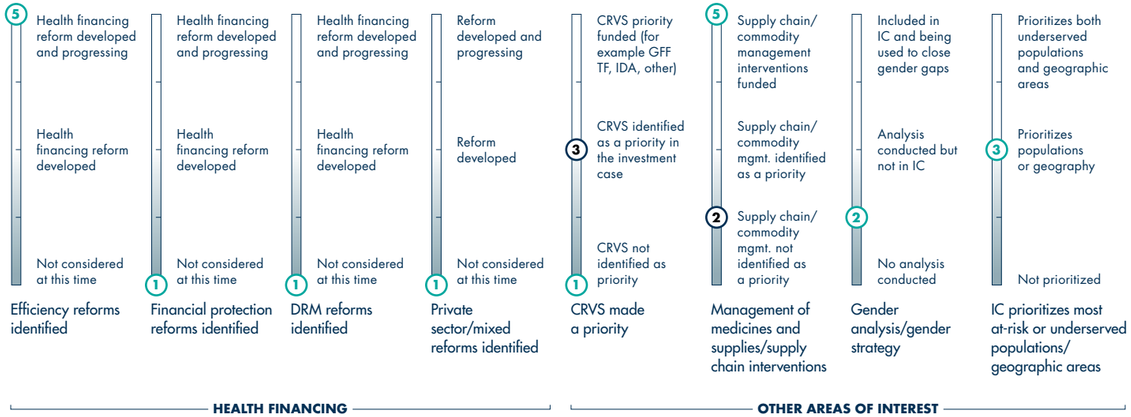
HEALTH FINANCING

Core Indicators	2015	2016	2017
Domestic General Government Health Expenditure (DGGHE), per capita (US$)	**7.7**	**9**	**9.1**
Domestic General Government Health Expenditure (DGGHE) as share of general government expenditure (%)	**7.9**	**7.9**	**7.9**
Out-of-pocket spending on health, per capita (US$)	**35.1**	**33.5**	**33.5**

Country-Specific Indicators	2016	2017	2018	2019
Share of government budget allocated to health (%)	**6.6**	**4.5**	**6**	**7**
Health budget execution (%)	**100**	**91**	**78**	**–**
Share of health expenditure going to frontline providers (%)	**3**	**2**	**3**	**–**

MONITORING THE COUNTRY-LED PROCESS





Annual report 2019/2020 score Annual report 2018/2019 score No change between last year and this year

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Somalia

THE GFF'S CATALYTIC ROLE

1 **Somalia joined the GFF in 2019 and is in the process of developing a prioritized investment case.** Somalia has already established a country-led multi-stakeholder platform that is meeting regularly and is working to identify CSO representation for engagement in the IC development process.

2 **Improve the health of women and children through development and delivery of a prioritized package of essential health services.** The GFF is supporting the essential package of health services (EPHS) prioritization process, which aims to identify interventions to maximize health outcomes, based on global evidence, Somalia's disease burden, the available resource envelope, and capacity to deliver services grounded in Somalia's current, partially implemented EPHS. Somalia's investment case is anticipated to include a focus on EPHS implementation to help address current challenges with the fragmentation of EPHS coverage.

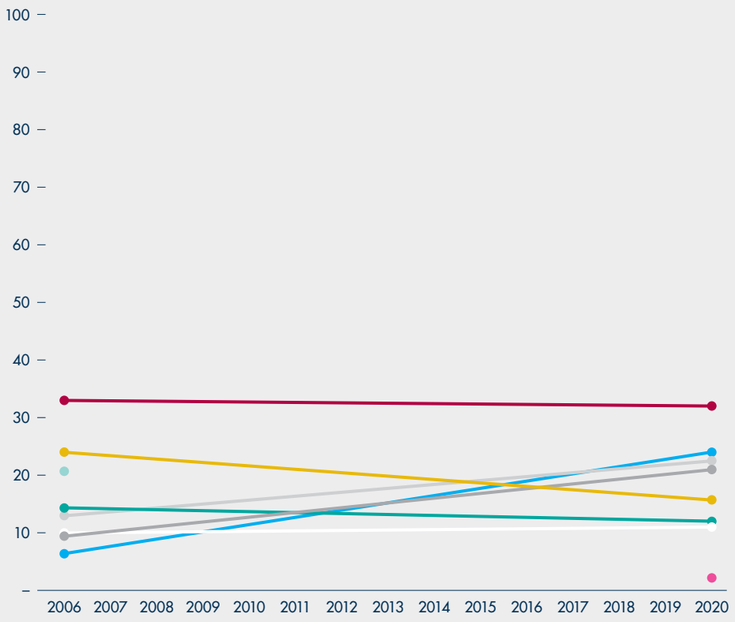
3 **Increase efficiency through resource mapping and improved partner coordination.** The GFF provides technical assistance for resource mapping to ensure that the government has a full understanding of the scope and geographical focus of external donors' commitment and expenditures, in order to efficiently align the country's investment case and health strategies with available resources.

4 **Strengthen routine MOH systems with a focus on health information systems, M&E, and supply chain management.** The GFF supports the government's leadership role, with a focus on stewardship functions for improved and increased data generation, coordination, and data use for decision making.

5 **Engage the private sector to improve health outcomes for women and children.** The GFF will support the implementation of a private sector engagement strategy being developed with support from GAVI, the Global Fund, and The World Bank.

RMNCAH-N COVERAGE INDICATORS

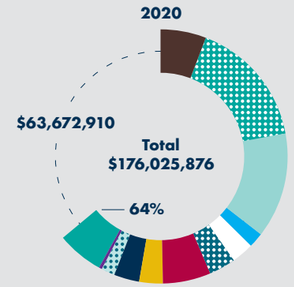
All RMNCAH-N coverage indicators are presented from the most recent available population-based surveys.



Because of security challenges in Somalia, health service delivery and outcome data have been extremely limited and therefore health service coverage indicators are only historically available for year 2006. The first Somalia Health and Demographic Survey (SHDS) was conducted in 2019 and released in 2020. The SHDS data have been extremely important to better understand the current state of health service delivery in Somalia, but gaps in historical data remain. Therefore, we have presented trends from 2006 MICS to the newest Somalia DHS.

RESOURCE MAPPING

Somalia conducted resource mapping and expenditure tracking as part of its first Investment Case (IC) development. Prior to the exercise, there was little information available on Somalia's health sector funding – including sources (who), projects and activities (what), and geographical distribution (where) – creating fragmentation. This problem was especially acute since external health financing constitutes a large share of total health sector funding, and most of it is off-budget. Resource mapping helped the government develop a full understanding of Somalia's health funding landscape to improve future planning and align the country's IC and health strategies with available resources. The exercise mapped resources – both humanitarian and development – to Somalia's 2nd Health Sector Strategic Plan (HSSP II) 2017-21, and essential package of health services (EPHS) at a sub-national level.



- GOVERNMENT
- UK DFID
- GFATM
- USAID
- GAVI
- KFW
- ITALY
- FINLAND
- SIDA
- NORWAY
- UNICEF
- OTHER DONORS
- GAP

Please note: Resource mapping and expenditure tracking is ongoing in Somalia. As such, the data on domestic spending and total costs are currently being updated. Data for external financing has been validated with all development partners in Somalia. The World Bank/GFF contribution is not factored in the resource mapping because the World Bank/GFF operation is under preparation and will be effective in 2021.

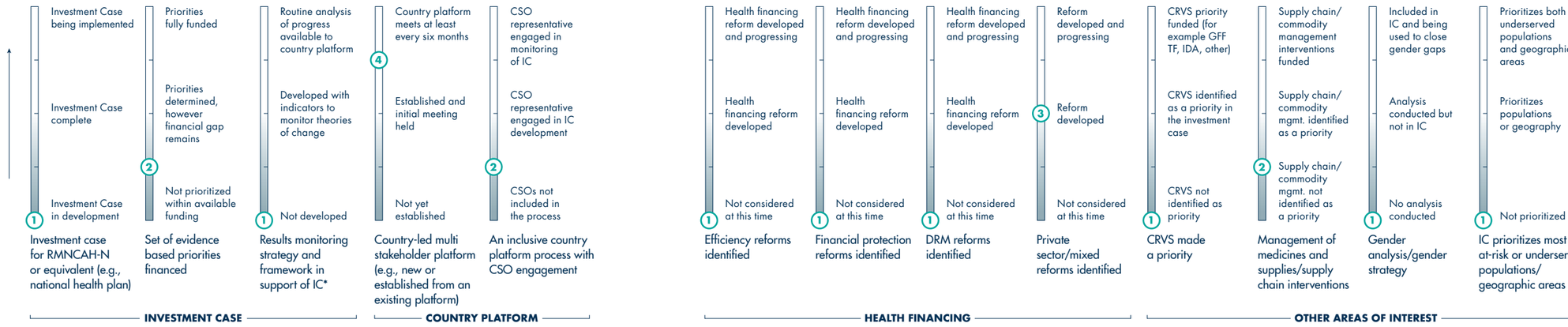
CORE RMNCAH-N IMPACT INDICATORS

	Previous		Recent	
Maternal mortality ratio (per 100,000 live births)	**1,044**	2006	**692**	2020
Under 5 mortality rate (per 1,000 live births)	**135**	2006	**–**	–
Neonatal mortality rate (per 1,000 live births)	**41**	2006	**–**	–
Adolescent birth rate – 15-19 (per 1,000 women)	**123**	2006	**140**	2020
Births <24 months after the preceding birth (%)	**–**	–	**41.2**	2020
Stunting among children under 5 years of age (%)	**38**	2006	**27.8**	2020
Moderate to severe wasting among children under 5 years of age (%)	**11**	2006	**11.6**	2020

HEALTH FINANCING

Because of security challenges in Somalia, health financing data have been extremely limited and therefore, recent data are missing for both core and country-specific health financing indicators. The first Somalia Health Resource Mapping and Expenditure Tracking was conducted in 2020 with support of GFF and it has been extremely important to better understand the current state of financing to the Somalia health sector.

MONITORING THE COUNTRY-LED PROCESS



◯ Annual report 2019/2020 score

* Both included in the IC document or a separate document

Republic of Tajikistan

THE GFF'S CATALYTIC ROLE

1 **The Republic of Tajikistan joined the GFF in 2019, is in the process of developing a prioritized investment case** which will be a prioritized action plan of the National Health Strategy 2021-2030, currently under development. A country-led multi-stakeholder platform has been launched and convened its first meeting.

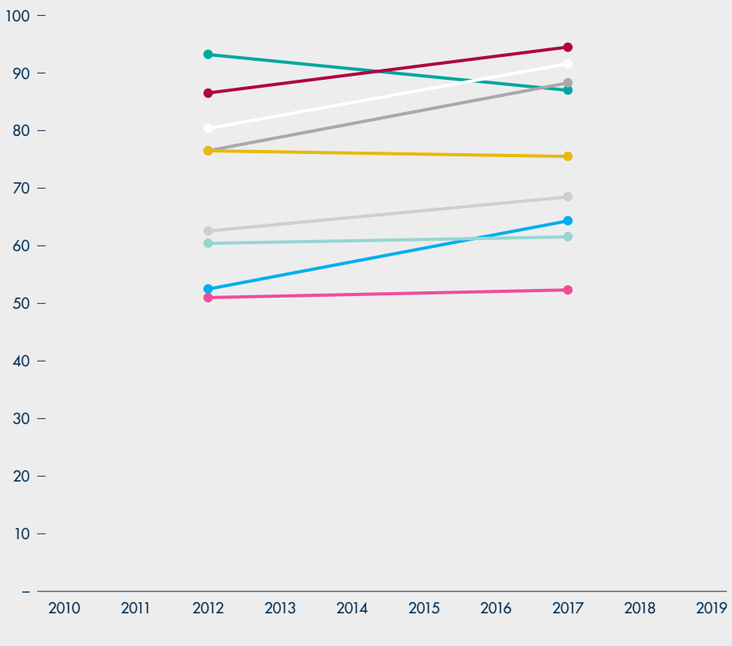
2 **Provide an opportunity for a more direct engagement between the health sector and the Ministry of Finance.** The Deputy Minister of Finance has been appointed as the GFF Government Coordinator/Focal Point, and the country platform has been set up as a technical working group established by a ministerial order from the Ministry of Finance to lead the GFF process in the country.

3 **Support the Ministry of Health and Social Protection of Population in developing the new National Health Strategy 2021-2030, a collaboration between the GFF, the European Union Delegation, and the WHO.** The National Health Strategy will set the direction for the health system and health financing reforms in the Republic of Tajikistan for the next 10 years. Over the next several months, the GFF platform will be working with the Ministry of Health and Social Protection of Population and the Ministry of Finance on developing a prioritized action plan for the implementation of the strategy over the coming years.

4 **The GFF Trust Fund is co-financing the World Bank-funded Early Childhood Development to Build Tajikistan's Human Capital Project.** This project is providing funding for the development and implementation of an ambitious early childhood development program spanning the health and education sectors. The GFF co-financing focuses on improving public financial management in primary health care to improve the execution of health facilities' budgets.

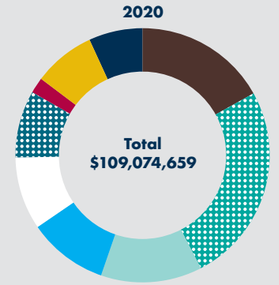
RMNCAH-N COVERAGE INDICATORS

All RMNCAH-N coverage indicators are presented from the most recent available population-based surveys.



RESOURCE MAPPING

In the Republic of Tajikistan, the investment case is in the early stages of development. It is conceptualized as a prioritized action plan for the National Health Strategy 2021-2030. The Strategy is currently being finalized. The resource mapping started in 2020 and will be finalized in September 2020. The resource mapping has allowed the Ministry of Health and Social Protection of Population (MOHSP) to capture data on 24 donors providing funding to the NHS, with 8 donors providing 95% of the total donor funding for NHS between 2021 and 2025 (USD 172M) and 109M in 2020, including USD 47M allocated to support the COVID 19 response. While the RMET team coordinates with the government, domestic funding data collection and how these matches with the NHS, existing donor's data disaggregated by regions showed that there is an opportunity for a reflection whether donor funding could be more equitable. Data of the NHS resource mapping will inform the 2021 planning and budgeting exercise of the Ministry of Health as well as of donors' and contribute to improve allocative efficiency/resource allocation within the health sector.



