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**Letter from the Director**

This has been a landmark year for global health. At various international conferences, world leaders and advocates reaffirmed their commitments to ending the preventable deaths of women, children, and adolescents by 2030, achieving universal health coverage (UHC) by strengthening primary health care, and closing the enormous global financing gap to achieve health and well-being for all.

For the Global Financing Facility for Women, Children and Adolescents (GFF), the past year was marked by two exciting milestones in our mission to expand the delivery of quality, affordable health care to the most vulnerable people around the globe. In November 2018, thanks to generous support from the governments of Burkina Faso, Canada, Cote D’Ivoire, Denmark, Germany, Japan, The Netherlands, Norway, Qatar, and the United Kingdom, as well as the Bill and Melinda Gates Foundation, the European Commission, Laerdal Global Health, and the Susan T. Buffett Foundation, the world pledged US$1 billion in additional funding for the GFF Multi-Donor Trust Fund. With this increased capacity, in May 2019 the GFF announced that it has enlarged its reach to an additional nine countries, bringing the total number of countries supported by the GFF partnership to 36.

This ability to extend the GFF’s impact is more urgent than ever. The countries supported by the partnership—one-third of which are classified as fragile and conflict-affected states—experience many of the world’s most pressing challenges in sexual and reproductive health, and they have the poorest outcomes in maternal, newborn, child, and adolescent health and nutrition. The latest data from the World Bank and the World Health Organization show that without significant changes in health financing for these countries, even by the year 2030 UHC will remain out of reach for billions of people.

Addressing these challenges starts with strong country leadership. GFF partner countries share a commitment to put women, children, and adolescents at the forefront of their health reform efforts and to invest in smart, sustainable health systems to ensure that no one is left behind. This report showcases how GFF-supported countries are taking ownership of their development, financing, and results agendas and are leading the way to close their health financing gaps.

In the four years since its founding, the GFF partnership has started on the path to transform development assistance for health by aligning external resources with domestic financing and linking these resources to proven performance in improving women’s, children’s, and adolescent health. Five core elements of the GFF partnership have contributed to our early results:

1. **Country-led**: GFF partners—governments, donors, technical partners, civil society and the private sector—are coming together to support government-led investment cases that prioritize the use of available resources and high-impact health services to benefit the poorest and most vulnerable communities.

2. **Alignment**: By aligning external funding around a country-led, country-owned plan, the GFF approach enables all partners to make more cost-effective and efficient investment decisions in health and nutrition.

3. **Evidence-driven**: The GFF approach promotes smarter decision-making and better health outcomes, using the most rigorous data and linking payments to achieving agreed targets for increasing access to and quality of services and domestic resource disbursements.

4. **Leverage**: By catalyzing innovative financing mechanisms—such as development impact bonds and the linking of GFF Trust Fund grants to concessional financing through the World Bank’s International Development Association (IDA)—the GFF is multiplying available resources for women’s, children’s, and adolescent health and is enabling countries to strengthen their health systems on a national scale.

5. **PHC to UHC**: Through their national platforms, countries are translating their visions of UHC into practice, with a focus on building well-functioning, integrated primary health care (PHC) systems that provide the necessary foundation to accelerate progress toward quality, affordable care for all.

Although the GFF partnership is still very young, I am convinced that if we stay focused on these five pillars, we will see continued progress in health equity toward our goal to give all women, children, and adolescents the opportunity to live healthy, productive lives.

I am honored to work with our many GFF partners around the globe in governments, civil society, international organizations, philanthropy, and business who share our commitment to this mission. This report shows what’s possible when all these partners come together to prioritize quality, sustainable results and empower countries and their citizens to lead.

Muhammad Ali Pate
Director, Global Financing Facility

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“The ability to extend the GFF’s impact is more urgent than ever.”
Big Year, Bigger Challenges

Despite the significant recent progress in global health and development outcomes, equitable access to affordable, quality health care still remains out of reach for nearly half the world’s population. Paying for the care they need causes financial hardship for more than 935 million people and pushes nearly 90 million people into extreme poverty every year. If current trends continue, up to 5 billion people will remain unable to access essential health care as of 2030—the deadline that world leaders have set for achieving universal health coverage (UHC) and the Sustainable Development Goals (SDGs). These are the stark messages of the 2019 Global Monitoring Report, which calls for countries to increase their investments in primary health care (PHC) as the pathway to achieving UHC.1

Quite simply, this is an urgent matter of life and death for women, children, and adolescents, who are most affected by the continuing lack of access to quality, affordable primary health care. An estimated 6.2 million children and adolescents under age 15 died in 2019, and more than 290,000 women died due to complications during pregnancy or childbirth in 2017. The latest estimates show that 2.8 million pregnant women and newborns die every year—one every 11 seconds—mostly of preventable causes.2 Hundreds of millions more are at high risk of not getting the health and nutrition they need to thrive, particularly in regions mired in instability and conflict.

Yet in most low and lower-middle-income countries today, health financing is too low, too inefficient, and too inequitable to address these challenges. Spending on health care from all sources averages just US$40 per capita in lower-middle-income countries, as compared with spending of US$455 per capita in upper-middle-income countries and more than US$3,100 per capita in high-income countries. The World Bank estimates that 54 low-income and lower-middle-income countries will need an additional US$176 billion by 2030 to finance an essential package of quality services for all.3

This is where the Global Financing Facility for Women, Children and Adolescents (GFF) partnership comes in: To help the poorest countries close their health financing gaps and improve the health and nutrition of women, children, and adolescents. In only its fourth year, as of 2019 the GFF has expanded its support to 36 countries, a ninefold expansion from the 4 countries the GFF supported when it was established in 2015.4 This growth was spurred by a strong expression of demand for the GFF-country-led approach, which aligns resources from international partners and links them to domestic health plans and budgets to drive better results.

The most recent growth in the GFF’s work was made possible by more than US$1 billion in pledges of additional financing over the past year for the GFF Trust Fund. This included continuing generous support from the GFF’s early champions, including the Bill & Melinda Gates Foundation, the governments of Canada, Norway, and the United Kingdom, and MSD for Mothers, as well as support from 10 new donors in 2018-19.5 Reaching these two milestones, GFF is well on the way to achieving its goal of supporting the 50 countries with the world’s highest maternal and child mortality burdens and financing needs.

While results vary widely from country to country, the GFF’s country-led and partnership-driven approach is already reaping dividends for the health of millions of poor and vulnerable women, children, and adolescents in several ways:

- Increasing domestic resource use and mobilization: Per-capita health expenditure financed by domestic sources has increased in 19 of the 27 GFF countries highlighted in this report, according to the most recent available data. The impact of these increases is translating into more resources for underserved communities across these nations. For example, in Kenya all 47 counties met the criteria of increased allocations to health in their budgets over the past two years, with some allocating more than 30 percent of their budget to health (well above the 20 percent requirement). Nineteen of the 47 counties in Kenya increased their budget allocations for health by at least 5 percent.

- Improving health outcomes: The most recent data available show that neonatal and under-five mortality have decreased in 27 countries receiving GFF support, and the adolescent fertility rate has decreased in 26 of them. These outcomes are the result of expanding the delivery of lifesaving health care for women, children, and adolescents. In Tanzania, for example, antenatal care improved from an average of 35.8 percent of pregnant women in 2014 to 64.1 percent in 2016, with almost one-third of Tanzania’s regions reaching 70 percent or more of pregnant women. Alongside these improvements in care in Tanzania were increases in the regional average for the share of births at a health facility, which rose from 67.0 percent in 2014 to 79.6 percent in 2016.6

- Catalyzing innovative financing: The GFF has helped mobilize more than US$2 billion in private capital to date, deploying a range of innovative financing tools. In partnership with World Bank Treasury, the GFF supported a Sustainable Development Bond series focused on the health and nutrition of women and children. The GFF Trust Fund’s co-financing and loan buy-down grants make this financing more accessible to GFF countries. In 2019, the GFF worked with Grand Challenges Canada, the World Bank, and other partners to launch a groundbreaking Development Impact Bond focused on newborn health in Cameroon, which seeks to save the lives of at least 2,200 infants each year by expanding the use of Kangaroo Mother Care.

4 In April 2019, the GFF expanded its support to 36 new countries—Chad, Ghana, Mauritania, Niger, Pakistan, Senegal, Tajikistan, Zambia, and Zimbabwe.
5 The 10 new donors that joined the GFF Trust Fund at the replenishment event were the European Commission, Laurels Global Health, and the Susan T. Buffett Foundation, along with the governments of Bolivia, France, Côte d’Ivoire, Denmark, Germany, Japan, the Netherlands, and Qatar.
GFF Countries Are Showing What’s Possible

This annual report contains profiles of 27 of the 36 countries currently supported by the GFF, along with in-depth case studies of 7 countries. Following are some highlights of the GFF partnership in action.

Advancing Health Equity in Cameroon through Performance-Based Financing in Cameroon

Despite its lower-middle-income status, Cameroon still suffers from poor basic health outcomes and widespread inequalities. The country’s investment case is focused on improving allocative efficiency—shifting more public health expenditures toward primary and secondary care rather than tertiary care and concentrating resources on the four most underserved regions of the country. With support from the GFF partners, the government aims to increase the share of the national health budget allocated to primary and secondary care from 8 percent of the health budget in 2017 to almost 20 percent by the end of 2020. Using a performance-based approach and health care vouchers, these additional resources are improving the quality of frontline health facilities, stimulating demand for health services, and making care affordable for the poorest families.

Advocating for Domestic Resource Mobilization in Côte d’Ivoire

A key objective of the GFF is to ensure that as a country’s economy grows, so do its domestic investments targeted to the health needs of the most-vulnerable population groups. Developed using the GFF approach, the investment case for Côte d’Ivoire calls for at least a 15 percent annual increase in the public health budget—a commitment made at the GFF replenishment event in Oslo in November 2018. All stakeholders—the government, the private sector, civil society, and other development partners—committed to come together and support an ambitious reform agenda aimed at improving the equity and efficiency of spending. Under the leadership of the prime minister and the minister of health and with the support of the GFF, Côte d’Ivoire established the National Platform for Health Financing, which held its first meeting in July 2019. This multisectoral platform aims to ensure effective implementation of these commitments and to better align external resources with the government’s agenda and budget.