CORE RMNCAH-N IMPACT INDICATORS

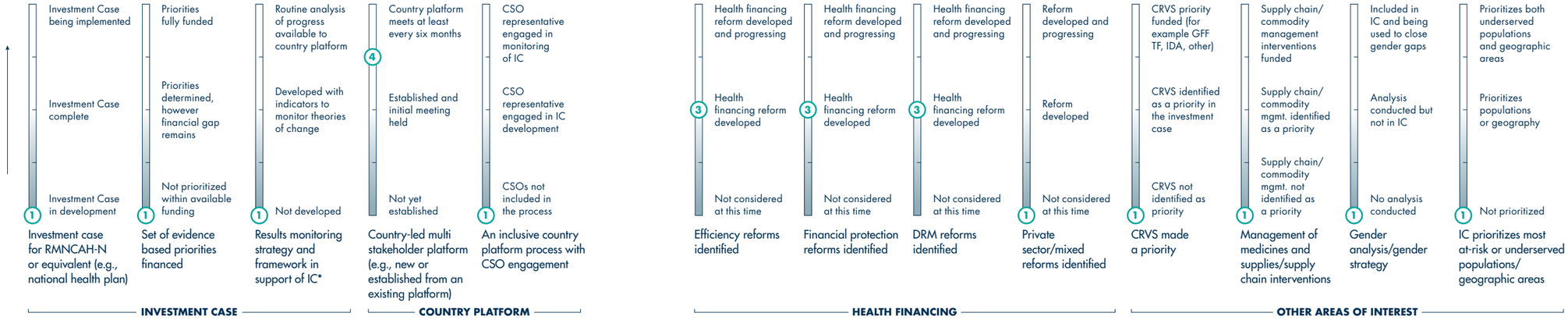
	Previous		Recent	
Maternal mortality ratio (per 100,000 live births)	**35**	2010	**32**	2015
Under 5 mortality rate (per 1,000 live births)	**43**	2012	**33**	2017
Neonatal mortality rate (per 1,000 live births)	**19**	2012	**13**	2017
Adolescent birth rate – 15-19 (per 1,000 women)	**54**	2012	**54**	2017
Births <24 months after the preceding birth (%)	**33.1**	2012	**35.9**	2017
Stunting among children under 5 years of age (%)	**26**	2012	**17.5**	2017
Moderate to severe wasting among children under 5 years of age (%)	**10**	2012	**5.6**	2017

HEALTH FINANCING

Core Indicators	2015	2016	2017
Domestic General Government Health Expenditure (DGGHE), per capita (US$)	**19.7**	**15.3**	**18.3**
Domestic General Government Health Expenditure (DGGHE) as share of general government expenditure (%)	**6.4**	**6.3**	**6.2**
Out-of-pocket spending on health, per capita (US$)	**40**	**37**	**37**

Country-Specific Indicators	2016	2017	2018	2019
Share of government budget allocated to health (%)	**6.3**	**6.2**	**6.4**	**7.6**
Health budget execution (%)	**92.4**	**94.2**	**93.7**	**99.7**
Share of health expenditure going to frontline providers (%)	**27.3**	**26**	**27**	**29.3**

MONITORING THE COUNTRY-LED PROCESS



Annual report 2019/2020 score

* Both included in the IC document or a separate document

■ THE GFF'S CATALYTIC ROLE

1 **Improve efficiency by scaling up output-based payment mechanisms.** The GFF has supported: (i) the preparation of a public expenditure review (PER); (ii) development of a set of short policy notes on key topics (fiscal space, budget execution, prioritization); (iii) a public financial management (PFM) assessment; and (iv) the development of a roadmap for alignment of financing streams.

2 **Continue supporting the strengthened alignment of partners and reduced fragmentation.** The GFF contributed to the development of "health basket" funding and the institutionalization of mapping of resources.

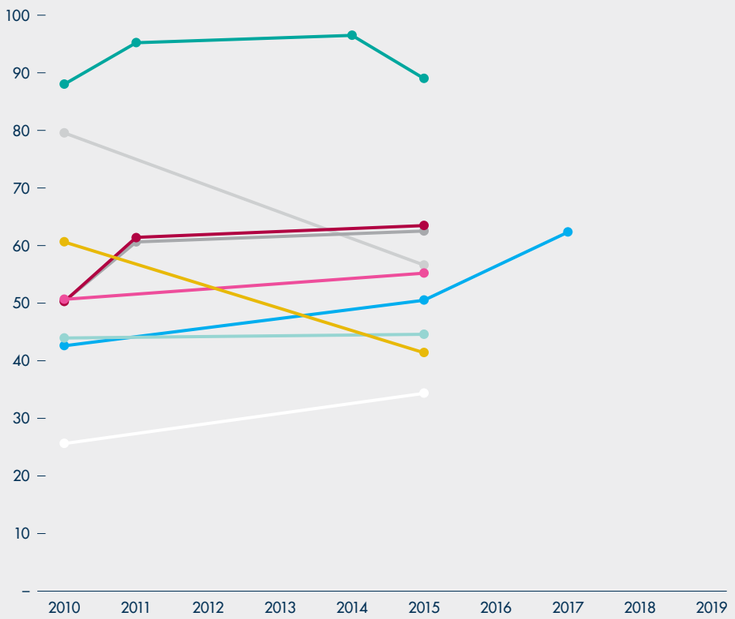
3 **Strengthen direct health facility financing, in order to empower primary health facilities to provide services, improve the quality of care, and address health system bottlenecks.** The GFF supports the nationwide implementation of direct facility financing.

4 **Track progress and help decision makers at all levels to reduce maternal and neonatal mortality by utilizing data from the quarterly RMNCAH scorecard.** The GFF has supported a three-step process: (i) a thorough review of data quality bottlenecks; (ii) based on the bottleneck review, a holistic data quality improvement and use strategy; and (iii) rationalization and harmonization of the verification, counter-verification and data quality assessment process.

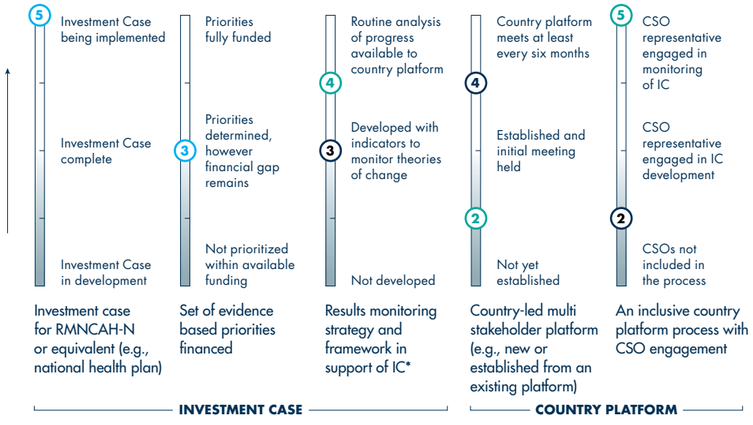
5 **Strengthen country capacity for data analytics.** The GFF, through collaboration with Countdown to 2030, supports capacity building of universities, research institutions, and government officials for data analysis.

■ RMNCAH-N COVERAGE INDICATORS

Data on immunization are presented from the WHO/UNICEF joint reporting process and recent population-based surveys. All other RMNCAH-N coverage indicators are presented from the most recent available population-based surveys.



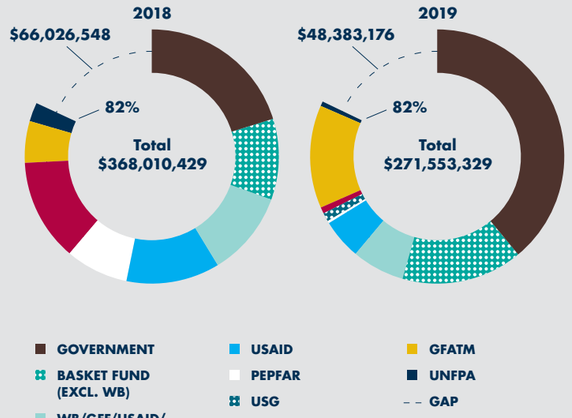
■ MONITORING THE COUNTRY-LED PROCESS



Tanzania

■ RESOURCE MAPPING

Tanzania's investment case is One Plan II. The resource mapping of One Plan II for 2019 and 2018 shows an improvement in domestic resource mobilization which increased in absolute and relative terms between 2018 and 2019. The Gov of Tanzania financed 20% of the IC in 2018 and 39% of it in 2019. The number of donors remains identical between the 2 years and donors contributions seems to have decreased both in absolute and relative terms. The cost of the One Plan II also decreased in 2019 which may have explained lower needs and contribution. Data from the updated resources mapping were used to understand the equity and efficiency of resource allocation around RMNCAH priorities and provinces. The MOH is also in the process of preparing a resource mapping for the new investment case to support its prioritization.



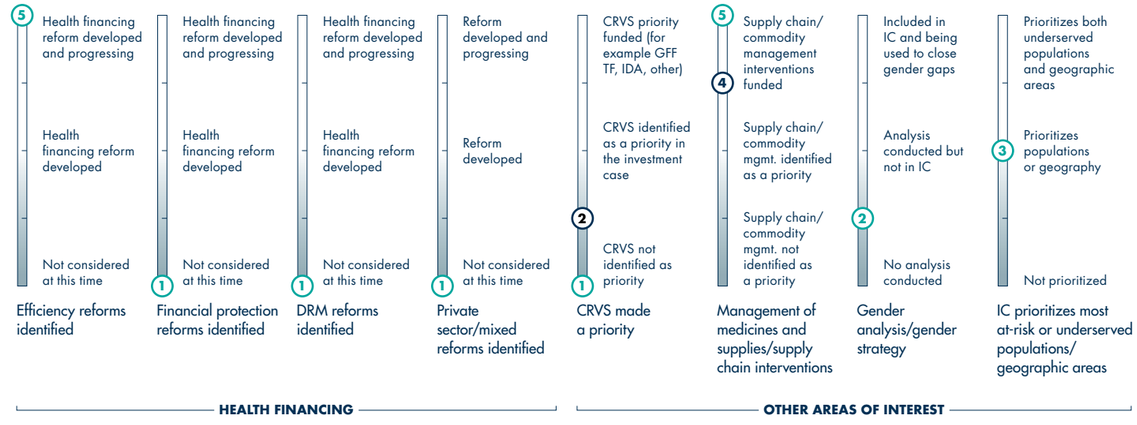
■ CORE RMNCAH-N IMPACT INDICATORS

	Previous		Recent	
Maternal mortality ratio (per 100,000 live births)	**454**	2010	**556**	2015
Under 5 mortality rate (per 1,000 live births)	**81**	2010	**67**	2015
Neonatal mortality rate (per 1,000 live births)	**26**	2010	**25**	2015
Adolescent birth rate – 15-19 (per 1,000 women)	**116**	2010	**132**	2015
Births <24 months after the preceding birth (%)	**15.6**	2010	**18.8**	2015
Stunting among children under 5 years of age (%)	**42**	2010	**34**	2015
Moderate to severe wasting among children under 5 years of age (%)	**4.8**	2010	**4.4**	2015

■ HEALTH FINANCING

Core Indicators	2015	2016	2017
Domestic General Government Health Expenditure (DGGHE), per capita (US$)	**10.9**	**14.5**	**14.7**
Domestic General Government Health Expenditure (DGGHE) as share of general government expenditure (%)	**7.3**	**9.5**	**9.5**
Out-of-pocket spending on health, per capita (US$)	**8.2**	**7.8**	**8.2**

Country-Specific Indicators	2016	2017	2018	2019
Share of government budget allocated to health (%)	**7.7**	**8.4**	**7.2**	–
Health budget execution (%)	**76**	**81**	**82**	**66**
Share of health expenditure going to frontline providers (%)	**88**	**76**	–	–
Number of facilities implementing RBF (in thousands)	**1.2**	**1.7**	**1.7**	**1.9**
Percentage of health facilities receiving funds through the direct health facility financing (DHFF) program	–	–	**66**	**100**



Annual report 2019/2020 score Annual report 2018/2019 score No change between last year and this year

* Both included in the IC document or a separate document

Uganda

THE GFF'S CATALYTIC ROLE

1 **Improve the quality and efficiency of health service delivery through results-based financing (RBF).** The GFF, through the World Bank co-financed project, contributed to the scale-up and implementation of the national RBF framework for the health sector as well as a health facility quality of care assessment program (HFQAP).

2 **Expand access to a package of high-impact RMNCAH interventions by level, with a focus on the high-burden populations and the 40 highest-burden districts.** The GFF process resulted in the revision of the national health plan for further intervention and geographic prioritization to serve as the Uganda IC. The GFF co-financed World Bank project supports the construction, renovation, and equipping of health facilities in high-burden districts.

3 **Improve community-based services and the functionality of health centers, to provide high-quality MNCH services.** The GFF supports the strengthening of human resources for health through the scale-up of clinical mentorship, staff recruitment, and training. In addition, the GFF supports an increase in district-level capacity to drive improvements in RMNCAH outcomes and service provider capacity by establishing skills hubs.

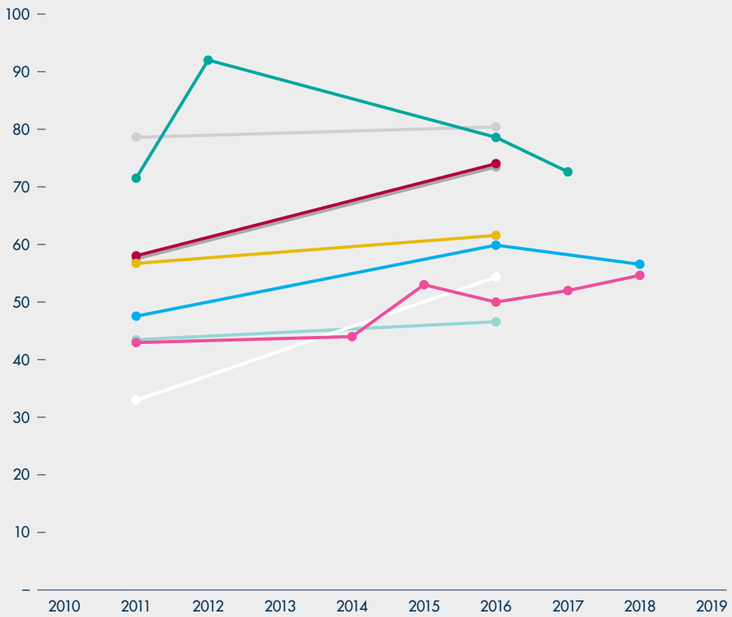
4 **Focus on the social determinants of health for adolescents.** The GFF supports the training of health workers, facility-level investments in youth-friendly health services, and social and behavior communications interventions to improve utilization of priority services among adolescents.

5 **Scale up birth and death registration services at the health facility and community levels and develop and disseminate a communication strategy for CRVS.** The GFF supports the strengthening of institutional capacity for CRVS to scale up birth and death registration services.

6 **Provide analytical support for domestic resource mobilization efforts.** As part of its technical investments, the GFF is financing a feasibility assessment of tax-financed trust funds to increase financing for the health sector and is supporting the development of a universal health coverage (UHC) operational plan.

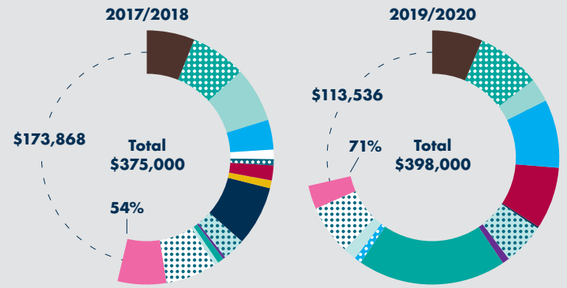
RMNCAH-N COVERAGE INDICATORS

Data on immunization are presented from the WHO/UNICEF joint reporting process and recent population-based surveys. Family planning indicators are presented from the PMA2020 database and recent population-based surveys. All other RMNCAH-N coverage indicators are presented from the most recent available population-based surveys.



RESOURCE MAPPING

Uganda's Investment Case for Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) Sharpened Plan spans over the period 2016/17 - 2019/20. In 2018/19, the MOH conducted a resource mapping of the IC looking at source of funding and funding gap at national and decentralized levels. Overall, the exercise shows that the IC funding gap decreased over time from 46% to 29% between 2017/18 and 2019/2020, thanks to increased donor contribution: donors funded 48% of the IC cost in 2017/2018 which jumped to 65% in 2019/20. This rise was mainly driven by increased contributions from GAVI, GFTAM and the WB/GFF. Because the cost of implementing the IC increased between 2017/18 and 2019/2020, government contribution remained the same over time in relative terms but did increase in absolute terms between 2017/18 and 2019/20. The GoU is under the process of preparing its new investment case and result of the previous resource mapping will help the MOH in prioritizing interventions to improve the DRM agenda in the policy dialogue with the MOF.