Expanding Provision of a Basic Package of Health Services to Accelerate UHC in Nigeria

In Nigeria, the government has struggled to translate economic growth into more public revenues. Public spending on health remains among the lowest in the world, even though the Basic Health Care Provision Fund (BHCPF) was mandated by the National Health Act of 2014 to ensure that all Nigerians can access a basic minimum package of health services. To build political will and help unlock necessary additional financing, the GFF Trust Fund and the Bill and Melinda Gates Foundation provided seed financing in three states to initiate the implementation of the BHCPF in order to improve coverage there. The GFF Trust Fund also financed an impact evaluation in these three states. The trust created by the initial GFF investment, as well as technical assistance provided by development partners, helped convince Nigerian policymakers to increase the budget allocation for BHCPF. It also showed how a gradual expansion of the package is within reach as the economy recovers and as reforms to increase and diversify tax revenue are implemented.

Guiding Cost-Effective Investment Choices in the Democratic Republic of Congo (DRC)

As countries with limited resources move toward UHC, the investment case guides policymakers through difficult choices on which health services to expand and which groups to target first. In the DRC, policymakers realized that the 2016–20 National Health Plan (Plan National de Santé or PNDS) was too ambitious to implement given the country’s current resource base. They used the investment case to prioritize PNDS interventions, focusing first on delivering a limited package of reproductive, maternal, newborn, and child health services as well as HIV, tuberculosis, and malaria treatment. The investment case was then used to update the 2019–22 PNDS. To ensure that these health priorities are adequately financed—not only by development partners but also by government resources—the GFF is providing technical assistance to link the investment case to the government planning and budgeting cycle.

Improving Health Budget Implementation in Myanmar

Accelerating progress toward UHC requires increasing public, pooled resources for the health sector. As part of its support for increasing domestic resource mobilization, the GFF helps countries use existing resources better and raise the priority of health in the national budget. Ministers of finance face competing demands from various sectors even under the most favorable macroeconomic conditions, so the GFF equips country health teams with the evidence they need to make compelling budget requests. Improving the execution rate of the existing health budget is an important prerequisite before any increase is likely. In Myanmar, strong overall economic growth made more resources available for the health system, but due to weak public financial management only 64 percent of the health budget was being executed in 2017–18. The GFF is supporting the Ministry of Health with strategies and tools to strengthen its budget efficiency and help unlock additional resources for health.

Increasing Access to Primary Health Care to Underserved Communities

Mozambique’s investment case was developed through a consultative process that included adolescent girls in underserved communities. In response, the GFF and partners supported the government’s Primary Health Care Strengthening Program, a transformational effort to achieve predefined results for

Engaging Civil Society and Youth

Civil society organizations (CSOs) are essential to the GFF’s partnership model. They play an important role in elevating the voices of affected populations, advocating for resources and policies, for monitoring and accountability, for research and technical assistance, and for service delivery. At the global level, CSOs are represented in the GFF’s governance structure in the GFF Investors Group by two principal members and two alternate members, including one youth representative. CSO Investors Group representatives are selected for a two-year term in a process managed by the Partnership for Maternal, Newborn and Child Health (PMNCH), an NGO constituency that includes more than 600 members across all geographies.

At the country level, CSOs are an important partner in the development of investment cases, in service delivery, and in holding governments accountable for implementation of national plans and budgets. The GFF Trust Fund Committee agreed to support country-level civil society activities and capacity building. In 2019, a team comprising Management Sciences for Health, the GFF, and PMNCH announced the recipients of the first round of funding from the Small Grants Mechanism to Support Civil Society Engagement, Alignment, and Coordinated Action for Improved Women’s, Children’s, and Adolescents’ Health. Civil society coalitions from Burkina Faso, Cambodia, Cameroon, Kenya, Malawi, Mozambique, Nigeria, Rwanda, and Uganda are using these grants to increase civil society engagement in their national planning and multistakeholder platforms, as well as to improve coordinated advocacy and accountability activities.
The GFF supports government-led, multi-stakeholder platforms to develop and implement a national, prioritized health plan (an investment case) that aims to improve the health outcomes of women, children, and adolescents, strengthen health systems, and, over time, increase domestic financing for health and nutrition. The GFF partnership provides tailored support that allows each country to take its own course to providing quality, affordable care for all, but all GFF-supported countries share a set of common elements:

1. Investment Cases: GFF countries identify an existing coordination mechanism to bring the partners together or, if the mechanism is inadequate or lacking, they create a new or better one. Led by the government with support from the GFF team, partners come together through this country platform to develop a national, prioritized plan to end preventable deaths of women, children, and adolescents—known as the investment case. The investment case helps countries prioritize the most cost-effective interventions, products, and services to enable them to expand coverage, address system bottlenecks, and advance health equity as rapidly and efficiently as possible. The investment case also provides the government and all country partners with a common and clear understanding of the available sources of domestic and international financing and the funding gaps.

2. More and Better Funding: GFF-supported countries commit to mobilizing additional domestic resources for health and nutrition, and partners agree to align their support around the investment case. This includes grants provided by the GFF Trust Fund that are directly linked to World Bank financing from the International Development Association (IDA) or the International Bank for Reconstruction and Development (IBRD), currently at a ratio of 1:7. The GFF also supports the alignment of bilateral aid donors and other multilateral funders—such as the Global Fund for AIDS, Tuberculosis and Malaria and Gavi, the Vaccine Alliance—around country priorities and high-impact services, and it crowds in private-sector capital through innovative financing mechanisms.

3. Results Framework: In building the investment case, GFF countries adopt a core set of indicators against which they will monitor gaps and achievements in health financing reforms, health systems strengthening, and improvements in reproductive, maternal, newborn, child, and adolescent health and nutrition outcomes. During implementation, countries use this data to inform program decisions and funding allocations and to course-correct as needed. The investment case is updated regularly to reflect shifting disease burdens, fiscal changes, or other developments that emerge from the data.

The GFF: A Pathfinder for a New Era of Financing Development

The GFF is helping countries improve the alignment of their investment cases, the collaborative, collective, and learning process. It is critical for mobilizing new resources and for laying the groundwork for increased domestic and international financing to achieve the SDGs. 

Global Initiatives, Country Opportunities

Several global developments in 2018–19 provide a solid foundation for the GFF partnership to strengthen its impact over the next several years. First is the launch of the World Bank’s Human Capital Project, which is supporting countries’ efforts to accelerate more and better investments in people for greater equity and economic growth. With GFF Trust Fund grants directly linked to World Bank financing, GFF countries can benefit from increased support for health and nutrition. GFF and the Human Capital Project are mutually reinforcing, with countries ranking at the bottom of the Human Capital Index benefiting the most from GFF support. Many of these countries are affected by humanitarian crises and conflict, and they suffer from increasing coverage and quality of health and nutrition services for women, children, and adolescents. In the first year of implementation, preliminary assessments show that the Mozambique government has exceeded most of its targets.7 These include increasing the number, reach, and capacity of community health workers as well as the share of technical health workers assigned to the PHC network. The government has also increased the ratio of health spending to total domestic expenditures. These systemic shifts are saving lives: for example, in 42 logging districts, the percentage of births taking place in a health care facility jumped from 66 percent in 2017 to 80 percent by December 2018.

Global Action Plan for Healthy Lives and Well-Being For All

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Also in September 2019, the GFF joined 11 other multilateral agencies in signing the Global Action Plan for Healthy Lives and Well-Being For All. With just over 10 years left to achieve the SDGs, it is imperative that the international health and development community changes the way it works with partner countries and with one another—to let countries lead and mobilize more domestic resources for health. The Global Action Plan aims to strengthen international collaboration at the country level through 7 “accelerators,” such as health financing, primary health care, civil society engagement, and data systems and use. The GFF is a partner with Gavi, the Global Fund, WHO, and the World Bank on the Global Action Plan’s health financing accelerator, which promotes joint advocacy, joint technical support (such as the analysis of fiscal space), increased deployment of joint funding mechanisms, and increased consensus on what does and does not work in domestic financing policies to advance UHC. By aligning partner support around country investment cases, the collaborative, country-led GFF approach embodies the Global Action Plan, and the GFF will pave the way for the plan’s success.

Accelerating Progress toward UHC

Armed with more resources and partners in 2019, in its fifth year the GFF will step up its catalytic support to low- and lower-middle-income countries on their road to UHC. The GFF is helping countries prioritize the smartest, most efficient, and most cost-effective ways to deliver health care to women, children, and adolescents in underserved communities and mobilize more domestic financing so they can expand provision of a comprehensive package of quality, affordable essential health services to all their citizens. By linking financing to results and aligning support from international partners around country plans, the GFF serves as a powerful mechanism for dismantling bottlenecks to progress and helping countries implement the health financing reforms necessary to reach UHC.

7 These results were reported by the government but have yet to be independently verified.
8 Target 3.8.1 is coverage of essential health services delivered to the population; Target 3.8.2 is proportion of population with access, among the general and the most disadvantaged population; Target 3.8.1 and 3.8.2—ensuring that everyone has access to a basic package of essential health services and protecting people from out-of-pocket payments for health that cause financial hardship. The declaration states that prioritizing and expanding the delivery of investments in PHC is the cornerstone of a sustainable health system and the foundation for achieving UHC. It also emphasizes gender equality and the principle of leaving no one behind. This high-level commitment and the expectations of global and national accountability will further strengthen the enabling environment for GFF support to countries to accelerate their scale-up of PHC for UHC.
9 For more information on the Global Action Plan, visit: https://www.who.int/sdg/global-action-plan
GFF Stories: Investing in the Power of Women and Girls

Every year in 50 countries across the world, more than 5 million mothers and children die from preventable conditions and their economies lose billions of dollars to poor health and nutrition. This is in large part due to a significant financing gap for health and nutrition.

The GFF is a multi-stakeholder partnership that is helping governments in low-income countries transform how they prioritize and finance the health and nutrition of their people. The GFF supports governments to bring partners together in a country-led plan, prioritizing high-impact but underinvested areas around a country-led platform, and aligning all key stakeholders around a strong primary health care system; and mobilizing and coordinating the financial resources needed to accelerate progress for the most vulnerable populations, often in the hardest-to-reach regions.

1. developing an investment case and implementation plan for prioritizing reproductive, maternal, newborn, child and adolescent health and nutrition and a strong primary health care system;
2. strengthening a country-led platform that aligns all key stakeholders around this investment case and plan; and
3. mobilizing and coordinating the financial resources needed to accelerate progress for the most vulnerable populations, often in the hardest-to-reach regions.

The GFF Trust Fund acts as a catalyst for financing, with countries using modest GFF Trust Fund grants to significantly increase their domestic resources alongside World Bank financing, aligned external financing, and private sector resources.

The work of the GFF partnership touches the lives of women and girls in some of the world’s poorest countries and regions. The photos in this exhibit tell just a few of their stories, as well as the stories of the people working to make a difference.

In Bangladesh, about half of girls are married before the age of 18 and one-third give birth as teenagers—increasing the risk of complications before and after delivery including neonatal mortality. The GFF’s investments in Bangladesh include activities to keep girls in school, and ultimately help delay marriage and child birth, such as incorporating health and hygiene into the school curriculum as well as constructing separate toilets for girls.

John-Pierre is a primary school principal and a community health worker in Kenge, the Democratic Republic of Congo. He spends his evenings visiting his community members. During these visits, John-Pierre informs members of communities about proper hand washing and malaria-prevention techniques that could save their lives. The community performance-based financing scheme is implemented by the Ministry of Public Health and aims to strengthen relationships between communities and health facilities, further stimulating demand.

In Burkina Faso, the leading cause of death for children under five is malaria and nearly 20 percent of children nationwide are stunted. To address these and other health challenges, the government has committed to increasing its spending on health from 11% to 15% of its budget and has deployed more than 17,000 community health workers nationwide. In Zieenga, Bibata has brought her children to a community health center to receive anti-malaria drugs. Health workers also use this visit to check Bibata’s kids for signs of malnutrition.

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“We can show the whole world that we women have value, that we can say no to pregnancy—no to an increase in poverty,” says Valéria (on the right). With GFF support, the Government of Mozambique is investing in a national scale-up of a school health program that seeks to improve sexual and reproductive health and rights of adolescent girls in a country, where more than half of the population is under 15 years old.

Damaris and her daughter Joyce live in Wamba, Nigeria. As it works toward Universal Health Coverage, the government of Nigeria is supporting investments in free family planning services for women and girls in poor communities. Free access to modern family planning methods has enabled Damaris to go back to school and focus on her studies to become a health worker before having her second child.

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“exclusive breastfeeding and Kangaroo Mother Care (KMC), which involves holding the baby skin-to-skin on the mother’s or other caregiver’s chest, are high-impact investments that save lives. In 2019, the GFF, Grand Challenges Canada, Fondation Kangourou Cameroun, Social Finance, MaRS Centre for Impact Investing, Nutrition International, and the World Bank, launched a first-of-its-kind development impact bond in Cameroon to scale up KMC in the country and to help newborns survive and thrive.

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“It’s important to have registration to enter school, for employment and travel,” says Ayodele, 35. At the Comprehensive Health Centre in Arakole, she will get a birth certificate for her 1-month old daughter Ayodele Happiness. Despite functional registration centers in Nigeria, implementation of the civil registration and vital statistics program still faces very low coverage because the number of registration centers is inadequate. The GFF supports the strengthening of CRVS systems by ensuring that CRVS systems are included in investment cases and helps identify gaps and key interventions required to strengthen CRVS.
This report provides the most current and available information, data, and results on the 27 countries that had received support from the GFF partnership as of mid-2019. The profiles summarize the health status for women, children, and adolescents and the status of the GFF-supported process in each country. The next GFF annual report will also include profiles for the 9 additional countries that joined the partnership in 2019.

The following pages also contain in-depth case studies for 7 GFF countries that show promising results in improving health outcomes for women, children, and adolescents and in ensuring that health systems are sustainably financed. It is important to note that the results reported here are not attributable to any single source of funding. Nevertheless, these results underscore the power of the GFF approach: to increase domestic resource mobilization, align and leverage support from multiple partners and funding sources around country plans, and link financing to results with the goal of improving health outcomes at scale.

Because each country’s investment case is unique, the sources of data and indicators used to assess progress and bottlenecks also differ by country. Reliable data collection and reporting remains a challenge in many GFF-supported countries, so the GFF is also helping to strengthen country capacity in these areas.

Core Health Financing Indicators
- Health expenditure per capita financed from domestic sources
- Ratio of government health expenditure to total government expenditure
- Percent of current health expenditure devoted to primary health care
- Incidence of financial catastrophe due to out-of-pocket payments

GFF Core Impact Indicators
- Maternal mortality ratio
- Under-5 mortality rate
- Newborn mortality rate
- Adolescent birth rate
- Birth spacing (proportion of the most recent children age 0-23 months who were born less than 24 months after preceding birth)
- Prevalence of stunting among children under 5
- Prevalence of moderate to severe wasting among children under 5
- Proportion of children who are developmentally on track (to be included when the definition of this indicator has achieved global consensus)
The Democratic Republic of the Congo (DRC) is home to vast natural resources, but it is also one of the world’s poorest countries, severely limiting its ability to improve health care systems. For years, the country endured armed conflict, political instability, and outbreaks of hemorrhagic disease—most recently an Ebola virus epidemic that is the second-worst ever recorded worldwide.

The extreme and chronic challenges the DRC has faced in recent decades have made it difficult to increase domestic health care spending. This is why the Government of the DRC, in partnership with the GFF and key stakeholders, has prioritized the development of financing mechanisms to support the expansion of the package of essential reproductive, maternal, newborn, child, and adolescent health and nutrition (RMNCAH-N) activities laid out in the country’s investment case, the National Health Development Plan 2019–2022. Strengthening the health system by improving the distribution and efficient use of financing in the DRC has already reduced costs of care for patients and quality and uptake of services. As these improvements continue to expand, attention will need to focus on stimulating demand for and access to services, while continuing to prioritize and maintain improvements in quality.

Supporting the PNDS using innovative financing mechanisms

In 2015, the Health Systems Strengthening for Better Maternal and Child Health Results Program (or PNDS, its acronym in French) introduced a basic benefit package of cost-effective quality maternal, adolescent, and child health services for 21.8 million Congolese across 165 districts and 11 of the country’s 26 provinces, covering close to a third of the population. This intervention uses the strategic purchasing of health services, which involves making payments to health facilities contingent on their achievement of outputs and results, in this case measured by the number of services provided and quality scores. Service packages are focused on maternal and child health preventive and promotive activities and infectious diseases such as tuberculosis, malaria, and HIV, all of this provided through extensive community-based activities in addition to access to curative care. Health facilities receive a quarterly advance equal to 60 percent of the previous quarter’s payment, with a second payment made after the quantity and quality of health services have been assessed and eventual sanctions to these payments have been applied. Out of the funding received, no more than 50 percent pertains to staff bonuses while at least 50 percent is used at the facility level for recurrent costs and strategies, as defined in their business plans to enhance quality and to reach health service utilization targets.

Direct-facility financing is another approach being used to deliver the essential health package, but it functions using an input-based approach, without the performance-based component. In other words, this form of financing is provided directly to the facilities, giving them autonomy and flexibility in how they use their funding so that it can be responsive to each facility’s needs and the disease burden of the respective area. The provision of this funding, however, is not dependent on the achievement of results.

Lastly, the single-contract mechanism is a contract between the Ministry of Health at the provincial level, the provincial health authority, and development partners. All financial resources for the given province are pooled to support one integrated health action plan, reducing the fragmentation of financing and promoting a more effective implementation and monitoring of the package of health services. The single contract was implemented beginning in 2017 across eight provinces (High Katanga, Kwilu, Kwango, Lualaba, Mai Ndombe, North Kivu, South Kivu, and South Ubangi).

Given the financial gap identified through the resource mapping exercise, the government recognizes that both an overall increase in domestic health funding and improved execution and efficiency of existing funds are needed to implement PNDS and achieve its objectives. In 2018, for example, less than 40 percent of the national health budget was spent, and many provinces spent only 20 percent of their budgeted resources, according to the Ministry of Health’s National Health Account. Therefore the government, with support from the World Bank and the GFF partnership, have introduced program-based budgeting, which establishes

Country Priorities: The National Health Development Plan

In 2018, the Ministry of Health reviewed the 2016–2020 National Health Development Plan (or PNDS, its acronym in French). The resulting document, the PNDS for 2019–2022, is the country’s investment case and includes a single set of costed, commonly agreed-upon priorities. Its central focus is the delivery of a primary health care services package that emphasizes improvements in reproductive, maternal, neonatal, child, and adolescent health and nutrition (RMNCAH-N) activities using innovative financing mechanisms, including strategic purchasing, direct-facility financing, and single-contract pooled funding. The GFF, in collaboration with other key technical and financial stakeholders, has supported the implementation of the PNDS using these financial mechanisms, as well as provided broader technical assistance to enhance policy dialogue on domestic resource mobilization and health financing based on comprehensive resource mapping and program-based budgeting, among others.

The GFF trust fund is providing up to $60 million in co-financing for the PNDS 2019–2022. The World Bank is co-financing the program through its Global Health Systems Strengthening for Better Maternal and Child Health Results Program (or PNDS) using an inputs-based approach, without the performance-based component. In other words, this form of financing is provided directly to the facilities, giving them autonomy and flexibility in how they use their funding so that it can be responsive to each facility’s needs and the disease burden of the respective area. The provision of this funding, however, is not dependent on the achievement of results.

Technical assistance to enhance policy dialogue around domestic resource mobilization and health financing

As part of the PNDS 2019–2022 development and with support from the Group of Donors for Health (or GIBS, its French acronym), the Ministry of Health conducted a detailed resource mapping that included all PNDS priorities mapped against the collective funds from domestic government budget sources and external funding partners (Figure 1). Although this exercise found that more than 10 external partners are aligned with and committed to financing the PNDS, a budgetary gap of 23 percent remains for fiscal year 2019.