CORE RMNCAH-N IMPACT INDICATORS

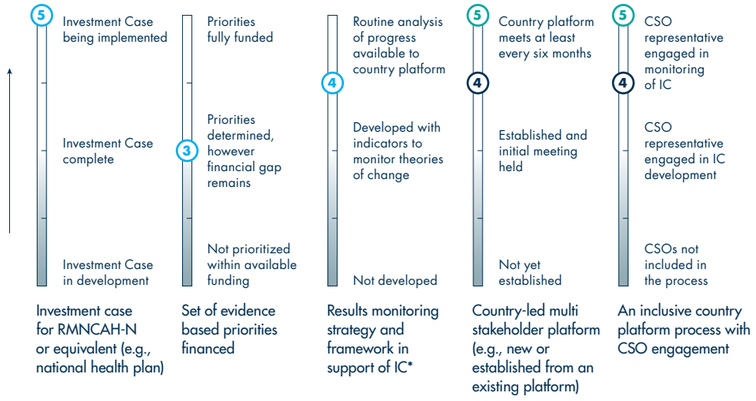
	Previous		Recent	
Maternal mortality ratio (per 100,000 live births)	**438**	2011	**336**	2016
Under 5 mortality rate (per 1,000 live births)	**90**	2011	**64**	2016
Neonatal mortality rate (per 1,000 live births)	**27**	2011	**27**	2016
Adolescent birth rate – 15-19 (per 1,000 women)	**134**	2011	**132**	2016
Births <24 months after the preceding birth (%)	**25.3**	2011	**24.3**	2016
Stunting among children under 5 years of age (%)	**33.4**	2011	**28.9**	2016
Moderate to severe wasting among children under 5 years of age (%)	**4.7**	2011	**3.4**	2016

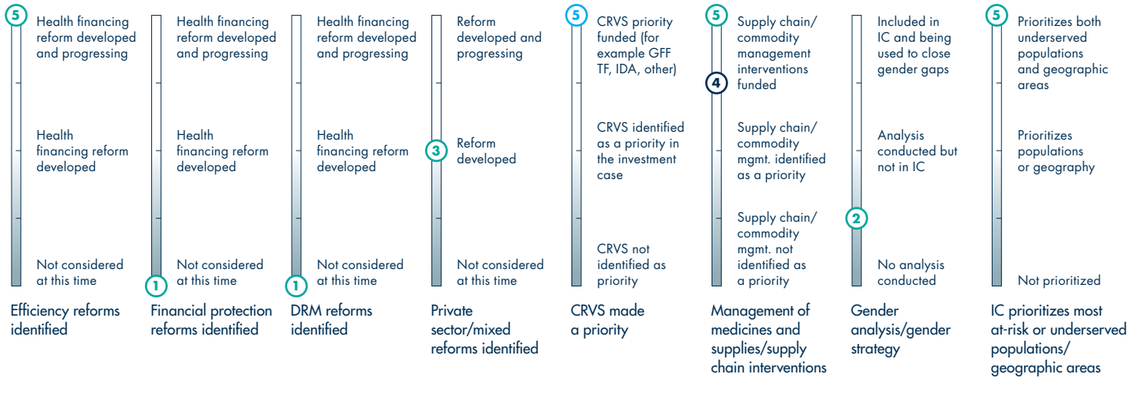
HEALTH FINANCING

Core Indicators	2015	2016	2017
Domestic General Government Health Expenditure (DGGHE), per capita (US$)	**6.3**	**6.2**	**6**
Domestic General Government Health Expenditure (DGGHE) as share of general government expenditure (%)	**5.1**	**5.1**	**5.1**
Out-of-pocket spending on health, per capita (US$)	**16.3**	**15**	**15**

Country-Specific Indicators	2016	2017	2018	2019
Share of government budget allocated to health (%)	**7**	**6.5**	**7.2**	**6.4**
Health budget execution (%)	**78.5**	**64**	–	–
Share of health expenditure going to frontline providers (%)	**23**	**28**	–	–
Number of districts implementing RBF	–	–	–	**79**
Number of health centers participating in RBF	–	–	–	**727**

MONITORING THE COUNTRY-LED PROCESS





○ Annual report 2019/2020 score ○ Annual report 2018/2019 score ○ No change between last year and this year

* Both included in the IC document or a separate document

Vietnam

THE GFF'S CATALYTIC ROLE

1 **Increase health system efficiency by improving the quality of the grassroots (commune level) health system.** The GFF buys down the interest rate of the World Bank project loan to more concessional terms, thereby facilitating the government's willingness to borrow for health. The project aims to enable commune health stations to screen and manage noncommunicable diseases (NCDs) while ensuring continued improvements in communicable diseases and RMNCAH management and improving the quality of maternal and child health services. The project supports the government to build new and upgrade about 500 commune health stations, provide appropriate equipment, and improve health workers' capacity for all commune health stations in 13 poor provinces.

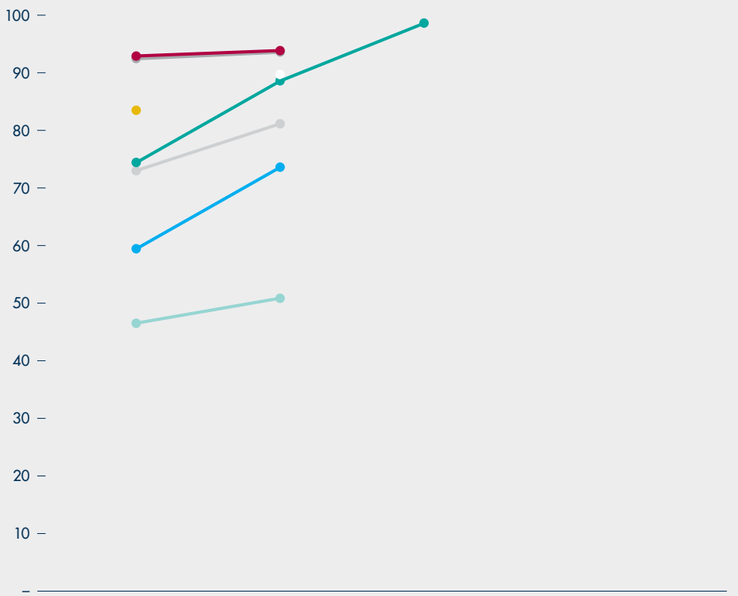
2 **Improve functioning of Social Health Insurance (SHI).** The GFF engagement is advancing health financing reforms, helping to align the investments of development partners who support social health insurance (SHI) and other health financing reforms and providing technical assistance to the revision of the SHI Law and associated policies.

3 **Strengthen the CRVS system through development of a CRVS Action Plan and tools to improve cause-of-death reporting.** GFF contributed to bringing in multiple partners, including WHO and Vital Strategies, along with in-country partners to align independent CRVS initiatives towards a common goal, and integrate them with MOH core activities. With this support, the MOH successfully prepared and approved the CRVS Action Plan. Through GFF support, technical assistance to the MOH is enabling the implementation of new standards for cause-of-death diagnosis and reporting at the health facility and commune level.

4 **Improve understanding of options for public-private partnerships that serve the public interest, through analysis and capacity building.** Supported in part by GFF resources, the World Bank team completed and disseminated a health public-private partnership study that assessed progress and barriers to health public-private partnership implementation in Vietnam and shared global experience.

RMNCAH-N COVERAGE INDICATORS

Data on immunization are presented from the WHO/UNICEF joint reporting process and recent population-based surveys. All other RMNCAH-N coverage indicators are presented from the most recent available population-based surveys.



RESOURCE MAPPING

Vietnam is no longer highly dependent on external assistance for the health sector, with external financing accounting for 2.7 percent in 2014. But some major development partners (e.g., the European Union (EU), Gavi and the Global Fund) have completed or are reducing the scale of their assistance, necessitating a shift to government budget or health insurance. The recently approved Grassroots Health Service Delivery project, under implementation beginning May 2020, fills an important financing gap for Vietnam. The project is supported by an IDA-Transitional Support (IDA-TS) credit of US$80 million, a co-financing grant of US$5 million from the Integrating Donor-Financed Health Programs Multi-Donor Trust Fund funded with Australian support, a co-financing grant of US$3 million from the Tackling Non-Communicable Diseases Challenges in Low- and Middle-income Countries MDTF (Pharmaceutical Governance Fund), and US$21.25 million from the Government of Vietnam in addition to the U$17 million GFF financing for the IDA-TS credit buydown.

CORE RMNCAH-N IMPACT INDICATORS

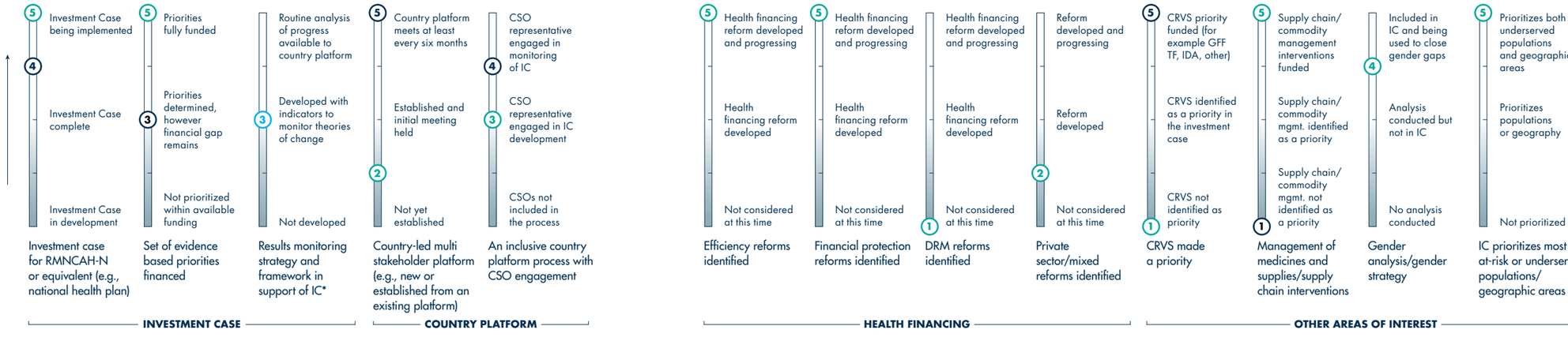
	Previous		Recent	
Maternal mortality ratio (per 100,000 live births)	**54**	2015	**43**	2017
Under 5 mortality rate (per 1,000 live births)	**16**	2011	**19.74**	2013
Neonatal mortality rate (per 1,000 live births)	**–**	–	**11.95**	2013
Adolescent birth rate – 15-19 (per 1,000 women)	**46**	2011	**45**	2013
Births <24 months after the preceding birth (%)	**–**	–	**–**	–
Stunting among children under 5 years of age (%)	**24.6**	2015	**23.8**	2017
Moderate to severe wasting among children under 5 years of age (%)	**6.4**	2015	**5.8**	2017

HEALTH FINANCING

Core Indicators	2015	2016	2017
Domestic General Government Health Expenditure (DGGHE), per capita (US$)	**49.8**	**59.5**	**63**
Domestic General Government Health Expenditure (DGGHE) as share of general government expenditure (%)	**8.1**	**9.5**	**9.5**
Out-of-pocket spending on health, per capita (US$)	**51.8**	**55.9**	**58.6**

Vietnam's policy on transparent dissemination of state budget spending in a standardized format has only recently been put in place and compliance is not yet complete for provincial budget reporting. The National Health Accounts are being compiled with technical assistance from the WHO for 2017, but are not yet finalized or disseminated.

MONITORING THE COUNTRY-LED PROCESS



Annual report 2019/2020 score Annual report 2018/2019 score No change between last year and this year

* Both included in the IC document or a separate document

Zambia

THE GFF'S CATALYTIC ROLE

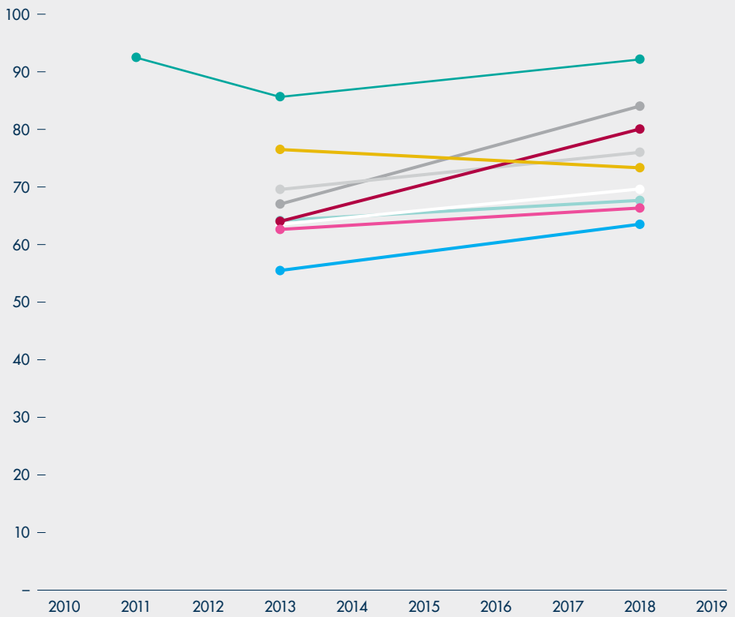
1 **Zambia joined the GFF in 2019 and is in the process of developing a prioritized investment case.** Zambia has already established a country-led multi-stakeholder platform that is meeting regularly and includes CSO representation already engaged in the IC development process.

2 Build on the MOH's RMNCAH-N Roadmap and support the Ministry of Health in **articulating a clear set of data-driven priorities** to overcome critical bottlenecks to improve RMNCAH-N outcomes, strengthening this analysis at both national and provincial levels.

3 Build on and update existing resource mapping and expenditure tracking, **support the MOH and development partners in better aligning domestic and external resources** behind these priorities, and reduce potential inefficiencies and duplication.

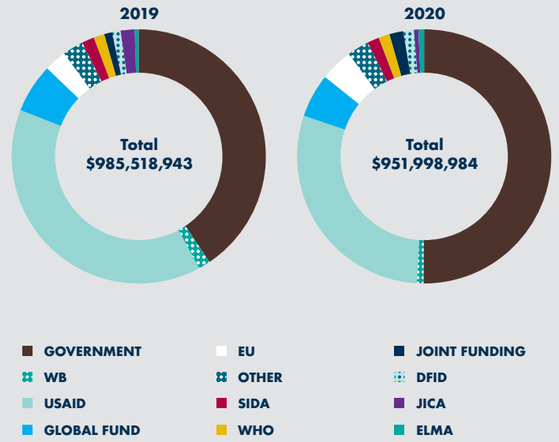
RMNCAH-N COVERAGE INDICATORS

Data on immunization are presented from the WHO/UNICEF joint reporting process and recent population-based surveys. All other RMNCAH-N coverage indicators are presented from the most recent available population-based surveys.



RESOURCE MAPPING

Since 2016, Zambia's Health Cooperating Partner group has routinely conducted high-level mapping of donor activities in health, with the aim to coordinate partner support across subnational regions. The depicted figure shows the projected funding breakdown in FY2020 for the entire health sector. However, the data from that exercise were not sufficiently granular for assessing funding sufficiency for the RMNCAH response. Therefore, the Ministry of Health launched an expanded resource mapping exercise in early 2020, which will capture funding commitments by program area, cost component, and region. It is anticipated that, in conjunction with the costed RMNCAH strategy, this data will lead to a detailed financial gap analysis that will support resource mobilization and increase the efficiency and equity of investments.