Figure 1: Mapping of resources contributing to the National Health Development Plan (PNDS) for the DRC, FY 2019

<table>
<thead>
<tr>
<th>Source</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>GOVERNMENT</td>
<td>$50,000,000</td>
</tr>
<tr>
<td>WORLD BANK</td>
<td>$50,000,000</td>
</tr>
<tr>
<td>GFATM/BMGF</td>
<td>$50,000,000</td>
</tr>
<tr>
<td>GAVI</td>
<td>$50,000,000</td>
</tr>
<tr>
<td>SWISS/SIDA</td>
<td>$50,000,000</td>
</tr>
<tr>
<td>CANADA</td>
<td>$50,000,000</td>
</tr>
<tr>
<td>WHO</td>
<td>$50,000,000</td>
</tr>
<tr>
<td>DFID</td>
<td>$50,000,000</td>
</tr>
<tr>
<td>JICA</td>
<td>$50,000,000</td>
</tr>
<tr>
<td>TOTAL</td>
<td>$300,000,000</td>
</tr>
</tbody>
</table>

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The scale-up of strategic purchasing, direct-facility financing, and single contract financing mechanisms has also been substantial in the last year. Figure 2 shows the progress in implementation of the strategic purchasing mechanism under the PDSS between 2017 and 2018. The PDSS has now been expanded to 1,963 facilities. The share of services delivered through this strategic purchasing mechanism has also doubled, on average, both for the number of women receiving one and four antenatal care visits (ANC1 and ANC4, respectively) and for assisted deliveries (Figure 3). Progress in scale-up is also being seen in the number of direct-facility financing facilities and single contracts signed. Since 2014, 843 facilities have been receiving direct-facility financing. Nine additional single contracts were signed in the fourth quarter of 2019, up from five single contracts signed in the first quarter of 2018.

Improvements in central- and provincial-level health financing investments and models have indicated significant shifts in the distribution of funding and services at the health facility level, which has translated to greater health service utilization and quality. A midline evaluation of the PDSS program provides insights into how health facility investments can capture expenditures, program-based budgeting allows both leaders and civil society to more effectively monitor whether the commitments of government agencies and donors are invested in specific programs.

Results

The Government of the DRC has demonstrated progress in increasing its domestic health funding: the 2019 national health accounts show that the share of the national budget allocated to health increased from 7.0 percent to 8.5 percent between 2016 and 2018, putting the country on track to reach the target of a 10 percent allocation for health by 2022. Implementation is also underway of program-based budgeting, which maps PNDS priorities to individual budget line items in the health budget. Program-based budgeting has created a clear and direct connection between budget inputs and the expected performance outputs and outcomes.

Table 1

<table>
<thead>
<tr>
<th>Use of antenatal care services and availability of related drugs and medical supplies in the DRC, 2016 and 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Percentage of strategic purchasing facilities (PDSS) providing service</strong></td>
</tr>
<tr>
<td><strong>Baseline (2016)</strong></td>
</tr>
<tr>
<td>Provides antenatal care (ANC) services</td>
</tr>
<tr>
<td>Days per week ANC provided</td>
</tr>
<tr>
<td>Always prescribes iron</td>
</tr>
<tr>
<td>Iron supplies available</td>
</tr>
<tr>
<td>Vitamins A supplies available</td>
</tr>
<tr>
<td>Always prescribes antiretrovirals</td>
</tr>
<tr>
<td>Malaria rapid test kit supplies available</td>
</tr>
<tr>
<td>Provides antenatal care card</td>
</tr>
<tr>
<td>Provides family planning services</td>
</tr>
<tr>
<td>Contraceptive pills (long-acting) available</td>
</tr>
<tr>
<td>Contraceptive pills (combined) available</td>
</tr>
<tr>
<td>Injectable supplies available</td>
</tr>
<tr>
<td>Implanon available</td>
</tr>
<tr>
<td>Contraceptive (IUD) supplies available</td>
</tr>
</tbody>
</table>

Source: Midline Assessment
performance has improved and where gaps remain. Examining the impact of both direct-facility financing and results-based financing on the delivery of RMNCAH services, the evaluation found that significant progress has been made in changing how services are paid for; between 2017 and 2018, the share of health facility revenues derived from out-of-pocket payments declined from 70 percent to 54 percent, while third-party payments increased from 6 percent to 15 percent (Figure 4). Overall, patients are paying a substantially smaller share of the cost of health care at the facility.

The midline evaluation also shows that the observed financial shifts at the facility level have led to positive impacts on the availability, quality, and patient use of RMNCAH and nutrition services (Table 1). For example, in facilities participating in the strategic purchasing mechanism, the average number of days during which antenatal care was provided increased. Provision of family planning services also increased, as did the availability of many essential core commodities, highlighting improvements in service delivery that may further promote utilization. For example, the use of family planning commodities rose, with a marked increase in long-acting injectables and implantables.

Some of these improvements in service access and utilization in districts targeted by DRC’s many financing mechanisms have translated to regional-level results. From 2017 to the end of 2018, data from the regions in which these mechanisms are implemented shows increases in the number of women seen for ANC 1, ANC 4, assisted delivery, and postnatal care (Figure 5). In January 2017, fewer than 300,000 women received ANC1 services; this figure rose to 310,000 women by the end of 2018. ANC4 showed similar increases. About 50,000 additional women had assisted deliveries, and 60,000 additional women sought postnatal care.

System strengthening investments, such as the use of varied financing mechanisms to health facilities, have demonstrated trickle-down effects on service access, quality, and utilization that are extremely promising in the DRC. The challenges that remain and will require continued effort looking ahead lies in the continued expansion of these models, in a way that retains quality but also that stimulates demand, especially among the country’s most vulnerable populations.
One of the first countries to join the GFF—in 2015—Ethiopia has made substantial progress in reducing under-five mortality, maternal deaths, and adolescent fertility. These achievements are impressive, but the Government of Ethiopia recognizes that continued progress in reducing under-five mortality, maternal deaths, and adolescent fertility is needed in coming years.

Country Priorities: The Health Sector Transformation Plan

The 2015/16–2019/20 HSTP, Ethiopia’s investment case aims to increase the use, equity, and coverage of essential health services, such as antenatal care, child and adolescent health services, family planning, and nutrition. To do so, it places a strong emphasis on the need to strengthen health systems through the implementation of systemic reforms. These reforms include, among others, a push for increased domestic health spending as a share of the national budget, as well as improved donor coordination to maximize the efficiency and harmonization of external financing for health. The government’s spending on health has increased in absolute terms over the last 15 years—driven primarily by economic growth—but it has remained flat as a share of general government expenditure.

The GFF partnership is supporting these efforts through various streams of work, including:

1. Policy dialogue to track, mobilize, and align resources (both domestic and external), improve efficiency of spending, and strengthen the implementation of the HSTP;
2. Support to the Health Sustainable Development Goals Program for Results project; and
3. Increasing private sector engagement in the health sector.

Recent surveys have demonstrated considerable progress in Ethiopia’s coverage of key maternal and child health services, such as assisted births, contraceptive prevalence, antenatal care, and child nutrition services. Broader progress on health systems has also been demonstrated, through improvement in indicators related to, among others, the availability of community-based health insurance schemes and the coverage of the civil registration and vital statistics system. However, several challenges remain. Geography, gender, and economic inequity in health outcomes persist. There is a need to improve the quality of health services by improving the availability and motivation of key health personnel (e.g., midwives, doctors) and the availability of essential drugs and supplies at the primary health care level. In addition, a greater focus on efficiency in health spending and on creating sustainable financing for health is needed in coming years.

Policy dialogue to track, mobilize, and align domestic and external resources for health

In 2018, a dialogue that focused on health financing was initiated in order to help policy makers at the Federal Ministry of Health (FMoH), the Ministry of Finance, regional bureaus of health, finance, and economic development, and partners develop a better understanding of how to mobilize and use domestic resources for health. This dialogue included the development and presentation of case studies describing Ethiopia’s accomplishments in domestic resource use and mobilization over the last two decades, as well as Ethiopia’s key challenges and lessons learned from other countries.

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The government is now seeking to increase health spending as a share of the national budget from 5 percent to 10 percent by 2020 as part of the HSTP.

To align and coordinate external resources, with the objective of accelerating progress on maternal and child health outcomes, the federal Ministry of Health manages the Sustainable Development Goals Performance Fund (SDG-PF), a pooled donor fund that includes financing from 11 donors, including the World Bank and GFF, with approximately US$700–750 million committed for the 2015–2020 period. At the outset, financing of the HSTP was expected to come from the Ethiopian government (40 percent), international donors (29 percent), community contributions (6 percent), and individual households (5 percent) through Ethiopia’s Community-Based Health Insurance (CBHI) scheme, leaving a financing gap of about 20 percent of estimated costs.

Resource tracking has been a critical input to policy dialogue around resource mobilization and improvement in the efficient use of funds. In Ethiopia, resource tracking has been done at two levels. First, external resource mapping has been conducted by the Ministry of Health to track external resources at all administrative levels (federal, regional, and district) that support the implementation of the HSTP (Figure 1), in order to improve efficiency at the regional and district level. The aim is to improve efficiency by tracking budget and expenditure data for annual planning purposes as well as to determine whether existing external funding is aligned with sector priorities and assess whether the resources are reaching intended beneficiaries.

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The GFF partnership is committed to supporting the government’s efforts to close this financial gap through improved domestic resource use and mobilization. It is also committed to supporting the achievement of HSTP objectives through (1) policy dialogue to track, mobilize, and align resources (both domestic and external), improve the efficiency of spending, and strengthen the implementation of the HSTP; (2) co-financing of the Health Sustainable Development Goals Program for Results; and (3) increasing private-sector engagement in the health sector.
However, this tracking approach is limited in its ability to capture a wider coverage of civil society organizations (CSOs) working at the regional level and track details of region-specific priorities, such as regional health emergencies.