CORE RMNCAH-N IMPACT INDICATORS

	Previous		Recent	
Maternal mortality ratio (per 100,000 live births)	**398**	2013	**252**	2018
Under 5 mortality rate (per 1,000 live births)	**75**	2013	**61**	2018
Neonatal mortality rate (per 1,000 live births)	**24**	2013	**27**	2018
Adolescent birth rate – 15-19 (per 1,000 women)	**141**	2013	**135**	2018
Births <24 months after the preceding birth (%)	**15.5**	2013	**14**	2018
Stunting among children under 5 years of age (%)	**40.1**	2013	**34.6**	2018
Moderate to severe wasting among children under 5 years of age (%)	**6**	2013	**4.2**	2018

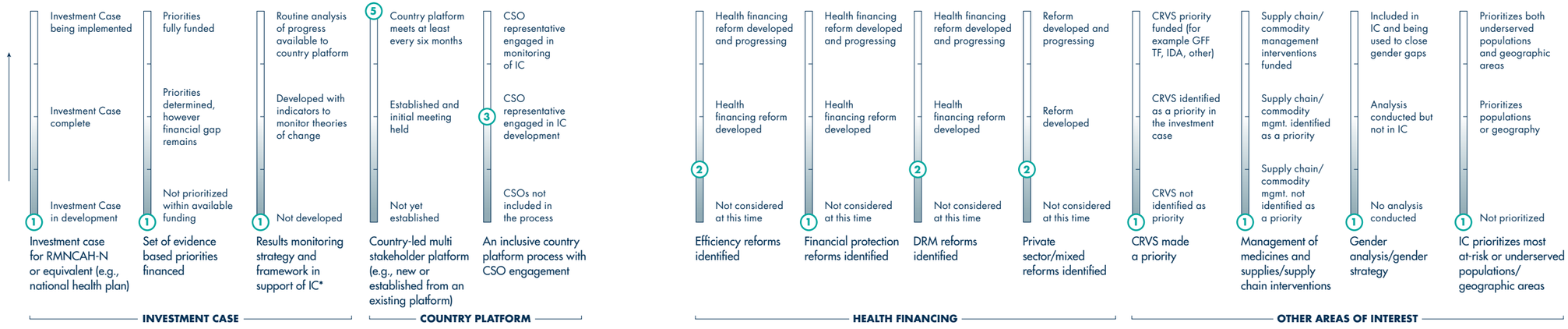
HEALTH FINANCING

Core Indicators	2015	2016	2017
Domestic General Government Health Expenditure (DGGHE), per capita (US$)	**31.3**	**25.9**	**26.1**
Domestic General Government Health Expenditure (DGGHE) as share of general government expenditure (%)	**7.4**	**7.1**	**6.9**
Out-of-pocket spending on health, per capita (US$)	**8.1**	**8.2**	**8**

Country-Specific Indicators	2016	2017	2018	2019
Share of government budget allocated to health (%)	–	**8.4**	**8.9**	–
Health budget execution (%)	**47**	**98**	**75**	–
Share of health expenditure going to frontline providers (%)*	–	–	–	–

*This is a new indicator that is still being defined at the country-level

MONITORING THE COUNTRY-LED PROCESS



Annual report 2019/2020 score

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Zimbabwe

THE GFF'S CATALYTIC ROLE

1 **Zimbabwe joined the GFF in 2019 and is in the process of developing a prioritized investment case.** Zimbabwe has already established a country-led multi-stakeholder platform that includes CSO representation already engaged in the IC development process.

2 **Improve RMNCAH outcomes through enhanced RMNCAH investments.** The GFF is currently supporting the preparation of the Additional Financing of the World Bank co-financed project. During project implementation, the GFF will provide technical assistance for the institutionalization and scale-up of RBF to provincial and central hospitals.

3 **Support government priorities in governance and health financing.** The GFF will support the development of a public expenditure review (PER), resource mapping and expenditure tracking studies as well as any other areas of interest identified by government in implementation of key health financing reforms.

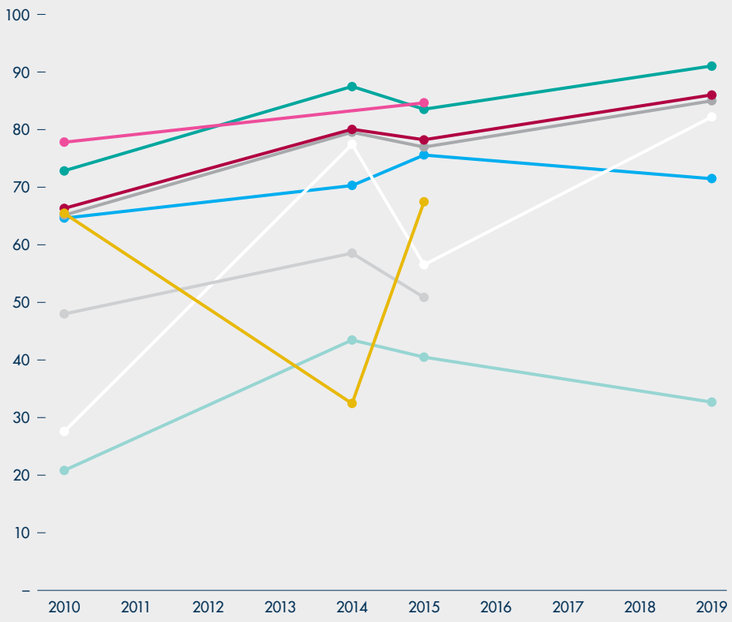
4 **Improve data availability, review, and analysis initiatives.** The GFF will provide support through capacity building for results monitoring and data analytics. In addition, the GFF will support the availability of in-country health facility and household surveys.

5 **Support an extended-term consultant in-country for two years.** The GFF will support a consultant to support the implementation, supervision, and monitoring of the GFF grant finance project.

6 **Strengthen civil registration and vital statistics (CRVS).** The GFF will support training and capacity building in death registration and cause-of-death recording for deaths occurring in health facilities and in the communities.

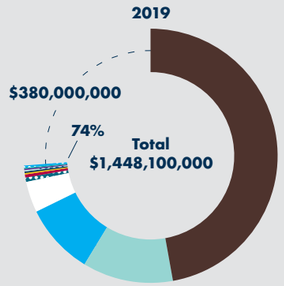
RMNCAH-N COVERAGE INDICATORS

All RMNCAH-N coverage indicators are presented from the most recent available population-based surveys.



RESOURCE MAPPING

The Ministry of Health and Child Care (MOHCC) has been conducting annual resource mapping and expenditure tracking since 2015. This exercise collects budget and expenditure data for domestic and external sources of funding within the health sector. The data have been used to inform planning and coordination of resources in the health sector (e.g. Global Fund grant applications); to identify and address inefficiencies in the health sector; and to inform the costing and gap analysis of national strategic plans, in particular the National Health Strategy 2016-2020. Zimbabwe is in the process of developing a Health Sector Investment Case 2021-2025, which will be finalised once the National Health Strategy 2021-2025 is in place, to ensure alignment between the two documents.



- GOVERNMENT
- WORLD BANK/ GFF TRUST FUND
- GLOBAL FUND
- USG
- HEALTH DONOR FUND (SIDA, DFID, EU, IRISH AID)
- DFID
- SIDA
- BMGF
- EU
- GAVI
- UNFPA
- UNICEF
- OTHER FINANCING SOURCES
- GAP

CORE RMNCAH-N IMPACT INDICATORS

	Previous		Recent	
Maternal mortality ratio (per 100,000 live births)	**614**	2014	**462**	2019
Under 5 mortality rate (per 1,000 live births)	**75**	2014	**65**	2019
Neonatal mortality rate (per 1,000 live births)	**29**	2014	**32**	2019
Adolescent birth rate – 15-19 (per 1,000 women)	**120**	2014	**108**	2019
Births <24 months after the preceding birth (%)	**–**	–	**–**	–
Stunting among children under 5 years of age (%)	**27.6**	2014	**23.5**	2019
Moderate to severe wasting among children under 5 years of age (%)	**3.3**	2014	**2.9**	2019

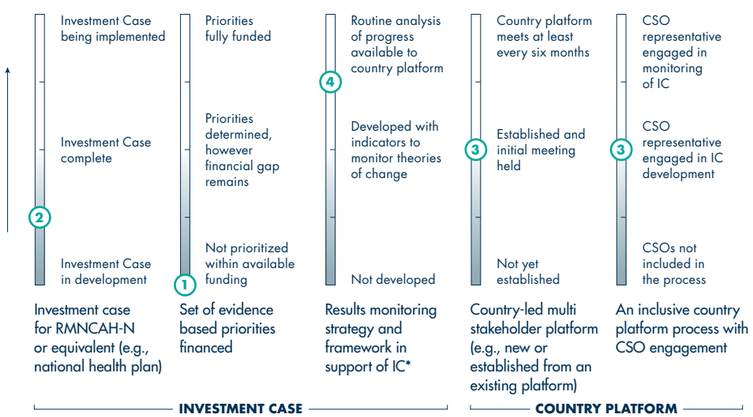
HEALTH FINANCING

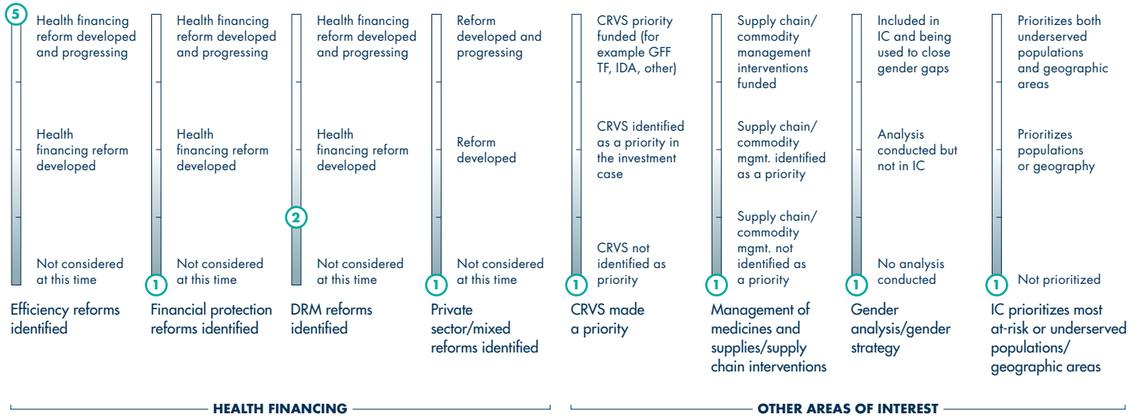
Core Indicators	2015	2016	2017
Domestic General Government Health Expenditure (DGGHE), per capita (US$)	**56.2**	**57.8**	**56.9**
Domestic General Government Health Expenditure (DGGHE) as share of general government expenditure (%)	**16.6**	**15.2**	**15.2**
Out-of-pocket spending on health, per capita (US$)	**31.7**	**28.7**	**22.7**

Country-Specific Indicators	2016	2017	2018	2019
Share of government budget allocated to health (%)	**7.5**	**6.9**	**8.8**	**10.7**
Health budget execution (%)	**98**	**99**	**94**	**91**
Share of health expenditure going to frontline providers (%)*	**–**	**–**	**–**	**–**

*This is a new indicator that is still being defined at the country-level

MONITORING THE COUNTRY-LED PROCESS





Annual report 2019/2020 score

* Both included in the IC document or a separate document

CONTRIBUTIONS, COMMITMENTS AND DISBURSEMENTS

Contributions

The GFF was launched in July 2015, building on the experience and the fund structure of the Health Results Innovation Trust Fund (HRITF)[1]. As of June 30, 2020, the total value of the contributions and new pledges to the Trust Fund is US$2.003 billion equivalent[2] from 16 donors, including US$473 million for HRITF and $1.53 billion for the GFF (Figure 1). Figure 2 provides the breakdown of the GFF signed and pledged contributions by donor.

Figure 1: **Total Fund Value, US$ Million**

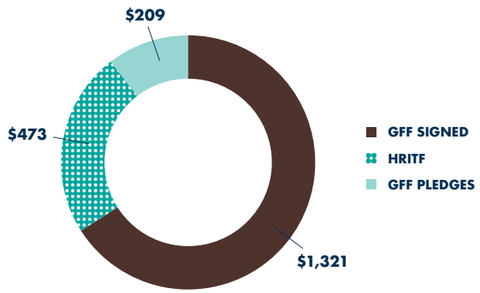
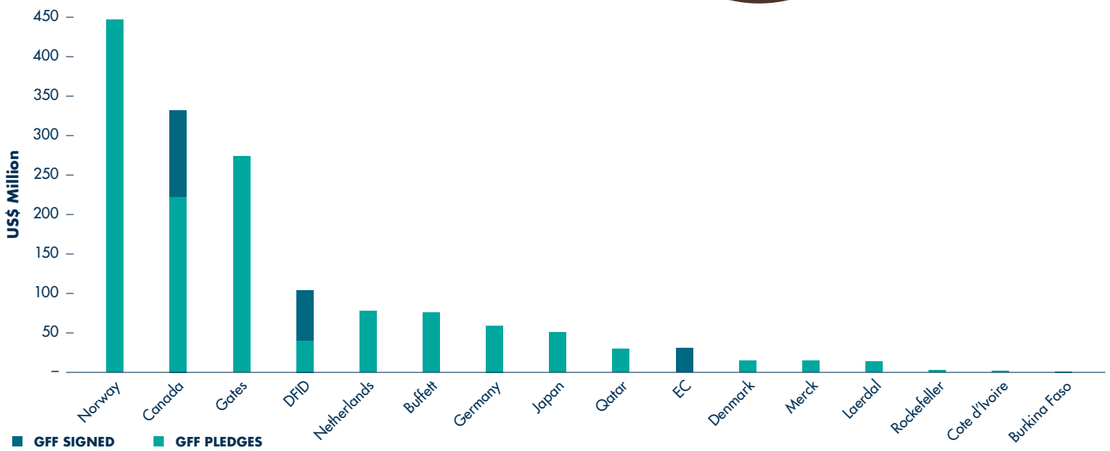


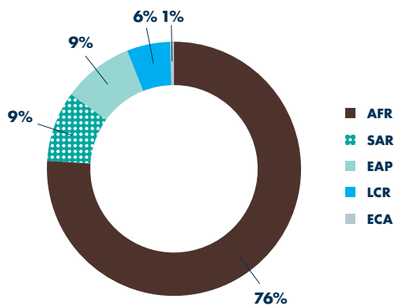
Figure 2: **GFF Contributions by Donor, US$ Million**



GFF Commitments

The GFF Trust Fund resources are used in a catalytic way to help align the priorities in the investment cases with the various funding sources in each GFF country. For instance, for 21 of GFF partner countries[3] where data is currently available through GFF resource mapping and expenditure tracking, a total of US$11 billion has been pledged for 2020 for implementing investment cases. The priorities in the 21 investment cases have been financed with US$5.9 billion in contributions from governments (53 percent), US$4.6 billion in partner commitments (42 percent), and $490 million in financing from IDA and the GFF Trust fund (4 percent). The US$11 billion represents more than two-thirds of what is needed to fully finance these 21 investment cases. A US$4.5 billion gap remains.

Figure 3: **GFF Board Approved Projects by Regions, % of Total**



In terms of commitments from the GFF Trust Fund, as of June 30, 2020, a total of US$814 million has been committed for 47 GFF projects in 36 countries. Of this amount, US$602 million, combined with additional $4.7 billion IDA/IBRD, has been approved by the World Bank's Board of Executive Directors (Table 1). The remaining US$212 million is in the pipeline, at an advance preparation stage.

Seventy-six percent of the World Bank Board-approved GFF amount supports GFF partner countries in Africa, followed by 10 percent in South Asia, 9 percent in East Asia, 4 percent in Latin America and the Caribbean region, and less than 1 percent in Europe and Central Asia Region (Figure 3). The complete list of the Board-approved projects is provided in Table 1.

GFF Trust Fund and IDA/IBRD Disbursements

As of June 2020, a total of US$268 million in GFF grants and US$1.6 billion of the board-approved IDA/IBRD amount has been disbursed. Figure 4 illustrates the actual disbursements and projections on a calendar year basis. Despite the COVID-19 pandemic, GFF disbursements during the first half of Calendar Year 2020 have already exceeded GFF disbursements in 2019. Based on the current implementation progress, a total of US$960 million that combines GFF Trust Fund funding and IDA/IBRD is expected to be disbursed in 2020.

Figure 4: **GFF Projects: Disbursements Projections and Actual Disbursements, as of June 30, 2020**

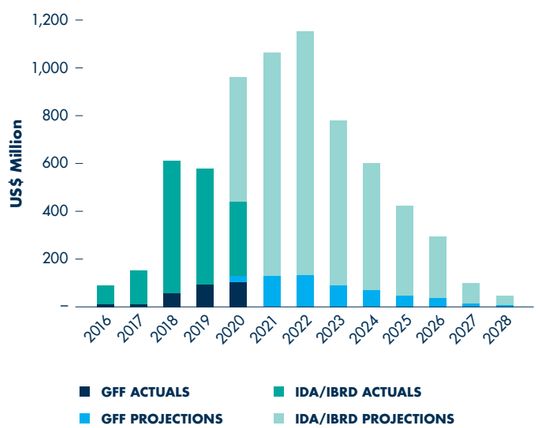


Table 1: **List of GFF Board Approved GFF Projects**

Project	Board Date	GFF amount	IDA amount	IBRD
Tanzania	5/28/2015	$40	$200	
DRC (AF-CRVS)	3/29/2016	$10	$30	
Cameroon	5/3/2016	$27	$100	
Nigeria (AF)	6/7/2016	$20	$100	
Kenya	6/15/2016	$40	$150	
Uganda	8/4/2016	$30	$110	
Liberia (AF)	2/23/2017	$16	$15	
Guatemala	3/24/2017	$9		$100
DRC (AF)	3/31/2017	$40	$340	
Ethiopia	5/9/2017	$60	$150	
Bangladesh	7/28/2017	$15	$500	
Bangladesh - Education	12/18/2017	$10	$510	
Mozambique	12/20/2017	$25	$80	
Rwanda (Health)	2/28/2018	$10	$25	
Afghanistan	3/28/2018	$35	$140	
Rwanda (SP-AF)	4/12/2018	$8	$80	
Guinea	4/25/2018	$10	$45	
Indonesia	6/21/2018	$20		$400
Nigeria (Nutrition)	6/27/2018	$7	$225	
Burkina Faso	7/6/2018	$20	$80	
Nigeria (Part 2)	8/13/2018	$20	$0	
CAR	9/27/2018	$10	$43	
Malawi	12/19/2018	$10	$50	
Mali	3/19/2019	$10	$50	
Cote d'Ivoire	3/22/2019	$20	$200	
Cambodia	4/4/2019	$10	$15	
Haiti	5/16/2019	$15	$55	
DRC Nutrition	5/28/2019	$10	$492	
Vietnam	6/19/2019	$17	$80	
Senegal	9/26/2019	$15	$140	
Tajikistan Early years	4/30/2020	$3	$70	
Myanmar	5/29/2020	$10	$100	
Total Board approved		**$602**	**$4,175**	**$500**

1 The HRITF was established in 2007 with US$296.1 million contribution from Norway and US$176.8 million contribution from DFID.

2 Contributions to the GFF Trust Fund are made in US$ and other donor currencies and are paid over a period of time in accordance with the payment schedule agreed with each donor. Contributions in donor currency are converted in US$ when the payment is made, and the remaining amount is subject to currency fluctuation until the contribution is fully paid. Therefore, this can cause fluctuations of the fund value over time.

3 Afghanistan, Bangladesh, Burkina Faso, Cambodia, Cameroon, Central African Republic, Cote d'Ivoire, DRC, Ethiopia, Liberia, Madagascar, Malawi, Mozambique, Senegal, Sierra Leone, Somalia, Tajikistan, Tanzania, Uganda, Zambia and Zimbabwe.

ABOUT THE GFF

The Global Financing Facility for Women, Children and Adolescents (GFF) is a multi-stakeholder global partnership housed at the World Bank that is committed to ensuring all women, children and adolescents can survive and thrive. Launched in July 2015, the GFF supports 36 low and lower-middle income countries with catalytic financing and technical assistance to develop and implement prioritized national health plans to scale up access to affordable, quality care for women, children and adolescents. The GFF also works with countries to maximize the use of domestic financing and external support for better, more sustainable health results.

The GFF is squarely focused on prioritizing and scaling up evidence-driven investments to improve reproductive, maternal, newborn, child and adolescent health and nutrition through targeted strengthening of primary health care systems – to save lives and as a critical first step toward accelerating progress on Universal Health Coverage (UHC) and the Sustainable Development Goals (SDGs).

The GFF has pioneered a shift from traditional development approaches to a more sustainable way forward where governments lead and bring global partners together to support a prioritized, costed national plan. Through this partnership, the GFF aims to mobilize additional funding through the combination of grants from a dedicated multi-donor trust fund (the GFF Trust Fund), financing from International Development Association (IDA) and International Bank for Reconstruction and Development (IBRD), and the crowding in of additional domestic and external resources. This approach has catalyzed high-impact investments for reproductive, maternal, newborn, child and adolescent health and nutrition in the world's most vulnerable countries.

Investors Group Members

ABT Associates (representing the private sector constituency)

Bill & Melinda Gates Foundation

Burkina Faso Youth Action Movement (representing the youth constituency)

Centre for Reproductive Health and Education Zambia (representing the civil society constituency)

European Commission

Gavi, the Vaccine Alliance

Global Fund to Fight AIDS, Tuberculosis, and Malaria

Government of Afghanistan

Government of Burkina Faso

Government of Cambodia

Government of Canada

Government of Central African Republic

Government of Côte d'Ivoire

Government of Denmark

Government of Ethiopia

Government of Germany

Government of Haiti

Government of Japan

Government of the Kingdom of the Netherlands

Government of Niger

Government of Norway

Government of United Kingdom

Government of United States

Government of Zimbabwe

Laerdal Global Health (representing the private sector constituency)

MSD for Mothers (representing the private sector constituency)

PAI (representing the civil society constituency)

PATH Kenya (representing the civil society constituency)

Pathfinder International (representing youth constituency)

Partnership for Maternal, Newborn, and Child Health

Qatar Fund for Development

The Susan Thompson Buffett Foundation

UNFPA

UNICEF

World Bank Group

World Health Organization

Trust Fund Contributors

The GFF Trust Fund is supported by the Governments of Burkina Faso, Canada, Côte d'Ivoire, Denmark, the European Commission, Germany, Japan, the Netherlands, Norway, Qatar, and the United Kingdom; the Bill & Melinda Gates Foundation; the Susan T. Buffett Foundation; Laerdal Global Health; MSD for Mothers and the Rockefeller Foundation.

List of Acronyms

AFD Agence Francaise de Dévelopement (France)

BMZ Federal Ministry of Economic Cooperation and Development (Germany)

ANC antenatal care

ANC4 four antenatal care visits

BEmONC Basic Emergency Obstetric and Newborn Care

BHCPF Basic Health Care Provision Fund

CEmONC Comprehensive Emergency Obstetric and Newborn Care

CSO civil society organization

DHS Demographic Health Survey

DRC Democratic Republic of Congo

FCDO Foreign, Commonwealth & Development Office

HDI Human Development Index

IBRD International Bank for Reconstruction and Development

KFW German Development Bank (government-owned)

IDA International Development Association

IPT2 intermittent preventative treatment (for malaria)

JICA Japan International Cooperation Agency

MICS Multiple Indicator Cluster Survey

ODA official development assistance

PBF performance-based financing

PMNCH Partnership for Maternal, Newborn, and Child Health

RMNCAH-N reproductive, maternal, newborn, child and adolescent health and nutrition

SDG Sustainable Development Goal

SIDA Swedish International Development Cooperation Agency

UHC Universal Health Coverage

UNFPA UN Population Fund

USAID United States Agency for International Development

WHO World Health Organization

Acknowledgements

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APPENDIX A

Indicators Description

	INDICATOR	DESCRIPTION
CORE RMNCAH-N IMPACT INDICATORS	Maternal Mortality Ratio	Number of female deaths from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, expressed per 100 000 live births, for a specified time period
	Under 5 Mortality Ratio	Probability of a child born in a specific year or period dying before reaching the age of 5 years, expressed per 1000 live births
	Neonatal Mortality Ratio	Probability of a child born in a specific year or period dying in the first month of life, expressed per 1000 live births
	Adolescent Birth Rate (15-19yrs)	Number of births to females aged 15–19 years per 1000 females in the three years preceding the survey
	Births <24 months after the preceding birth	Percentage of non-first births in the five years preceding the survey whose previous birth interval is 7-23 months. This excludes the first birth.
	Prevalence of stunting among children under 5 years of age	Percentage of children under five years of age with a height for age less than -2 Standard Deviation of height for age according to the WHO Growth Standards median
	Moderate to severe wasting among children under 5 years of age	Percentage of children aged under five years of age with weight-for-height less than -2 Standard Deviations of the WHO Children Growth Standards median
RMNCAH-N COVERAGE INDICATORS	Demand for FP satisfied by Modern Methods	Percentage of demand for family planning satisfied by modern methods is calculated as the number of all women using modern methods of family planning divided by the number of all women with demand for family planning (either with unmet need or currently using any family planning)
	Antenatal Care: Received Iron supplementation for 90+ days	Percentage of women with a birth in the five years preceding the survey who took iron tablets or syrup for 90+ days
	Antenatal Coverage : 4+ visits	Percentage of women who had a live birth in the five (or three) years preceding the survey who had 4+ antenatal care visits
	Care Seeking for Pneumonia	Percentage of children under age 5 who had symptoms of ARI in the last two weeks, for whom advice or treatment was sought from a health facility or provider.
	DPT3 coverage	Percentage of children 12-23 months who had received DPT3 vaccination as reported by either mothers recall or the vaccination card
	Institutional Delivery	Percentage of live births in the five (or three) years preceding the survey delivered at a health facility
	Exclusive Breast Feeding	Percentage of children between 0 to 5 months of age living with the mother who are exclusively breastfed
	Minimum Adequate Diet	Number of children 6-23 months that satisfy the Minimum dietary diversity and Minimum Meal Frequency requirement for breast fed and non-breast fed children.
	Oral rehydration salts treatment of diarrhea	Percentage of children born in the five (or three) years preceding the survey with diarrhea in the two weeks preceding the survey who received oral rehydration solution (ORS), that is either fluid from an ORS packet or a pre-packaged ORS fluid.
	Postnatal care for mothers	Percentage of women with a live birth in the 2 years preceding the survey who received a postnatal check during the first 2 days after giving birth
	Skilled Attendance at Birth	Percentage of live births in the five (or three) years preceding the survey assisted by a skilled provider. Skilled provider includes doctor, nurse, midwife and auxiliary nurse or midwife.
	Vitamin A supplementation, full Coverage	Percentage of children age 6-59 months who received at least one high dose Vitamin A supplement in the last 6 months
	Adjusted net enrollment rate; lower secondary; both sexes (%)	Adjusted net enrollment is the number of pupils of the school-age group for lower secondary education, enrolled in lower secondary education, expressed as a percentage of the total population in that age group.
	Adjusted net enrollment rate; lower secondary; female (%)	Adjusted net enrollment is the number of female pupile of the school-age group for lower secondary education, enrolled in lower secondary education, expressed as a percentage of the total population of females in that age group.
	Lower secondary completion rate; both sexes (%)	Lower secondary education completion rate is measured as the gross intake ratio to the last grade of lower secondary education (general and pre-vocational). It is calculated as the number of new entrants in the last grade of lower secondary education, regardless of age, divided by the population at the entrance age for the last grade of lower secondary education.
	Lower secondary completion rate; female (%)	Lower secondary education completion rate is measured as the gross intake ratio to the last grade of lower secondary education (general and pre-vocational). It is calculated as the number of new female entrants in the last grade of lower secondary education, regardless of age, divided by the female population at the entrance age for the last grade of lower secondary education.

APPENDIX A

Indicators Description *(continued)*

	INDICATOR	DESCRIPTION
HEALTH FINANCING INDICATORS	Domestic General Government Health Expenditure (DGGHE) as share of General Government Expenditure (GGE) (%)	Share of domestic government health spending to total government expenditures (numerator: Total domestic government expenditures for health; denominator: Total government expenditures from domestic sources)
	Domestic General Government Health Expenditure (DGGHE) per capita (US$)	Government health expenditure per inhabitant (numerator: Total government health expenditures; denominator: Total Population)
	Out-of-pocket spending on health, per capita (US$)	Sum of household out-of-pocket payments on health, per capita (US$)
	Share of government budget allocated to health (%)	Share of the government budget allocated to health (numerator: total government budget allocated to health; denominator: total government budget)
	Health budget execution (%)	Share of government health spending to total government health budget (numerator: Total government spending on health; denominator: total government budget allocated to health).
	Share of health expenditure going to frontline providers (%)	Share of domestic government health spending to frontline providers (country-specific definition) to total government health spending (numerator: total domestic government expenditure on frontline providers (country definition); denominator: total government expenditure on health). This indicator is not comparable across countries.
	Budget planning and allocation are improved: Operational plans approved including activities and budgets for achievement of DLIs	Number of operational plans approved including activities and budgets for achievement of disbursement-linked indicators (DLIs)
	Procurement process is improved using IT: Percentage of National Competitive Tenders (NCTs) using electronic government procurement (e-GP) system issued by MOHFW	National Competitive Tenders (NCTs) using electronic government procurement (e-GP) system as a percentage of all specified NCT issued by the the Ministry of Health and Family Welfare.
	Number of DPS (*division provinciale de la santé*) implementing single contract	Number of provincial level divisions (DPS: division provinciale de la santé) implementing the single contract (contrat unique)
	Domestic health expenditure allocated to RMNCAH	Share of RMNCAH-N spending to total domestic government health spending (numerator: Total RMNCAH-N expenditures ; denominator:Total government health spending from domestic sources)
	Domestic budget execution on RMNCAH+ 3 diseases (TB, Malaria, HIV/AIDS)	Share of government health spending on RMNCAH+ 3 diseases (TB, Malaria, HIV/AIDS) to total government health budget (numerator: Total government spending on RMNCAH+ 3 diseases (TB, Malaria, HIV/AIDS); denominator: total government budget allocated to health).
	Percent of PHC facilities having all drugs from the MoH list of essential drugs available	Proportion of primary healthcare facilities (PHC) with all drugs from the MoH list of essential drugs available (numerator: total number of PHC facilities with with all drugs from the MoH list of essential drugs available; denominator: total number of PHC facilities)
	CBHI coverage: percent of districts with functional community-based health insurance (CBHI) schemes	Proportion of districts with functional community based health insurance (CBHI) schemes (numerator: Number of districts with functional CBHI scheme; denominator: Total number of districts)
	Proportion of counties aligning planning and budgeting processes (%)	Proportion of counties aligning planning and budgeting processes (numerator: Number of counties that receive planning, budgeting, monitoring, and reporting (PBMR) technical assistance that made full use of policies, strategies, and budget data and aligned prgram headings and AWP sub-programs; denominator: Number of counties that receive planning budgeting monitoring, and reporting (PBMR) technical assistance)
	Proportion of counties allocating at least 30 percent of budget to health (%)	Proportion of counties allocating at least 30 percent of budget to health (numerator: number of counties that receive technical assistance with approved county budgets that allocate at least 30 percent of budget to health, less donor and government conditional grants for health; denominator: total number of counties that recieve technical assistance and have approved county budgets)
	Number of accredited facilities receiving payments for services financed through the Fee-for-Service (FFS) mechanism (public and private)	Number of accredited facilities receiving payments for services financed through the Fee-for-Service (FFS) mechanism, disaggregated by public and private
	Domestic resource contribution to the Basic Health Care Provision Fund (BHCPF)	Total domestic resources contributed to the Basic Health Care Provision Fund (BHCPF)
	Number of facilities implementing RBF	Number of facilities implementing results-based financing
	Percentage of health facilities receiving funds through the direct health facility financing (DHFF) program	Percentage of health facilities receiving funds through the direct health facility financing program (numerator: number of health facilities receiving funds through the direct health facility financing program; denominator: total number of health facilities)
	Amount of outpatient Health Equity Fund services in target areas	Number of of outpatient Health Equity Fund services in target areas
	Proportion of health facilities covered by PBF	Proportion of health facilities covered by program-based financing (PBF) (numerator: number of health facilities covered by PBF; denominator: total number of health facilities)
	Number of PBF covered districts	Number of district covered by program-based financing
	Number of people covered by the CMU (*couverture maladie universelle*)	Number of people covered by the couverture maladie universelle
	Number of poor and vulnerable covered by CMU (*couverture maladie universelle*)	Number of poor and vulnerable covered by the couverture maladie universelle
	Number of technical health personnel assigned to primary care	Number of technical health personnel assigned to primary care
	Number of trained and active community healthcare workers (CHWs)	Number of trained and active community healthcare workers
	Number of children under 5 enrolled in the free health care policy	Number of children under 5 enrolled in the free health care policy
	Number of districts implementing RBF	Number of districts implementing results-based financing
	Number of health centers participating in RBF	Number of health centers participating in results-based financing