One important pilot of the regional-level external mapping has been a collaboration between UNICEF, the GFF, and the World Bank in the Somali region, where region-specific resource mapping has been conducted and used to integrate emergency response budgets with routine regional HSTP planning and budgeting. This is particularly relevant in this region, because it ensures that implementation of the HSTP is not harmed by unplanned, unbudgeted, and uncoordinated emergency responses. Further, as a result of the support for the resource mapping and integrated budget development in this region, the regional government has been better able to reprioritize activities and improve partnerships with regional CSOs and nongovernmental organizations (NGOs) working toward a more resilient health system that is better prepared to address health emergencies.

The second level of resource mapping is oriented toward domestic funding. This is done through the use of the government’s integrated budget and expenditure data base (IBEX). The GFF/World Bank are analyzing the IBEX data with the objective of accelerating budget reforms in the Ministry of Finance so that domestic expenditures can become linked with HSTP priorities. This is to reorient key stakeholders, focusing on a comprehensive mechanism to regularly monitor whether the priorities of the investment case are being invested in, and challenges in the current government’s system of budget and expenditure classification and reporting in the IBEX system, which only permits the tracking of a small proportion of expenditures as investments in HSTP priorities.

To improve the technical efficiency of health spending, the federal Ministry of Health, with support from the GFF partnership, is using results from a recent public expenditure review (PER). The review showed that budget execution in recurring non-salary budgets is limited (equal to 20 percent of the health budget), as well as a need to improve regional budget execution. Regional budget execution is considered to be one of the prerequisites for future increases in health funding, so a subnational public expenditure review is now being conducted to identify the bottlenecks in prevention of further or available resources at the regional level, woreda (local administrative district) level, and health facility level. Results from the national and subnational PER may be used to inform the implementation of a system of program-based budgeting and expenditure reporting, one that allows the government to regularly monitor investments in HSTP priorities at all levels.

Policy dialogue to strengthen the implementation of the HSTP

Leaders in the Ministry of Health are exploring how strategic purchasing of an essential package of health services could improve the GIF’s partnership with the health care system. This is in response to results of a midterm review of the HSTP, which identified more challenges for the health system should address to improve the access, quality, and coverage. To better inform this dialogue, the GFF partnership conducted a political economy study to examine how a strategy for financing mechanisms could address these challenges. The study, which is intended to inform the planning process for the next five-year health plan, included discussions that focused on concrete topics such as health financing and woreda transformation.

Support to the Health Sustainable Development Goals Program for Results

The GFF Trust Fund, World Bank, and Power of Nutrition are co-financiers of the Ethiopia Health Sustainable Development Goals Program for Results. Financing for this program is contingent on Ethiopia meeting maternal and child health and health system disbursement-linked indicators. The indicators measure, among other things, woreda-level insurance coverage (the percent of woredas with functional community-based health insurance schemes) as well as increases in the coverage and quality of key maternal and child health services (antenatal care and child immunizations, among others).

The objective of improving financial protection among the poor was developed in response to the problem of the health sector’s over-reliance on household out-of-pocket payments as a source of financing and as the primary source of revenue for improving the quality of health service delivery at the health-facility level. This policy may have leaders, focused on preventing financial exclusion, contributed to the observed increase in the incidence of catastrophic health expenditures for the poor in Ethiopia, which was from 12 percent in 2011 to 5 percent in 2015. 2 CBHI schemes were established by the Ministry of Health to increase access to health services, reduce household vulnerability to catastrophic health expenditures, and subsidize the poor at the woreda level. A target has been set in the health sector development plans of 40 percent of the population being covered by CBHI by 2020. The proportion of woredas with established CBHI schemes increased from 15 percent in 2015 to 80 percent by 2020. This target is incentivized through a disbursement-linked indicator under the Health Sustainable Development Goals Program for Results.

Increasing private sector engagement in the health sector

The Ethiopian government has identified private sector participation in health services as a priority area in the health sector. The GFF partnership, including the World Bank, is supporting this engagement with private sector analytics, capacity building, and technical assistance activities, such as:

- A private sector health assessment to understand the landscape of private sector health actors, identify the regulations and policies applied to the private health sector, and identify opportunities for and challenges to leveraging the private sector for health-sector improvements.
- Capacity building for the Federal Ministry of Health to enable a more strategic engagement with the private sector in health, including the design and management of public–private initiatives.
- Development of public-private dialogue structures in Ethiopia where a private health sector, which has already resulted in the creation of a federalization for private sector stakeholders in health, comprising 12 actors from private hospitals, pharmaceutical companies, civil society organizations, and others; and
- Strengthening regulatory and quality control functions at the Ethiopian Food and Drug Administration for the local production of pharmaceutical and health commodities.

Results

With the support of the GFF partnership, a national Service Availability and Readiness Assessment was conducted in 2018 and a “mini” Demographic and Health Survey (DHS) was conducted in early 2019. The Service Availability and Readiness Assessment survey demonstrated improvements in the availability of essential inputs for service delivery. Preliminary results of the mini-DHS show considerable progress in coverage of key maternal and child health services, such as assisted birth deliveries (including in emerging and low-performing regions such as Oromia, Afar, and Somali), contraceptive prevalence, antenatal care, and child nutrition services (Table 1). In addition, several health system indicators—such as functional CBHI schemes, data collection, data use, reporting, and civil registration—have also demonstrated improvements. For example, the share of health centers reporting their health management information system (HMIS) data on time increased from 64 percent in 2017 to 78 percent in 2018, the number of children 0–23 months participating in growth monitoring and promotion increased from 48 percent in 2017 to 58 percent in 2018, and the number of newborns registered in the HSTP increased from 20 percent in 2017 to 80 percent in 2018. To improve the technical efficiency of health spending, the federal Ministry of Health, with support from the GFF partnership, is using results from a recent public expenditure review (PER). The review showed that budget execution in recurring non-salary budgets is limited (equal to 20 percent of the health budget), as well as a need to improve regional budget execution. Regional budget execution is considered to be one of the prerequisites for future increases in health funding, so a subnational public expenditure review is now being conducted to identify the bottlenecks in prevention of further or available resources at the regional level, woreda (local administrative district) level, and health facility level. Results from the national and subnational PER may be used to inform the implementation of a system of program-based budgeting and expenditure reporting, one that allows the government to regularly monitor investments in HSTP priorities at all levels.

Table 1

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Baseline (2016)</th>
<th>Baseline data (2017)</th>
<th>July 2019 (percent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deliveries attended by skilled birth providers in the rural regions</td>
<td>19</td>
<td>2016</td>
<td>41</td>
</tr>
<tr>
<td>Deliveries attended by skilled birth providers in the few low performing regions (Afar, Oromia, and Somali)</td>
<td>19</td>
<td>2016</td>
<td>41</td>
</tr>
<tr>
<td>Contraceptive prevalence rate</td>
<td>49</td>
<td>2016</td>
<td>69</td>
</tr>
<tr>
<td>Pregnan women receiving at least four antenatal care visits</td>
<td>49</td>
<td>2016</td>
<td>69</td>
</tr>
<tr>
<td>Children 0–23 months participating in growth monitoring and promotion</td>
<td>27</td>
<td>2016</td>
<td>44</td>
</tr>
<tr>
<td>Primary care facilities having available all drugs from the Ministry of Health’s list of drugs</td>
<td>42</td>
<td>2016</td>
<td>48</td>
</tr>
<tr>
<td>Health centers reporting HMIS data on time</td>
<td>42</td>
<td>2016</td>
<td>48</td>
</tr>
<tr>
<td>Pregnan women taking iron folic acid tablets</td>
<td>50</td>
<td>2016</td>
<td>48</td>
</tr>
<tr>
<td>到位与 functional community-based health insurance schemes</td>
<td>42</td>
<td>2016</td>
<td>48</td>
</tr>
</tbody>
</table>

Conclusion

The GFF partnership will continue to support the implementation of interventions and reforms prioritized in the HSTP and the country’s health care financing strategy, focusing on improving efficiency, equity, and effectiveness of Ethiopia’s health system. In addition to programmatic support from IDA, GFF, and Power of Nutrition through the SDG Health Program for Results project, the GFF will continue to support analytics, policy dialogue, and implementation research that will expand the evidence base for future investments in the health sector.

The next five-year HSTP will be prepared in the coming year, and the GFF will continue to contribute to the development and implementation of the HSTP to improve lives and quality of lives of mothers, children and adolescents.
CASE STUDY

Kenya

Kenya has made substantial advances in reducing maternal and child deaths since the late 1990s. The country is continuing to tackle maternal and child mortality through several financing and programmatic mechanisms, all of which are aligned with the priorities laid out in Kenya’s Health Sector Strategic Plan (KHSSP) and Investment Framework. To assist in putting this Investment Framework into action, the GFF partnership and key donors’ are working with national and county governments to support both financing and technical assistance activities aimed at strengthening improvements in health service quality, alignment, financing, and implementation.

In the last two years, progress has been made both in improving financing and in expanding services. All 47 counties in Kenya have increased allocations to health in their budgets, and the coverage of antenatal care, skilled birth attendance, and family planning has increased. This is especially impressive given the significant disruptions faced by the health sector in 2017 due to nurse and doctor strikes, which lasted close to a year and contributed to deteriorations in most health service delivery indicators. At the same time, despite improvements since 2017, progress remains mixed across counties and for certain indicators, such as the coverage of child immunizations. Continued support to strengthen county-level shifts in planning, budgeting, and data use will be critical to better targeting health services and achieving the goals of the KHSSP.

Country Priorities: The Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) Investment Framework

In early 2013, the Government of Kenya enacted a process of devolution, which included the transfer of planning and budgeting functions to county governments. This is why, in 2015 when Kenya became a GFF-supported country, the decision was made to create an Investment Framework that would provide general guidance to counties on relevant health areas. Specifically, the framework would guide counties on where to focus their health financing and service delivery in order to achieve national-level goals in reproductive, maternal, newborn, child, and adolescent health and nutrition (RMNCAH-N). This Investment Framework is therefore closely aligned with the KHSSP.

Given the decentralization of health planning and budgetary functions in Kenya, the Investment Framework is put into effect at the county level through annual workplans. These workplans are county-specific, and they are monitored using an RMNCAH-N scorecard that tracks KHSSP indicators pulled monthly from the routine monitoring system (DHIS2). On a quarterly basis, counties submit reports new RMNCAH data, such as skilled birth attendance, the percent of infants who are exclusively breastfed, and Vitamin A coverage for children 12 to 59 months in age. It indicates whether counties are on track, making progress, or off track to meet targets and whether the indicators increased or decreased since the previous report. It also includes an “action tracker” that highlights areas of high priority and need for support.