APPENDIX B

Data Sources

INDICATOR / SOURCE (YEAR)	Afghanistan	Bangladesh	Burkina Faso	Cambodia	Cameroon	Central African Republic	Chad	Cote d'Ivoire	DRC	Ethiopia	Ghana	Guatemala	Guinea	Haiti	Indonesia	Kenya	Liberia	Madagascar
GFF CORE IMPACT INDICATORS																		
Maternal Mortality Ratio	UN Inter Agency Report 2015;UN Inter Agency Report 2017	SVRS 2018;SVRS 2019	DHS 2010;EMDS 2015	DHS 2010;DHS 2014	DHS 2011;DHS 2018	n/a	MICS 2010;DHS 2014-15	DHS 2011-12;MICS 2016	DHS 2014;MICS 2017-18	DHS 2016;DHS 2019	DHS 2014;DMHS 2017	DHS 2014-15	DHS 2012;MICS 2016	DHS 2012;DHS 2016-17	DHS 2012;SUPAS 2015	DHS 2008-09;DHS 2014	DHS 2013;DHS 2019	DHS 2008;MICS 2018
Under 5 Mortality Rate	AHS 2015;AHS 2018	DHS 2014;DHS 2017-18	DHS 2010;EMDS 2015	DHS 2010;DHS 2014	MICS 2014;DHS 2018	n/a	MICS 2010;DHS 2014-15	DHS 2011-12;MICS 2016	DHS 2014;MICS 2017-18	DHS 2016;DHS 2019	DHS 2014;MICS 2017-18	DHS 2014-15	DHS 2012;DHS 2018	DHS 2012;DHS 2016-17	DHS 2012;DHS 2017	DHS 2008-09;DHS 2014	DHS 2013;DHS 2019	DHS 2008;MICS 2018
Neonatal Mortality Rate	AHS 2015;AHS 2018	DHS 2014;DHS 2017-18	DHS 2010;EMDS 2015	DHS 2010;DHS 2014	MICS 2014;DHS 2018	n/a	MICS 2010;DHS 2014-15	DHS 2011-12;MICS 2016	DHS 2014;MICS 2017-18	DHS 2016;DHS 2019	DHS 2014;MICS 2017-18	DHS 2014-15	DHS 2012;DHS 2018	DHS 2012;DHS 2016-17	DHS 2012;DHS 2017	DHS 2008-09;DHS 2014	DHS 2013;DHS 2019	DHS 2008;MICS 2018
Adolescent Birth Rate (15-19)	AHS 2015;AHS 2018	DHS 2014;DHS 2017-18	MIS 2014;MIS 2017-2018	DHS 2010;DHS 2014	MICS 2014;DHS 2018	n/a	MICS 2010;DHS 2014-15	DHS 2011-12;MICS 2016	DHS 2014;MICS 2017-18	DHS 2016;DHS 2019	DHS 2014;MICS 2017-18	DHS 2014-15	DHS 2012;DHS 2018	DHS 2012;DHS 2016-17	DHS 2012;DHS 2017	DHS 2008-09;DHS 2014	DHS 2013;DHS 2019	DHS 2008;MICS 2018
Births <24 months after the preceding birth	DHS 2015;AHS 2018	DHS 2014;DHS 2017-18	MIS 2014;MIS 2017-2018	DHS 2010;DHS 2014	DHS 2011;DHS 2018	n/a	MICS 2010;DHS 2014-15	DHS 2011-12;MICS 2016	DHS 2014;MICS 2017-18	DHS 2016;DHS 2019	DHS 2014;ND	DHS 2014-15	DHS 2012;DHS 2018	DHS 2012;DHS 2016-17	DHS 2012;DHS 2017	DHS 2008-09;DHS 2014	DHS 2013;ND	DHS 2008;ND
Stunting among children under 5 years of age	Afghanistan National Nutrition Survey 2013;AHS 2018	DHS 2014;DHS 2017-2018	National Nutrition Survey 2017;National Nutrition Survey 2018	DHS 2010;DHS 2014	MICS 2014;DHS 2018	n/a	SMART 2018;SMART 2019	DHS 2011-12;MICS 2016	DHS 2014;MICS 2017-18	DHS 2016;DHS 2019	DHS 2014;MICS 2017-18	DHS 2014-15	DHS 2012;DHS 2018	DHS 2012;DHS 2016-17	RISKESDAS 2018;SUSENAS 2019	DHS 2008-09;DHS 2014	DHS 2013;DHS 2019	Millennium Development Goals National Monitoring Survey (ENSOMD) 2012-2013;MICS 2018
Moderate to severe wasting among children under 5 years of age	Afghanistan National Nutrition Survey 2013;AHS 2018	DHS 2014;DHS 2017-2018	National Nutrition Survey 2017;National Nutrition Survey 2018	DHS 2010;DHS 2014	MICS 2014;DHS 2018	n/a	SMART 2018;SMART 2019	DHS 2011-12;MICS 2016	DHS 2014;MICS 2017-18	DHS 2016;DHS 2019	DHS 2014;MICS 2017-18	DHS 2014-15	DHS 2012;DHS 2018	DHS 2012;DHS 2016-17	RISKESDAS 2018;SUSENAS 2019	DHS 2008-09;DHS 2014	DHS 2013;DHS 2019	Millennium Development Goals National Monitoring Survey (ENSOMD) 2012-2013;MICS 2018
RMNCAH-N COVERAGE INDICATORS																		
Antenatal visits for pregnancy: 4+ visits	MICS 2010-11; DHS 2015; AHS 2018	MICS 2012-13; DHS 2014; DHS 2017-18; MICS 2019; DHS 2011	EDSBF-MICS IV; 2010; MIS 2014	DHS 2014; DHS 2010	MICS 2014; DHS 2018; EDS-MICS 2011	n/a	MICS 2010; EDS-MICS 2014-15	DHS 2011-12; MICS 2016	MICS 2010; DHS 2013-14; MICS 2017-18	Mini DHS 2014; DHS 2016; DHS 2011; DHS 2019	MICS 2011; GMHS 2017; MICS 2017-18; DHS 2014	n/a	MICS 2016; DHS 2018; EDS-MICS 2012	DHS 2016-17; DHS 2012	DHS 2012; RISKESDAS 2013; DHS 2017	MIS 2015; DHS 2014; DHS 2008-2009	DHS 2013; MIS 2016; DHS 2019	ENSOMD 2012-2013; MICS 2018; DHS 2008-09
Careseeking for symptoms of pneumonia	MICS 2010-11; DHS 2015	MICS 2012-13; DHS 2014; DHS 2011; MICS 2019	EDSBF-MICS IV 2010	DHS 2014; DHS 2010	MICS 2014; DHS 2018; EDS-MICS 2011	n/a	MICS 2010; EDS-MICS 2014-15	DHS 2011-12; MICS 2016	MICS 2010; DHS 2013-14; MICS 2017-18	DHS 2011; DHS 2016	MICS 2011; MICS 2017-18; DHS 2014	n/a	MICS 2016; DHS 2018; EDS-MICS 2012	DHS 2012; DHS 2016-17	DHS 2012; DHS 2017	DHS 2014; DHS 2008-2009	DHS 2013; DHS 2019	MICS 2018; ENSOMD 2012-2013; DHS 2008-09
Demand for family planning satisfied by modern methods	n/a	DHS 2017-18; MICS 2019; DHS 2014; DHS 2011	EDSBF-MICS IV 2010; PMA2020 2015, 2016, 2017, 2018, 2019	DHS 2014; DHS 2010	DHS 2018; EDS-MICS 2011	n/a	EDS-MICS 2014-15	DHS 2011-12; PMA2020 2017, 2018	DHS 2013-14; MICS 2017-18	DHS 2016; DHS 2011; PMA2020 2014, 2017, 2018;	DHS 2014; PMA2020 2013, 2015, 2016, 2017	n/a	DHS 2018; EDS-MICS 2012	DHS 2016-17; DHS 2012	DHS 2012; PMA2020 2015; DHS 2017	DHS 2014; PMA2020 2015, 2016, 2017, 2018; DHS 2008-2009	DHS 2013	MICS 2018; DHS 2008-09
DPT3 (Immunized with three doses of diphtheria, tetanus, pertussis)	MICS 2010-11; AHS 2012; Afghanistan National EPI Coverage Survey 2013; DHS 2015; AHS 2018	DHS 2011; DHS 2014; EPI Coverage Evaluation Survey 2013; EPI Coverage Evaluation Survey 2016; DHS 2017-18	EDSBF-MICS IV 2010	DHS 2010; DHS 2014	EDS-MICS 2011; DHS 2018; MICS 2014	n/a	MICS 2010; Vaccination Coverage Survey 2012; EDS-MICS 2014-15; Vaccination Coverage Survey 2017	EPI Review 2010; DHS 2011-12; Vaccination Coverage Survey 2013; Evaluation of Measles Campaign 2014; External Review of the Immunization System 2015; MICS 2016	MICS 2010; DRC Immunization Coverage Survey 2012; DHS 2013-14	DHS 2011; Ethiopian Immunization Coverage Survey 2012; DHS 2016; DHS 2019	MICS 2011; Ghana EPI Cluster Survey 2012; DHS 2014; MICS 2017-18	n/a	EPI External Review 2011; EDS-MICS 2012; MICS 2016	DHS 2012; DHS 2016-17	RISKESDAS 2010; DHS 2012; RISKESDAS 2013; DHS 2017; Indonesia Laporan Nasional Riskesdas 2018	DHS 2008-2009; DHS 2014	Routine Immunization Survey 2012; DHS 2013; DHS 2019	Immunization Coverage Evaluation 2011; ENSOMD 2012-2013; DHS 2008-09
Institutional Delivery	MICS 2010-11; DHS 2015; AHS 2018	DHS 2014; MICS 2019; MICS 2012-13; DHS 2017-18; DHS 2011	EDSBF-MICS IV; 2010	DHS 2014; DHS 2010	MICS 2014; DHS 2018; EDS-MICS 2011	n/a	EDS-MICS 2014-15; MICS 2010	DHS 2011-12; MICS 2016	MICS 2010; DHS 2013-14; MICS 2017-18	DHS 2016; DHS 2011; DHS 2019	MICS 2017-18; DHS 2014; MICS 2011	n/a	DHS 2018; EDS-MICS 2012; MICS 2016	DHS 2016-17; DHS 2012	DHS 2012; RISKESDAS 2013; DHS 2017; RISKESDAS 2018	DHS 2014; DHS 2008-2009	DHS 2013; MIS 2016; DHS 2019	MICS 2018; ENSOMD 2012-2013; DHS 2008-09
Postnatal care for mothers	DHS 2015	MICS 2012-13; MICS 2019; DHS 2014; DHS 2011; DHS 2017-18	EDSBF-MICS IV; 2010	DHS 2014; DHS 2010	MICS 2014; DHS 2018; EDS-MICS 2011	n/a	EDS-MICS 2014-15	DHS 2011-12; MICS 2016	DHS 2013-14; MICS 2017-18	DHS 2016; DHS 2019; DHS 2011	GMHS 2017; DHS 2014; MICS 2011; MICS 2017-18	n/a	MICS 2016; DHS 2018; EDS-MICS 2012	DHS 2016-17; DHS 2012	DHS 2012; DHS 2017	DHS 2014; DHS 2008-2009	DHS 2013; MIS 2016; DHS 2019	MICS 2018; DHS 2008-09
Skilled attendant at delivery	MICS 2010-11; AHS 2012; DHS 2015; AHS 2018	MICS 2019; MICS 2012-13; DHS 2014; DHS 2017-18; DHS 2011	EDSBF-MICS IV 2010	DHS 2014; DHS 2010	MICS 2014; DHS 2018; EDS-MICS 2011	n/a	MICS 2010; EDS-MICS 2014-15	DHS 2011-12; MICS 2016	MICS 2010; DHS 2013-14; MICS 2017-18	DHS 2019; DHS 2016; DHS 2011	GMHS 2017; DHS 2014; MICS 2011	n/a	DHS 2018; EDS-MICS 2012; MICS 2016	DHS 2016-17; DHS 2012	DHS 2012; DHS 2017; BPS 2018	DHS 2014; DHS 2008-2009	DHS 2013; DHS 2019	ENSOMD 2012-2013; MICS 2018; DHS 2008-09
Oral rehydration salts treatment of diarrhea	MICS 2010-11; DHS 2015	MICS 2019; MICS 2012-13; DHS 2014; DHS 2011; DHS 2017-18	EDSBF-MICS IV 2010	DHS 2014; DHS 2010	MICS 2014; DHS 2018; EDS-MICS 2011	n/a	MICS 2010; EDS-MICS 2014-15	DHS 2011-12; MICS 2016	MICS 2010; DHS 2013-14; MICS 2017-18	DHS 2011; DHS 2016	MICS 2011; MICS 2017-18; DHS 2014	n/a	MICS 2016; DHS 2018; EDS-MICS 2012	DHS 2012; DHS 2016-17	DHS 2012; DHS 2017	DHS 2014; DHS 2008-2009	DHS 2013; DHS 2019	MICS 2018; ENSOMD 2012-2013; DHS 2008-09
Vitamin A Supplementation, Full Coverage	DHS 2015; MICS 2010-11	DHS 2017-18; DHS 2014; DHS 2011	EDSBF-MICS IV 2010	DHS 2010; DHS 2014	DHS 2018; EDS-MICS 2011	n/a	MICS 2010; EDS-MICS 2014-15		DHS 2013-14	DHS 2016; DHS 2011; DHS 2019	DHS 2014; MICS 2011	n/a	DHS 2018; EDS-MICS 2012	DHS 2016-17; DHS 2012	DHS 2012; DHS 2017	DHS 2014; DHS 2008-2009	DHS 2013	DHS 2008-09; ENSOMD 2012-2013
NUTRITION SPECIFIC INDICATORS																		
Pregnant women who received iron folic acid supplementation or syrup for 90+days	n/a		EDSBF-MICS IV 2010	DHS 2014; DHS 2010	n/a	n/a	n/a	n/a	DHS 2013-14	n/a	n/a	n/a	n/a	n/a	DHS 2012; RISKESDAS 2013; DHS 2017	n/a	n/a	DHS 2015-16; DHS 2010
Exclusive breast feeding	n/a	DHS 2011; MICS 2012-13; DHS 2014; DHS 2017-18; MICS 2019	NNS/SMART 2009; Burkina Faso: Nutrition unit 2009; EDSBF-MICS IV 2010; NNS/SMART 2012; NNS/SMART 2013; NNS/SMART 2014; SMART 2017; SMART 2018	DHS 2010; DHS 2014	n/a	n/a	n/a	n/a	DHS 2013-14; MICS 2010	n/a	n/a	n/a	n/a	n/a	DHS 2017; DHS 2012	n/a	n/a	MICS 2013-14; DHS 2015-16; DHS 2010
Minimum Acceptable Diet	n/a	DHS 2011; DHS 2017-18; DHS 2014; MICS 2019	EDSBF-MICS IV; 2010	DHS 2010; DHS 2014	n/a	n/a	n/a	n/a	DHS 2013-14; MICS 2017-18	n/a	n/a	n/a	n/a	n/a	DHS 2017; DHS 2012	n/a	n/a	DHS 2010; DHS 2015-16; MICS 2013-14