To support quality improvements, alignment, financing, and implementation of annual county work plans, various partners, including the GFF partnership, have provided both financing and technical assistance. Two main vehicles are used to channel this support: (1) the Transforming Health Systems for Universal Care Project, which uses a results-based approach, and (2) the RMNCAH Technical Assistance Multi-Donor Trust Fund (MDTF).

Support to the Transforming Health Systems for Universal Care Project

By tying funding directly to performance, the Transforming Health Systems for Universal Care Project (THS-UCP), cofinanced by the World Bank and the RMNCAH Trust Fund, is encouraging county governments to shift from a health-inputs to a health-results model to a health-results model. This creates an incentive to prioritize both the delivery of essential health services and the utilization of these essential services.

Scorecards

Kenya is addressing information gaps that hinder implementation of its universal health coverage (UHC) agenda. A scorecard that measures progress on RMNCAH indicators, supported by UNICEF and the African Leaders Malaria Alliance (ALMA), serves as the primary monitoring tool for strengthening accountability at the county and subcounty levels.

Data are automatically uploaded each quarter. For example, every quarter the scorecard reports new RMNCAH data, such as skilled birth attendance, the percent of infants who are exclusively breastfed, and Vitamin A coverage for children 12 to 59 months in age. It indicates whether counties are on track, making progress, or off track to meet targets and whether the indicators increased or decreased since the previous report. It also includes an “action tracker” that highlights areas of high priority and need for support.

Other focus areas of the THS-UCP, which aims at the overall objective of helping the Kenyan government achieve universal health coverage (UHC) by 2022, are health financing reforms and improved mobilization and use of domestic resources. First, to stimulate greater mobilization and use of domestic resources at the county level, the THS-UCP project’s eligibility criteria include a requirement that county governments allocate at least 20 percent of their budgets to health and that this percentage be increased over the previous year’s allocation if a county had allocated less than 30 percent of their budget to health. Second, the government has begun implementing Phase I of UHC in four counties, using a supply-side financing approach.

Technical assistance to support RMNCAH services

The RMNCAH Technical Assistance Multi-Donor Trust Fund (MDTF), cofinanced by the U.S. Agency for International Development (USAID), the Department for International Development (DFID), and the Danish International Development Agency (Danida), complements the THS-UCP and the investment framework by providing technical assistance to enhance the effectiveness of Kenya’s national and county governments to achieve better and more sustainable RMNCAH results. Although the MDTF does not receive financial contributions from the GFF partnership, it represents an important collaboration and complementarity, since the MDTF objectives are directly aligned with the THS-UCP and provide key inputs to the Investment Framework work at the county level.

Technical assistance has been provided in a number of areas that strengthen the health system, including: (1) for capacity building among national and county governments by standardizing counties’ planning and budgeting processes, which were highly fragmented; (2) for
In FY 2018/19, 43 of Kenya's 47 counties increased their health budgets.

Disrupted health system functioning for almost a year: Lengthy nationwide strikes by doctors and nurses impacted service delivery, as evidenced by sudden drops in the coverage of key services in 2017, as shown in this case study. Kenya's recovery from this shock has been impressive: in the span of only one year (by 2018/19), the country has been able to achieve—and in many cases surpass—pre-strike levels of coverage that had been deteriorating since 2015.

Progress in mobilizing and using domestic resources for health at the county planning and budgeting level has also been observed: All 47 counties met the THS-UCP's eligibility criteria of increased allocations to health in their budgets in the past two years, and some are allocating more than 30 percent of their budget to health (well above the 20 percent requirement). Six counties increased their budgets by more than 10 percent, 13 counties increased them by 5–10 percent, 26 counties increased them by less than 5 percent, and two counties kept their budgets constant (Figure 1). Of the remaining two counties, only Meru County declined significantly, dropping from 32 to 28 percent; the budget of the other county declined by just 1 percentage point.

 Counties are also working to eliminate delays and improve the flow of funding, especially from the county revenue fund to the special purpose account, a ring-fenced account for conditional donor grants for health. On average, between 43 and 46 of the 47 counties transfer funds within 15 working days, a significant improvement from conditions before reform, when transfers of funding to and within counties and facilities could take 3 to 12 months due to a lack of clear mechanisms on how those funds should flow.

In summary, the introduction of high-impact, cost-effective RMNCAH interventions, the promotion of joint learning, and the monitoring of progress toward the core health goals have helped Kenya make measurable progress in its four focus indicators of antenatal care, skilled birth attendance, immunization, and family planning (Figure 2).

Women's antenatal care (ANC) visits increased significantly between 2015 and 2018. In 2018, 48.6 percent of pregnant women attended at least four ANC (ANC4) visits, a 9.5 percentage-point increase over 2015 (Figure 3). Despite these increases, Figure 3 also highlights wide variations across counties, with 19 counties showing increases of 10 to 43 percentage points and 11 counties showing little or no progress (increases of less than 5 percentage points). The percentage of deliveries by skilled birth...
attendants also rose between 2015 and 2018, from 56.9 to 65.0 percent.

The proportion of children in Kenya under the age of one who were fully immunized remained almost flat between 2015 and 2018, rising slightly from 75.1 to 75.5 percent. It is important to note, however, that this indicator showed a strong rebound after the strikes, rising from 63.8 percent in 2017 to 75.3 percent in 2018. As with ANCA coverage, progress varied widely across counties, with 20 counties experiencing increases and 27 experiencing declines in immunization rates (Figure 4). Large increases were seen in a few counties: Nyeri County saw the largest increase, rising from 37.4 percent in 2015 to 77.5 percent in 2018, a 40.1 percentage-point increase. Turkana County experienced the next-highest increase, rising from 45.1 percent in 2015 to 84.5 percent in 2018, a 39.4 percentage-point rise. Increases ranged from 2 to 19 percentage points in 15 counties and were less than 2 percentage points in 3 counties. Twenty-seven counties experienced declines, with immunization rates in 5 counties falling by less than 2 percentage points and rates in the other 22 counties falling by more than 2 percentage points. The decline in the rate of immunization was steepest in Kwale County, where it fell 34.4 percentage points.

The percentage of women of reproductive age who received modern family planning commodities dropped between 2015 and 2017, from 47.8 to 36.3 percent in 2017, a decline that is believed to be driven by the strike by doctors and nurses in 2017. Use of family planning services rose in 2018, reaching 44.1 percent, but did not fully recover to pre-strike levels. To further promote the increase of availability and use of family planning services, the THS-LCP project recently spent US$7 million on family planning commodities, with the objective of increasing supply and access. Nevertheless, an ongoing funding gap for procurement of family planning commodities could hamper progress.

**Conclusion**

Overall, Kenya has improved the coverage of key maternal and child health services such as antenatal care, skilled birth attendance, and family planning. The disruptions to the health system due to long-term nurse and doctor strikes, however, are not to be underestimated. Their impact is reflected in the mixed progress across indicators (child immunization, for example) and regions. Continuing to support and strengthen county-level shifts in planning, budgeting, and data use will be critical in identifying and addressing bottlenecks to achieve the goals of the KNHSSP, with specific action plans that are tailored and responsive to the particular needs of each county.

**Figure 3** Percent of pregnant women in Kenya attending ANC4, annually, 2016–2018

*All except 10 counties have shown increases in women’s antenatal care coverage (at least four antenatal care visits) since 2015, but all 47 counties rebounded from the disruption of the nurses and doctors’ strike in 2017."

**Figure 4** Percent of children in Kenya under the age of one who were fully immunized, 2015 vs. 2018

*Progress in coverage of immunization rates varied widely across counties compared to 2015 levels, but almost all counties (42) saw increases in coverage since 2017*
Since its civil war ended in 1992, Mozambique has achieved substantial reductions in maternal, under-five, and neonatal mortality rates. However, progress in these areas has been uneven and limited for people in the poorest income quintiles and for rural populations. Under the leadership of the Government of Mozambique and in collaboration with a range of partners, including the GFF, a five-year investment case was developed. The investment case prioritized high-burden districts in 10 provinces with a combination of health system strengthening activities that are needed to overcome bottlenecks in providing services in reproductive, maternal, newborn, child, and adolescent health and nutrition (RMNCAH-N).

In parallel with those activities, and despite a very challenging macroeconomic environment with pressure to reduce government expenditures, the government has begun to increase the ratio of its domestic health expenditures to its total domestic government expenditures. Data from December 2018 show significant progress on targets related to capacity building and health staffing, as well as more systematic data use. This progress has begun to translate into better results in facility and health service usage, such as increases in the use of antenatal care services, facility-based deliveries, and family planning services.

**Country Priorities: Mozambique’s Investment Case**

Mozambique’s five-year investment case was developed through an inclusive, government-led process that the GFF and a range of key actors were involved in, including historically underserved groups, such as adolescent girls. The government’s Health Sector Strategic Plan (PSS) for 2014–19, which orients all interventions in the sector, was used as the basis for establishing the priorities of the investment case. Part of this prioritization exercise involved categorizing Mozambique’s 142 districts by their needs, such as availability of resources and coverage of services, and potential for achieving results. This is illustrated in Figure 1, where dark-colored districts have the greatest potential for results and light-colored ones the least. A majority of the dark-colored districts have a hospital and both greater population density and a denser health network than the national average; they also have higher current coverage rates. At the same time, both darker and lighter districts require investments. Darker districts require investment to reinforce their role as reference districts for neonatal and maternal emergency care, while lighter districts need a stronger focus on outreach solutions, such as community health workers and mobile brigades targeting dispersed populations.

Based on this work, the investment case identified 42 lagging districts in 10 provinces in which to target investments and interventions.

The investment case defines three priorities for strengthening the National Health Service:

1. Improvements in coverage, quality, and access to essential primary health care services through a combination of supply- and demand-side investments that extend to sparsely and high-burden districts, for example through the use of community health workers;
2. Systems-strengthening interventions, such as efforts to improve data collection and monitoring in the civil registration and vital statistics (CRVS) system; and
3. Increases in the volume, efficiency, and equity of domestic and external health financing.