APPENDIX B

Data Sources *(continued)*

INDICATOR / SOURCE (YEAR)	Malawi	Mali	Mauritania	Mozambique	Myanmar	Niger	Nigeria	Pakistan	Rwanda	Senegal	Sierra Leone	Somalia	Republic of Tajikistan	Tanzania	Uganda	Vietnam	Zambia	Zimbabwe
GFF CORE IMPACT INDICATORS																		
Maternal Mortality Ratio	DHS 2010;DHS 2015-16	DHS 2012-13;DHS 2018	MICS 2011;MICS 2015	DHS 2011;AIS 2015	MICS 2009-10;DHS 2015-16	DHS 2012;ENISED 2015	DHS 2013;DHS 2018	UNIA 2014-15;UNIA 2019	DHS 2010;DHS 2014	DHS 2017	DHS 2013;DHS 2019	MICS 2006;SHDS 2020	UN InterAgency Report; 2010.;UN InterAgency Report; 2015	DHS 2010;DHS 2015	DHS 2011;DHS 2016	UN-MMEIG 2015;UN-MMEIG 2017	DHS 2013-14;DHS 2018	MICS 2014;MICS 2019
Under 5 Mortality Rate	DHS 2010;DHS 2015-16	MICS 2015;DHS 2018	MICS 2011;MICS 2015	DHS 2011;AIS 2015	UNIGME 2012; UNIGME 2020	DHS 2012;ENISED 2015	DHS 2013;DHS 2018	DHS 2012-13;DHS 2017-18	DHS 2010;DHS 2014	DHS 2018;DHS 2019 preliminary report	DHS 2013;DHS 2019	MICS 2006;SHDS 2020	DHS 2012;DHS 2017	DHS 2010;DHS 2015	DHS 2011;DHS 2016	MICS 2011;MICS 2013-14	DHS 2013-14;DHS 2018	MICS 2014;MICS 2019
Neonatal Mortality Rate	DHS 2010;DHS 2015-16	MICS 2015;DHS 2018	MICS 2011;MICS 2015	DHS 2011;AIS 2015	UNIGME 2011; UNIGME 2019	DHS 2012;ENISED 2015	DHS 2013;DHS 2018	DHS 2012-13;DHS 2017-18	DHS 2010;DHS 2014	DHS 2018;DHS 2019 preliminary report	DHS 2013;DHS 2019	MICS 2006;SHDS 2020	DHS 2012;DHS 2017	DHS 2010;DHS 2015	DHS 2011;DHS 2016	MICS 2011;MICS 2013-14	DHS 2013-14;DHS 2018	MICS 2014;MICS 2019
Adolescent Birth Rate (15-19)	DHS 2010;DHS 2015-16	MICS 2015;DHS 2018	MICS 2011;MICS 2015	DHS 2011;AIS 2015	MICS 2009-10;DHS 2015-16	DHS 2012;ENISED 2015	DHS 2013;DHS 2018	DHS 2012-13;DHS 2017-18	DHS 2010;DHS 2014	DHS 2018;DHS 2019 preliminary report	DHS 2013;DHS 2019	MICS 2006;SHDS 2020	DHS 2012;DHS 2017	DHS 2010;DHS 2015	DHS 2011;DHS 2016	MICS 2011;MICS 2013-14	DHS 2013-14;DHS 2018	MICS 2014;MICS 2019
Births <24 months after the preceding birth	DHS 2010;DHS 2015-16	DHS 2012-13;DHS 2018	MICS 2011;MICS 2015	DHS 2011;AIS 2015	MICS 2009-10;DHS 2015-16	DHS 2012;ENISED 2015	DHS 2013;DHS 2018	DHS 2012-13;DHS 2017-18	DHS 2010;DHS 2014	DHS 2017;DHS 2018	DHS 2013;DHS 2019	MICS 2006;SHDS 2020	DHS 2012;DHS 2017	DHS 2010;DHS 2015	DHS 2011;DHS 2016	MICS 2011;MICS 2013-14	DHS 2013-14;DHS 2018	MICS 2014;MICS 2019
Stunting among children under 5 years of age	DHS 2010;DHS 2015-16	MICS 2015;DHS 2018	SMART 2012;SMART 2018	DHS 2011;Baseline evaluation of the Nutrition Intervention Package (NIP) 2019	MICS 2009-10;DHS 2015-16	SMART 2018;SMART 2019	DHS 2013;DHS 2018	DHS 2012-13;DHS 2017-18	DHS 2010;DHS 2014	DHS 2018;DHS 2019 preliminary report	DHS 2013;DHS 2019	MICS 2006;SHDS 2020	DHS 2012;DHS 2017	DHS 2010;DHS 2015	DHS 2011;DHS 2016	National Institute of Nutrition 2015;National Institute of Nutrition 2017	DHS 2013-14;DHS 2018	MICS 2014;MICS 2019
Moderate to severe wasting among children under 5 years of age	DHS 2010;DHS 2015-16	MICS 2015;DHS 2018	SMART 2012;SMART 2018	DHS 2011;Baseline evaluation of the Nutrition Intervention Package (NIP) 2019	MICS 2009-10;DHS 2015-16	SMART 2018;SMART 2019	DHS 2013;DHS 2018	DHS 2012-13;DHS 2017-18	DHS 2010;DHS 2014	DHS 2018;DHS 2019 preliminary report	DHS 2013;DHS 2019	MICS 2006;SHDS 2020	DHS 2012;DHS 2017	DHS 2010;DHS 2015	DHS 2011;DHS 2016	National Institute of Nutrition 2015;National Institute of Nutrition 2017	DHS 2013-14;DHS 2018	MICS 2014;MICS 2019
RMNCAH-N COVERAGE INDICATORS																		
Antenatal visits for pregnancy: 4+ visits	MICS 2013-14; DHS 2015-16; DHS 2010	MICS 2009-10; DHS 2018; EDSM-V 2012-13; MICS 2015	MICS 2011; MICS 2015	MIS 2018; AIS 2015; DHS 2011	DHS 2015-16	ENISED 2015; EDSN-MICS IV 2012	DHS 2013; MICS 2011; MICS 2016-17; DHS 2018	DHS 2017-18; DHS 2012-13	DHS 2014-15; DHS 2010	DHS 2010-11; DHS 2012-13; DHS 2014; DHS 2015; DHS 2016; DHS 2017; DHS 2018	MICS 2010; DHS 2013; MICS 2017; DHS 2019	SHDH 2020; MICS 2006	DHS 2012; DHS 2017	DHS 2010; DHS 2015-16; MIS 2017	DHS 2011; DHS 2016; MIS 2018-19	MICS 2011; MICS 2013-14	DHS 2013-14; DHS 2018	DHS 2010-11; MICS 2014; DHS 2015; MICS 2019
Careseeking for symptoms of pneumonia	MICS 2013-14; DHS 2015-16; DHS 2010	MICS 2009-10; MICS 2015; DHS 2018; EDSM-V 2012-13	MICS 2011; MICS 2015	AIS 2015; DHS 2011	MICS 2009-10; DHS 2015-16	ENISED 2015; EDSN-MICS IV 2012	DHS 2013; MICS 2011; MICS 2016-17; DHS 2018	DHS 2017-18; DHS 2012-13	DHS 2010; DHS 2014-15	DHS 2010-11; DHS 2012-13; DHS 2014; DHS 2015; DHS 2016; DHS 2017; DHS 2018	MICS 2010; DHS 2013; MICS 2017; DHS 2019	SHDH 2020; MICS 2006	DHS 2012; DHS 2017	DHS 2010; DHS 2015-16	DHS 2011; DHS 2016	MICS 2011; MICS 2013-14	DHS 2013-14; DHS 2018	DHS 2010-11; MICS 2014; DHS 2015
Demand for family planning satisfied by modern methods	DHS 2015-16; DHS 2010	DHS 2018; EDSM-V 2012-13		AIS 2015; DHS 2011	DHS 2015-16	EDSN-MICS IV 2012; PMA2020 2016, 2017	DHS 2013; PMA2020 2016, 2017, 2018; DHS 2018	DHS 2012-13; DHS 2017-18	DHS 2014-15; DHS 2010	DHS 2010-11; DHS 2012-13; DHS 2014; DHS 2015; DHS 2016; DHS 2017; DHS 2018	DHS 2013; MICS 2017; DHS 2019	SHDH 2020	DHS 2012; DHS 2017	DHS 2010; DHS 2015-16	DHS 2011; PMA2020 2016, 2017, 2018		DHS 2013-14; DHS 2018	DHS 2010-11; DHS 2015
DPT3 (Immunized with three doses of diphtheria, tetanus, pertussis)	DHS 2015-16; DHS 2010	DHS 2018; MICS 2009-10; EDSM-V 2012-13; MICS 2015; Expanded Programme of Immunization Review 2016	MICS 2011; EPI Review 2014; MICS 2015	AIS 2015; DHS 2011	DHS 2015-16; MICS 2009-10	Niger Child Mortality and Survival Survey 2010; EDSN-MICS IV 2012; Coverage evaluation survey 2013; Vaccination Coverage Survey 2017	DHS 2013; Immunization Coverage Survey 2010; MICS 2011; National Nutrition and Health Survey 2015; MICS 2016-17; NNHS 2018; DHS 2018	PSLM 2010-2011; National Nutrition Survey Pakistan 2011; DHS 2012-13; PSLM 2014-15; DHS 2017-18	DHS 2010; Coverage Evaluation Survey 2013; DHS 2014-15	DHS 2010-11; DHS 2012-13; DHS 2014; DHS 2015; DHS 2016; DHS 2017; DHS 2018	MICS 2010; DHS 2013; MICS 2017; DHS 2019	SHDH 2020; MICS 2006	DHS 2012; DHS 2017	DHS 2010; Coverage Evaluation Survey 2011; Immunization Coverage Survey 2014; DHS 2015-16	DHS 2011; Immunization Coverage Survey 2012; DHS 2016; UNICS 2017	MICS 2011; MICS 2013-14; Immunization coverage survey 2015	DHS 2018; Expanded Program on Immunization Survey 2011; DHS 2013-14	DHS 2010-11; MICS 2014; DHS 2015; MICS 2019
Institutional Delivery	MICS 2013-14; DHS 2015-16; DHS 2010	MICS 2015; DHS 2018; EDSM-V 2012-13	MICS 2011; MICS 2015	DHS 2011; AIS 2015	DHS 2015-16; MICS 2009-10	ENISED 2015; EDSN-MICS IV 2012	DHS 2013; MICS 2016-17; MICS 2011; DHS 2018	DHS 2017-18; DHS 2012-13	DHS 2014-15; DHS 2010	DHS 2010-11; DHS 2012-13; DHS 2014; DHS 2015; DHS 2016; DHS 2017; DHS 2018	MICS 2010; DHS 2013; MICS 2017; DHS 2019	SHDH 2020; MICS 2006	DHS 2012; DHS 2017	DHS 2010; AIS 2011-12; DHS 2015-16	DHS 2011; DHS 2016	MICS 2011; MICS 2013-14	DHS 2013-14; DHS 2018	DHS 2010-11; MICS 2014; DHS 2015; MICS 2019
Postnatal care for mothers	DHS 2015-16; MICS 2013-14; DHS 2010	DHS 2018; MICS 2015; EDSM-V 2012-13	MICS 2011; MICS 2015	AIS 2015	DHS 2015-16	EDSN-MICS IV 2012	DHS 2013; MICS 2016-17; DHS 2018	DHS 2017-18; DHS 2012-13	DHS 2014-15; DHS 2010	DHS 2012-13; DHS 2015; DHS 2016; DHS 2017; DHS 2018	DHS 2013; MICS 2017; DHS 2019	SHDH 2020; MICS 2006	DHS 2012; DHS 2017	DHS 2010; DHS 2015-16	DHS 2011; DHS 2016	MICS 2013-14	DHS 2013-14; DHS 2018	DHS 2010-11; MICS 2014; DHS 2015; MICS 2019
Skilled attendant at delivery	DHS 2015-16; DHS 2010; MICS 2013-14	DHS 2018; EDSM-V 2012-13; MICS 2015; MICS 2009-10	MICS 2015; MICS 2011	AIS 2015; DHS 2011	DHS 2015-16; MICS 2009-10	ENISED 2015; EDSN-MICS IV 2012	DHS 2013; MICS 2011; MICS 2016-17; DHS 2018	DHS 2017-18; DHS 2012-13	DHS 2014-15; DHS 2010	DHS 2010-11; DHS 2012-13; DHS 2014; DHS 2015; DHS 2016; DHS 2017; DHS 2018	MICS 2010; DHS 2013; MICS 2017; DHS 2019	SHDH 2020; MICS 2006	DHS 2012; DHS 2017	DHS 2010; AIS 2011-12; DHS 2015-16	DHS 2011; DHS 2016	MICS 2011; MICS 2013-14	DHS 2013-14; DHS 2018	DHS 2010-11; MICS 2014; DHS 2015; MICS 2019
Oral rehydration salts treatment of diarrhea	DHS 2010; MICS 2013-14; DHS 2015-16	MICS 2009-10; MICS 2015; DHS 2018; EDSM-V 2012-13	MICS 2011; MICS 2015	AIS 2015; DHS 2011	MICS 2009-10; DHS 2015-16	ENISED 2015; EDSN-MICS IV 2012	DHS 2013; MICS 2011; MICS 2016-17; DHS 2018	DHS 2017-18; DHS 2012-13	DHS 2010; DHS 2014-15	DHS 2010-11; DHS 2012-13; DHS 2014; DHS 2015; DHS 2016; DHS 2017; DHS 2018	MICS 2010; DHS 2013; MICS 2017; DHS 2019	MICS 2006	DHS 2012; DHS 2017	DHS 2010; DHS 2015-16	DHS 2011; DHS 2016	MICS 2011; MICS 2013-14	DHS 2013-14; DHS 2018	DHS 2010-11; MICS 2014; DHS 2015; MICS 2019
Vitamin A Supplementation, Full Coverage	DHS 2010; DHS 2015-16	DHS 2018; EDSM-V 2012-13; MICS 2009-10	MICS 2011	DHS 2011	MICS 2009-10; DHS 2015-16	EDSN-MICS IV 2012	DHS 2018; DHS 2013; MICS 2011	DHS 2012-13; DHS 2017-18	DHS 2010; DHS 2014-15	DHS 2010-11; DHS 2012-13; DHS 2014; DHS 2015; DHS 2016; DHS 2017; DHS 2018	MICS 2010; DHS 2013	MICS 2006; Somalia Micronutrient Survey 2019-2020	DHS 2012; DHS 2017	DHS 2010; DHS 2015-16	DHS 2011; DHS 2016	MICS 2011	DHS 2013-14; DHS 2018	DHS 2015; DHS 2010-11; MICS 2014
NUTRITION SPECIFIC INDICATORS																		
Pregnant women who received iron folic acid supplementation or syrup for 90+days	DHS 2015-16; DHS 2010	n/a	n/a	n/a	n/a	n/a	DHS 2018; DHS 2013	n/a	DHS 2014-15; DHS 2010	n/a	n/a	n/a	n/a	n/a	DHS 2012; RISKESDAS 2013; DHS 2017	n/a	n/a	DHS 2015-16; DHS 2010
Exclusive breast feeding	MICS 2013-14; DHS 2015-16; DHS 2010	n/a	n/a	n/a	n/a	n/a	DHS 2013; MICS 2011; MICS 2016-17; DHS 2018	n/a	DHS 2010; DHS 2014-15	n/a	n/a	n/a	n/a	n/a	DHS 2017; DHS 2012	n/a	n/a	MICS 2013-14; DHS 2015-16; DHS 2010
Minimum Acceptable Diet	DHS 2010; DHS 2015-16; MICS 2013-14	n/a	n/a	n/a	n/a	n/a	DHS 2013; MICS 2016-17; DHS 2018	n/a	DHS 2010; DHS 2014-15	n/a	n/a	n/a	n/a	n/a	DHS 2017; DHS 2012	n/a	n/a	DHS 2010; DHS 2015-16; MICS 2013-14

APPENDIX B

Data Sources *(continued)*

INDICATOR / SOURCE (YEAR)	Afghanistan	Bangladesh	Burkina Faso	Cambodia	Cameroon	Central African Republic	Chad	Cote d'Ivoire	DRC	Ethiopia	Ghana	Guatemala	Guinea	Haiti	Indonesia	Kenya	Liberia	Madagascar
EDUCATION INDICATORS																		
Adjusted net enrollment rate; lower secondary; both sexes (%)	n/a	WDI 2010, 2011, 2012, 2013, 2015, 2016, 2017, 2018	n/a	n/a	WDI 2012, 2013, 2014, 2015, 2016	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Adjusted net enrollment rate; lower secondary; female (%)	n/a	WDI 2010, 2011, 2012, 2013, 2015, 2016, 2017, 2018	n/a	n/a	WDI 2012, 2013, 2014, 2015, 2016	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Lower secondary completion rate; both sexes (%)	n/a	WDI 2010, 2011, 2013, 2016	n/a	n/a	WDI 2011, 2013, 2014, 2015, 2016, 2017, 2018	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Lower secondary completion rate; female (%)	n/a	WDI 2010, 2011, 2013, 2016	n/a	n/a	WDI 2011, 2013, 2014, 2015, 2016, 2017, 2018	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
GFF HEALTH FINANCING INDICATORS																		
Domestic General Government Health Expenditure (DGGHE), per capita (US$)	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017
Sum of Domestic General Government Health Expenditure (DGGHE) as share of General Government Expenditure (%)	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017
Sum of Out-of-pocket spending on health, per capita (US$)	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017
GFF HEALTH FINANCING - COUNTRY SPECIFIC INDICATORS																		
Share of government budget allocated to health (%)	Boost 2016-2018	2020-2021 Health Budget Brief	MOH annual statistics report 2016-2018; MOH Administrative and Finance Department for 2019	Open Budget Surveys 2016-2019	Boost 2016-2018; Ministry of Health Finance Department for 2019	Fiscal Space Analysis for the health sector report 2019	Ministry of Public Health Finance Department report	Ministry of Health Finance Department	Budget (Program-Based Budgeting)	Boost 2016-2018	Ministry of Health Budget Unit	Budget Law Decrees 2017-2020	BOOST 2016-2017; Ministry of Health Annual Report 2018-2019	Budget Laws 2016-2018	NHA 2017	Boost 2016-2018	Boost 2016-2018	Q4 Budget Reports for 2016-2018 and Q2 for 2019
Health budget execution (%)	Boost 2016-2018	2020-2021 Health Budget Brief	MOH annual statistics report 2016-2018; MOH Administrative and Finance Department for 2020	n/a	Ministry of Health Finance Department for 2019	Fiscal Space Analysis for the health sector report 2019	Ministry of Public Health Finance Department report	Ministry of Health Finance Department	Budget (Program-Based Budgeting)	Boost 2016-2018	Ministry of Health Budget Unit	n/a	BOOST 2016-2017; Ministry of Health Annual Report 2018-2019	Budget Laws 2016	NHA 2017	Boost 2016-2018	Boost 2016-2018	Q4 budget reports for 2016-2018 and Q2 for 2019
Share of health expenditure going to frontline providers (%)	Boost 2016-2018	Medium Term Budget Framework 2019-2020	n/a	n/a	Boost 2017-2018	n/a	n/a	n/a	Budget (Program-Based Budgeting)	Boost 2016-2018	n/a	n/a	n/a	n/a	NHA 2017	Boost 2016-2018	Boost 2016-2018	n/a
Domestic health expenditures as a percentage of total domestic government expenditures	n/a		n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Budget planning and allocation are improved: Operational plans approved including activities and budgets for achievement of DLIs	n/a	Ministry of Health and Family Welfare	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Procurement process is improved using IT: Percentage of National Competitive Tenders (NCTs) using electronic government procurement (e-GP) system issued by MOHFW	n/a	Ministry of Health and Family Welfare	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Number of DPS (*division provinciale de la santé*) implementing single contract	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	Single contract quarterly evaluation done by MOH	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Domestic health expenditure allocated to RMNCAH	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	Budget (Program-Based Budgeting)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Domestic budget execution on RMNCAH+ 3 diseases (TB, Malaria, HIV/AIDS)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	Budget (Program-Based Budgeting)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Percent of PHC facilities having all drugs from the MoH list of essential drugs available	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	Service Availability and Readiness Assessment (SARA)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
CBHI coverage: percent of districts with functional community-based health insurance (CBHI) schemes	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	Ethiopian Health Insurance Agency Administrative report	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Proportion of counties aligning planning and budgeting processes (%)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	RMNCAH Technical Assistance Multi-Donor Trust Fund Annual Report	n/a	n/a
Proportion of counties allocating at least 30 percent of budget to health (%)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	RMNCAH Technical Assistance Multi-Donor Trust Fund Annual Report	n/a	n/a
Number of accredited facilities receiving payments for services financed through the Fee-for-Service (FFS) mechanism (public and private)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Domestic resource contribution to the Basic Health Care Provision Fund (BHCPF)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Number of facilities implementing RBF	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Percentage of health facilities receiving funds through the direct health facility financing (DHFF) program	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Amount of outpatient Health Equity Fund services in target areas	n/a	n/a	n/a	National Health Congress 2018 and 2019 reports	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

APPENDIX B

Data Sources *(continued)*

INDICATOR / SOURCE (YEAR)	Malawi	Mali	Mauritania	Mozambique	Myanmar	Niger	Nigeria	Pakistan	Rwanda	Senegal	Sierra Leone	Somalia	Republic of Tajikistan	Tanzania	Uganda	Vietnam	Zambia	Zimbabwe
EDUCATION INDICATORS																		
Adjusted net enrollment rate; lower secondary; both sexes (%)	n/a	n/a	n/a	WDI 2010, 2011, 2012, 2013, 2014, 2015	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Adjusted net enrollment rate; lower secondary; female (%)	n/a	n/a	n/a	WDI 2010, 2011, 2012, 2013, 2014, 2015	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Lower secondary completion rate; both sexes (%)	n/a	n/a	n/a	WDI 2010, 2011, 2012, 2013, 2014, 2015	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Lower secondary completion rate; female (%)	n/a	n/a	n/a	2010, 2011, 2012, 2013, 2014, 2015 WDI	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
GFF HEALTH FINANCING INDICATORS																		
Domestic General Government Health Expenditure (DGGHE), per capita (US$)	NHA 2020	WHO-GHED 2015-2017	NHA and Household Survey (EPCV)	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	n/a	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017
Sum of Domestic General Government Health Expenditure (DGGHE) as share of General Government Expenditure (%)	NHA 2020	WHO-GHED 2015-2017	NHA and Household Survey (EPCV)	n/a	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	n/a	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017
Sum of Out-of-pocket spending on health, per capita (US$)	NHA 2020	WHO-GHED 2015-2017	NHA and Household Survey (EPCV)	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	n/a	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017	WHO-GHED 2015-2017
GFF HEALTH FINANCING - COUNTRY SPECIFIC INDICATORS																		
Share of government budget allocated to health (%)	Ministry of Health Department of Planning and Policy Development	Boost 2016-2019	Budget 2016-2019	Boost 2016-2018	Myanmar NHA 2016-2018	Budget 2016-2019	Health Budget 2016-2019	Poverty Reduction Strategy Paper (Finance Division)	Finance Laws 2016-2019	* Boost 2016-2018 Department of General Administration and Equipment (DAGE) report 2019*	Boost 2016-2018; 2019: FY 2020 budget profile	n/a	Budget data from Ministry of Finance	Boost 2016-2017; 2018 from NHA	Budget data from Ministry of Finance	n/a	Financial reports 2017 and 2018	Financing and Implementation of the National Health Strategy 2016-2020 – A Mid-Term Review
Health budget execution (%)	Ministry of Health Department of Planning and Policy Development	Boost 2016-2018	MOH annual report 2017-2020	Boost 2016-2018	Boost 2016-2018	Budget 2016-2019	Q4 Budget Execution Report 2018-2019	Annual Budget publications 2016-2018	Integrated Financial Management Information System	Department of General Administration and Equipment (DAGE) report	Boost 2016-2018	n/a	Budget data from Ministry of Finance	Boost 2016-2017; 2018 from NHA	Budget data from Ministry of Finance	n/a	Health Financing Note on Zambia 2017-2019	Financing and Implementation of the National Health Strategy 2016-2020 – A Mid-Term Review
Share of health expenditure going to frontline providers (%)	n/a	n/a	n/a	Boost 2016-2018	n/a	NHA	NHA 2017	Official Reporting and Auditing System (PIFRA)	Integrated Financial Management Information System	Boost 2016-2018	Boost 2016-2018	n/a	Ministry of Finance	Boost 2016-2017	Budget data from Ministry of Finance	n/a	n/a	n/a
Domestic health expenditures as a percentage of total domestic government expenditures	n/a	n/a	n/a	Electronic State Financial Management System (e-SISTAFE)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Budget planning and allocation are improved: Operational plans approved including activities and budgets for achievement of DLIs	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Procurement process is improved using IT: Percentage of National Competitive Tenders (NCTs) using electronic government procurement (e-GP) system issued by MOHFW	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Number of DPS (*division provinciale de la santé*) implementing single contract	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Domestic health expenditure allocated to RMNCAH	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Domestic budget execution on RMNCAH+ 3 diseases (TB, Malaria, HIV/AIDS)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Percent of PHC facilities having all drugs from the MoH list of essential drugs available	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
CBHI coverage: percent of districts with functional community-based health insurance (CBHI) schemes	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Proportion of counties aligning planning and budgeting processes (%)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Proportion of counties allocating at least 30 percent of budget to health (%)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Number of accredited facilities receiving payments for services financed through the Fee-for-Service (FFS) mechanism (public and private)	n/a	n/a	n/a	n/a	n/a	n/a	Federal Ministry of Health	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Domestic resource contribution to the Basic Health Care Provision Fund (BHCPF)	n/a	n/a	n/a	n/a	n/a	n/a	National Budget	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Number of facilities implementing RBF	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	DHIS2	n/a	n/a	n/a	n/a
Percentage of health facilities receiving funds through the direct health facility financing (DHFF) program	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	Direct Health Facility Financing quarterly reports	n/a	n/a	n/a	n/a
Amount of outpatient Health Equity Fund services in target areas	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

APPENDIX B

Data Sources *(continued)*

INDICATOR / SOURCE (YEAR)	Afghanistan	Bangladesh	Burkina Faso	Cambodia	Cameroon	Central African Republic	Chad	Cote d'Ivoire	DRC	Ethiopia	Ghana	Guatemala	Guinea	Haiti	Indonesia	Kenya	Liberia	Madagascar
GFF HEALTH FINANCING - COUNTRY SPECIFIC INDICATORS (continued)																		
Proportion of health facilities covered by PBF	n/a	n/a	n/a	n/a	n/a	Program-Based Financing Portal	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Number of PBF covered districts	n/a	n/a	n/a	n/a	n/a	n/a	n/a	Program-Based Financing Portal	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Number of people covered by the CMU (*couverture maladie universelle*)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	Caisse Nationale d'Assurance Maladie (CNAM) database	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Number of poor and vulnerable covered by CMU (*couverture maladie universelle*)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	Caisse Nationale d'Assurance Maladie (CNAM) database	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Number of technical health personnel assigned to primary care	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Number of trained and active community healthcare workers (CHWs)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Number of children under 5 enrolled in the free health care policy	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Number of districts implementing RBF	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Number of health centers participating in RBF	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
OTHERS																		
Resource Mapping	Data on domestic financing from government budgets and expenditure reports. Data on external financing based on submissions by development partners	Data on domestic financing from government budgets and expenditure reports. Data on external financing based on submissions by development partners	Data on domestic financing from government budgets and expenditure reports. Data on external financing based on submissions by development partners. Technical support from CHAI.	Data on domestic financing from government budgets and expenditure reports. Data on external financing based on submissions by development partners	Data on domestic financing from government budgets and expenditure reports. Data on external financing based on submissions by development partners	Data on domestic financing from government budgets and expenditure reports. Data on external financing based on submissions by development partners	n/a	Data on domestic financing from government budgets and expenditure reports. Data on external financing based on submissions by development partners	Data on domestic financing from government budgets and expenditure reports. Data on external financing based on submissions by development partners	Data on domestic financing from government budgets and expenditure reports. Data on external financing based on submissions by development partners	n/a	n/a	n/a	n/a	n/a	n/a	Data on domestic financing from government budgets and expenditure reports. Data on external financing based on submissions by development partners	Data on domestic financing from government budgets and expenditure reports. Data on external financing based on submissions by development partners

APPENDIX B

Data Sources *(continued)*

INDICATOR / SOURCE (YEAR)	Malawi	Mali	Mauritania	Mozambique	Myanmar	Niger	Nigeria	Pakistan	Rwanda	Senegal	Sierra Leone	Somalia	Republic of Tajikistan	Tanzania	Uganda	Vietnam	Zambia	Zimbabwe
GFF HEALTH FINANCING - COUNTRY SPECIFIC INDICATORS (continued)																		
Proportion of health facilities covered by PBF	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Number of PBF covered districts	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Number of people covered by the CMU (*couverture maladie universelle*)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a		n/a	n/a	n/a
Number of poor and vulnerable covered by CMU (*couverture maladie universelle*)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a		n/a	n/a	n/a
Number of technical health personnel assigned to primary care	n/a	n/a	n/a	Human Resources for Health Information system (SIP)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a		n/a	n/a	n/a
Number of trained and active community healthcare workers (CHWs)	n/a	n/a	n/a	SISMA (Sistema de Informação de Saúde para Monitoria e Avaliação)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a		n/a	n/a	n/a
Number of children under 5 enrolled in the free health care policy	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	Agence de la Couverture Maladie Universelle (ACMU) report	n/a	n/a	n/a	n/a		n/a	n/a	n/a
Number of districts implementing RBF	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	Results Based Financing Unit	n/a	n/a	n/a
Number of health centers participating in RBF	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	Results Based Financing Unit	n/a	n/a	n/a
OTHERS																		
Resource Mapping	Data on domestic financing from government budgets and expenditure reports. Data on external financing based on submissions by development partners	n/a	n/a	Data on domestic financing from government budgets and expenditure reports. Data on external financing based on submissions by development partners	n/a	n/a	n/a	n/a	n/a	Data on domestic financing from government budgets and expenditure reports. Data on external financing based on submissions by development partners	Data on domestic financing from government budgets and expenditure reports. Data on external financing based on submissions by development partners	Data on domestic financing from government budgets and expenditure reports. Data on external financing based on submissions by development partners	Data on domestic financing from government budgets and expenditure reports. Data on external financing based on submissions by development partners	Data on domestic financing from government budgets and expenditure reports. Data on external financing based on submissions by development partners	Data on domestic financing from government budgets and expenditure reports. Data on external financing based on submissions by development partners	n/a	Data on domestic financing from government budgets and expenditure reports. Data on external financing based on submissions by development partners	Data on domestic financing from government budgets and expenditure reports. Data on external financing based on submissions by development partners

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