GFF engagement in Mozambique has been centered on supporting the inclusive, government-led preparation, financing, and implementation of the investment case. This includes an extensive resource mapping that is directly linked with and fully finances the investment case over the 2018–2022 period (Figure 2). Mozambique was strongly committed to having a fully funded investment case, with most funding channeled through government systems.

The GFF’s support to Mozambique is focused on results through co-financing of the investment case through the Primary Health Care Strengthening Program. Among other things, this program promotes: (1) maintaining and eventually increasing the government’s ratio of domestic health expenditures to total domestic expenditures; (2) increasing...
the number, reach, and capacity of community health workers who are delivering key RMNCAH-N interventions in prioritized districts; (3) collecting and using data for decision-making; and (4) expanding the quality and coverage of RMNCAH-N services in districts that have both a high burden and high potential for results.

Results

The implementation of the Primary Health Care Strengthening Program, which is directly linked to the investment case, has exceeded most of its targets (Table 1).1 In December 2018, the Ministry of Economy and Finance reported a 9 percent ratio of domestic health expenditures to total domestic government expenditures, putting it on track to achieve the 2021 commitment of 9.5 percent. The government also committed to increasing health expenditures for the 42 prioritized districts from US$0 in 2017 to US$9 million by 2019 and US$36 million by 2021, but this target was not met the first year.

Increases in primary health care and community health staffing have also been demonstrated: the targeted number of trained and active community health workers was 3,390 in 2018, with a goal of 8,800 by 2022. The target for the first year was met, with training for 5,363 community health workers already completed. The targeted number of technical health personnel assigned to the primary health care network was 14,344 in 2018 (from a baseline of 11,970 in 2017) and has a goal of reaching 17,662 by 2022.

Efforts toward the systemic recording and use of data have also improved. To facilitate progress in tracking the implementation of the investment case, and in response to significant challenges in monitoring activities at the subnational level, the government and its partners are developing a national dashboard with jointly agreed-upon indicators. In the meantime, quality-of-care scorecards for health centers and hospitals have been piloted and will be scaled. Also, vital statistics registration, which is a key focus area of the investment case, has improved, with the share of facilities using the Data Management Module (MDGHi) to record cause of death rising from 70 to 100 percent among hospitals and from 0 to 50 percent among health facilities.

Lastly, many of the RMNCAH-N indicators and targets set forth in the Primary Health Care Strengthening Program for 2018 have been achieved or exceeded (Table 1). The share of births that occurred in health facilities reached 80 percent, a number that exceeded the 2018 goals. Nutrition goals for 2018 focused mostly on training key nutrition personnel and rolling out the Nutrition Intervention Package (NIP) in the eight highest-burden provinces; these goals were also achieved. Between 2017 and December 2018, 3,609,078 additional children received basic nutrition services.

To improve sexual and reproductive health outcomes, Mozambique has placed a high priority on reducing the unmet need for family planning and increasing access to modern contraceptives. To monitor utilization of this service, Mozambique uses “couple years of protection” (CYPs), and on this indicator saw a 26 percent increase in 2018 compared to the previous year, exceeding national goals.

Conclusion

Looking forward, it is critical for Mozambique to further strengthen existing coordination structures to establish a well-functioning country platform. Areas of focus for the country platform will include monitoring the implementation of the investment case on a regular (quarterly) basis to facilitate timely and relevant course-correction. Data quality also remains a challenge; it needs to be strengthened further since it is a key input to the country platform’s functioning and data monitoring role.

Table 1

<table>
<thead>
<tr>
<th>Results indicators</th>
<th>December 2017 (baseline)</th>
<th>2018 targets</th>
<th>December 2018 achievements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of institutional deliveries in 42 lagging districts</td>
<td>66.10%</td>
<td>66.80%</td>
<td>80%2</td>
</tr>
<tr>
<td>Number of couple-years of protection (CYPs)</td>
<td>1,722,692</td>
<td>2,135,012</td>
<td>3,358,928</td>
</tr>
<tr>
<td>Number of women and children who have received basic nutrition services</td>
<td>0</td>
<td>Training of health workers completed, M&amp;E system developed</td>
<td>Training of health workers completed, M&amp;E system developed</td>
</tr>
<tr>
<td>Number of trained and active community health workers (APEs)</td>
<td>3,380</td>
<td>4,723</td>
<td>4,789</td>
</tr>
<tr>
<td>Number of technical health personnel assigned to the primary health care network</td>
<td>11,970</td>
<td>12,205</td>
<td>14,344</td>
</tr>
</tbody>
</table>

1 These results were reported by the government but are yet to be verified by an independent verifier.
2 As of 1-Oct-18.
As a lower-middle-income country with a large, rapidly growing population, Nigeria is facing considerable pressure on how it provides and pays for health services for its people. Nigeria, which joined the GFF in 2015, has among the lowest per capita health expenditures in the world and spends less on health than other countries with comparable income levels. At the same time, the Boko Haram insurgency has left the country’s North East region a particularly fragile area, curtailing service delivery, destroying health infrastructure, and leaving households with limited access to health and nutrition services. This period of social and political unrest and division has hindered efforts to address poverty and inequality.

In an effort to increase funding for health and deliver a universal Basic Minimum Package of Health Services (BMPSH) to all Nigerians, the federal government established the Basic Health Care Provision Fund (BHCPF). To accelerate the focus on the nation’s poorest and most vulnerable populations, and in alignment with the investment case, the Nigeria State Health Investment Project (NSHIP) has been expanded into the conflict-affected Northern regions of the country. Though it is not possible to attribute results to any one entity, intervention, or health reform, data from a recent Demographic and Health Survey (DHS, 2018) are indicative of progress in several key reproductive, maternal, neonatal, child, and adolescent health and nutrition (RMNCAH-N) indicators, including in the Northern regions where the NSHIP has been scaled up. However, these results also highlight remaining gaps in service delivery, quality, and access, alongside a concerning nutrition situation affecting children under 5.

To accelerate progress in achieving these outcomes, the GFF partnership has supported the Government of Nigeria to (i) increase the overall funding envelope for the implementation of the National Health Act and improve the efficiency with which these funds are used; and (ii) reach the nation’s poorest and most vulnerable populations, through the expansion of the NSHIP into the conflict-affected North East of the country, where historically it has been extremely difficult to provide services.

Increasing the allocation and efficient use of funds for the operationalization of the National Health Act and Basic Minimum Package of Health Services

The principal funding vehicle for the BMPSH is the Basic Health Care Provision Fund (BHCPF), which is being introduced in all 36 states and the Federal Capital Territory of Abuja, as a mechanism to channel increased domestic and international financing. In 2018, the GFF and the Bill and Melinda Gates Foundation, with technical assistance from partners including the World Bank and USAID, provided funding to the BHCPF to test the proof of concept. In addition, the GFF partnership motivated the government of Nigeria to pledge US$180 million (1% of the annual federal budget) in domestic resources to support the BHCPF annually. A first allocation from the government budget was made in 2018.

The BHCPF includes an accreditation system to strengthen the monitoring of quality of care and clinical governance. A scoreboard system is used to monitor performance in 10 priority areas (Figure 1), with additional oversight from the governance and accountability secretariat, which will conduct periodic assessments to determine compliance and effectiveness. The quality scoreboard allows the BHCPF to focus on results and uses an electronic reimbursement technology for each facility.

To improve the efficiency of funds allocated to the operationalization of the BMPSH, the Government of Nigeria, with support from the GFF, conducted a preliminary resource mapping to improve alignment of external financing. This exercise was an important step in determining where and how external financing was to be budgeted, as well as to detect areas of duplication and gaps in financing and activities. The resource mapping highlighted that the investment case remains underfunded (88 percent gap in financing), and that efforts need to be made to bring additional funding aligned around the BHCPF. This resource mapping will be repeated on an annual basis; a more detailed subnational resource mapping will be completed by early 2020.
Private Sector Innovations

The private sector in Nigeria is organized into federations in the health sector, enabling constructive engagement between the government and the private sector. One of the ways the private sector engaged in developing the investment case was by inviting the Healthcare Federation of Nigeria and the Private Sector Health Alliance of Nigeria to organize a competition to select the most promising innovations for improving coverage and quality of RMNCAH-N outcomes. Proposals submitted by the private sector were designed to complement government capacity and initiatives in fragile settings around 4 tracks: (1) coverage of RMNCAH-N services, (2) quality of care; (3) civil registration and vital statistics, and (4) access to medicines. A requirement of the innovations was that they would also focus on the North-East part of the country, which suffers from the effects of the Boko Haram insurgency. The final three innovations selected and included in the investment case were these:

- **InStrat Global Health Solutions**, which will implement a mobile training application that supports multi-media training content to enable health workers to improve their skills in delivering high-quality care, such as through better engagement with patients around key messages relating to their conditions;

- **PharmAccess Foundation**, which will introduce the SafeCare standards, which will implement a mobile training application that supports multi-media training content to enable health workers to improve their skills in delivering high-quality care, such as through better engagement with patients around key messages relating to their conditions; and

- **Riders for Health**, a managed transportation system consisting of motorcycles and ambulances that will work to ensure that pregnant women requiring obstetric care are able to get to the nearest health center, free of cost and as quickly as possible.

Rebuilding the health system in the conflict-affected North East through the expansion of the Nigeria State Health Investment Project

The GFF is a co-financier of the NSHIP, which supports the expansion of the Nigeria State Health Investment Project (NSHIP) that will expand service delivery in the conflict-affected North-East through the expansion of the Nigeria State Health Investment Project (NSHIP) that will expand service delivery in the conflict-affected North-East through the expansion of the Nigeria State Health Investment Project (NSHIP) that will expand service delivery in the conflict-affected North-East through the expansion of the Nigeria State Health Investment Project (NSHIP). The final three innovations selected and included in the investment case were these:

- **PharmAccess Foundation**, which will introduce the SafeCare standards, which will implement a mobile training application that supports multi-media training content to enable health workers to improve their skills in delivering high-quality care, such as through better engagement with patients around key messages relating to their conditions; and

- **Riders for Health**, a managed transportation system consisting of motorcycles and ambulances that will work to ensure that pregnant women requiring obstetric care are able to get to the nearest health center, free of cost and as quickly as possible.

Results

In the conflict-affected region supported by NSHIP and other partners, several achievements were recorded in 2018, both in increasing access and use of health care services and in strengthening health systems. Services financed by NSHIP were expanded to 39 local government agencies serving 13.3 million people. In these areas, 38 secondary health care facilities and 437 primary health care facilities were revitalized, including both infrastructure and human resource improvements. Likely driven by such improvements, an additional 43,000 women received antenatal services and an additional 51,000 deliveries were attended by a skilled birth attendant, with an overall increase in deliveries assisted by a skilled birth attendant from 60 percent in 2017 to 70 percent in 2018. An additional 40,000 children under the age of 1 year were immunized, with vaccine coverage (DPT3) increasing from 34 percent in 2017 to 48 percent in 2018.

Because the implementation of the BHCPF (2018) is so recent and the development of systems to collect and report data on RMNCAH-N indicators is ongoing, data are not yet available on improvements in quality, clinical governance of service delivery, and RMNCAH-N outcomes specifically attributable to the BHCPF roll-out. Despite the inability to attribute results to any one entity, intervention, or health reform, data from a recent Demographic and Health Survey (DHS, 2018) indicate progress on several key RMNCAH-N indicators, including in the Northern regions where the NSHIP has been scaled up, as described above. Improvements in the coverage and quality of maternal and child services included in the BMHPS have been seen at both national and regional levels. This includes, for example, improvements in the percentage of women benefitting from deliveries assisted by a skilled birth attendant, postnatal consultations, use of insecticide-treated nets (ITN) and intermittent preventive treatment, and reductions in child wasting.

While key RMNCAH-N indicators in the North-East and North-West regions lag well below national levels, the rate of improvement seen in these regions over time is in several cases well above national level improvements. For example, the 2008–2018 period, skilled birth attendance rose by 11.2 percentage points (from 16.5 to 27.7 percent) in the North-East and by 8.3 percentage points (from 10.7 to 19 percent) in the North-West (Figure 2). The percentage of women receiving postnatal consultations within 2 days after giving birth also showed gains at the national level. Between 2013 and 2018, among women who gave birth in the two years preceding the survey, the proportion who had their first postnatal consultation rose from 39.6 to 41.8 percent nationally (a 6 percent increase), with improvements in the North-East and North-West rates representing increases of 6 and 23.5 percent, respectively (Figure 3).

Dramatic improvements in malaria prevention, a key intervention under the BMHPS and at the core of funding provided by external partners such as the Global Fund and the World Bank, have also been observed in Nigeria over time. This is reflected in large increases in bed net use among both children and women (Figure 4), as well as in the delivery of intermittent preventive treatment (IPT) during antenatal care (Figure 5). Trends in bed net use are similar for children and women, as well as in Northern regions compared to national trends. Drops in bed net usage are observed in 2013, but 2018 data show an impressive recovery, with coverage rates for both 2013 and 2018 numbers.

The national and regional increases in the proportion of women who had access to two and three or more doses of IPT (IPT2+ and IPT3+), have been dramatic, signaling a trend in improvements in the quality of antenatal care services. These trends were observed both at national and regional levels, with the Northern regions exhibiting improvements that were equal to or greater than those seen at the national level. For example, nationwide IPT2+ coverage increased eight-fold (from 4.9 to 40.4 percent), while in the North-East and North-West, the increase in this coverage was 14-fold (from 2.9 to 40.7 percent) and 8-fold (from 3.9 to 34.1 percent), respectively.

Progress on nutrition indicators in Nigeria has been mixed (Figure 6). Significant improvements in the proportion of children suffering from wasting were observed in the last decade, likely contributing to reductions in child mortality given the close linkages between wasting and mortality. In both of the Northern regions, wasting was reduced by half or more, from 22.2 percent in 2008 to 10.1 percent in 2018 in the North-East, and from 19.9 percent in 2008 to 10.1 percent in 2018 in the North-West. These trends reflect significant funding provided for the treatment of severe acute malnutrition in recent years. Alongside these impressive improvements in the proportion of women receiving postnatal consultations increased over the last 5 years, with increases in the Northern regions equivalent to or greater than those seen at the national level.
Figure 4  Use of treated mosquito nets among children under 5 and pregnant women in Nigeria, nationwide and northern regions, 2008, 2013, and 2018

Drastic increases in bed net usage were observed at both national and regional levels in Nigeria, especially from 2013-2018

Figure 5  Percentage of women (ages 15-49) with live births who during pregnancy took two or more doses of IPT, nationwide and northern regions, 2008, 2013, and 2018

In the 2008 DHS survey, results from the 2018 DHS survey demonstrate that significant progress has been made in improving key RMNCAH-N outcomes. However, these results also highlight remaining gaps in service delivery, quality, and access, alongside a continuing nutrition situation that is of concern. Looking forward, and in order to accelerate the reduction of child stunting—which is a priority under the Government of Nigeria, together with the World Bank, GFF, and other technical partners, will implement the ANRIN project. This US$232 million project is co-financed by the GFF and IDA, and benefits from a technical assistance pooling mechanism funded by the Power of Nutrition, the Aliko Dangote Foundation, and the Bill and Melinda Gates Foundation. The project is geographically centered on the 12 states, in all regions of the country, where the prevalence of stunting is the highest, and it will use a results-based contracting approach that leverages the capacity of non-state actors. The project will address the nutritional needs of mothers and children, with a special emphasis on the nutritional needs of adolescent girls and their children.

Conclusions and Work Going Forward

With the expansion of the NSHIP into Northern, conflict-affected regions of the country, results from the 2018 DHS survey

reduce the in prevalence of stunting, including in Northern regions of the country. This indicates—as recognized by the Government of Nigeria through its ANRIN project—the need to go beyond financing the “nutrition emergency” (i.e., severe acute malnutrition), to address the “nutrition crisis” (i.e., child stunting, maternal malnutrition, and micronutrient deficiencies) that affects far larger numbers of women and children.
Tanzania recorded major improvements in several RMNCAH-N outcomes in the decade between 2005 and 2015 (Box 1). At the same time, progress on some indicators has been mixed, with significant regional variations. Tanzania’s commitment to improving maternal, newborn, child, and adolescent health and nutrition (RMNCAH-N) outcomes is evidenced by the country’s commitment to join the GFF. In a bid to improve RMNCAH-N outcomes, the country has continued to strengthen its work with partners to coordinate the financing and implementation of RMNCAH-N programs aimed at improving the quality and coverage of health services in alignment with its investment case, One Plan II. This collaborative effort has led to improvements in maternal and child health service coverage, quality, and services, as measured by the indicators that have been routinely monitored and are described in this case study. The findings also highlight that to continue progress toward further RMNCAH-N improvements, more targeted efforts are needed to expand the coverage of some services (ANC, for example) in certain regions where coverage remains below 50 percent while sustaining the quality improvements that have been recorded in the last two years.

Trends in key RMNCAH-N indicators (2005 to 2015, DHS)

- Maternal mortality ratio: Declined from 578 to 556 per 100,000 live births
- Neonatal mortality rate: Declined from 32 to 25 deaths per 1,000 live births
- Under-five mortality rate: Declined from 112 to 67 deaths per 1,000 live births
- Stunting prevalence among children under five: Declined from 44.3 to 34.4 percent
- Wasting prevalence among children under five: Rose from 3.0 to 4.4 percent
- Share of women who had another child less than 24 months after their previous child: Rose from 16 to 18 percent
- Total fertility rate: Declined from 5.7 to 5.2 children per woman

Country Priorities: One Plan II

One Plan II, Tanzania’s investment case, focuses on improving RMNCAH-N with an emphasis on improving the quality and availability of health services to reduce morbidity and mortality. One Plan II is implemented on the premise of the Government of Tanzania’s vision of increasing local ownership by giving health facilities greater autonomy to make decisions about service provision and quality of care and relieving health system bottlenecks through mechanisms that provide direct financing to facilities linked to results. This model is meant to empower frontline providers and health facility managers to improve quality and access to healthcare services, while basing their financing on the achievement of results and context-specific health priorities. In addition, it increases accountability at the community level by giving the oversight and stewardship functions to each facility’s governing committee. Further, the reliance and focus on data use enables facilities to plan, monitor, and develop solutions relevant to their specific regions.

The GFF’s engagement in Tanzania has evolved into support for health systems strengthening activities and data use that can contribute to improvements in coverage, quality, and access to services. Specifically, these include (i) alignment of partners around a common domestic health financing agenda and better coordination to reduce fragmentation in allocation of funds; (ii) co-financing of One Plan II through the results-based Primary Health Care for Results (PHC4R) program; and (iii) support for a mid-term review of One Plan II.

Alignment of partners around a common domestic resource mobilization agenda and coordination for better allocation of funds

The Government of Tanzania spends 7 percent of its general budget on healthcare, according to a public expenditure review. Government spending still represents just 28 percent of total health spending in the country, with the remainder provided by donors (37 percent), households (26 percent), and a prepayment scheme (9 percent). Although government expenditure for health as a percentage of general government budget is modest, retaining or increasing the level of domestic government expenditure is a critical goal in Tanzania. High-level consultative meetings with the Ministry of Health and Parliamentarians were held to discuss the importance of increasing domestic resources from the government, which has enhanced the Ministry of Health’s ability to advocate for more funding for the sector. The GFF and the World Bank have been supporting this health financing objective through a specific disbursement-linked indicator (DLI) aiming to increase domestic funding for health over time.

To reduce fragmentation of funding, a government-led RMNCAH technical working group and a SectorWide Approach technical working group, which focuses on the financial side, together form the country platform in Tanzania. Enhancing efficiency, pooling of resources, and strategic purchasing, especially at the facility level, are priorities for both the partners and the Government of Tanzania. Harmonized planning and spending guidelines for facilities, to be applied to all sources of funds at the facility level, further this effort.

1 Partners: the governments of Canada, Denmark, Ireland, and Switzerland; the Korea International Cooperation Agency (KOICA); the World Bank and the Global Financing Facility (GFF); the US Agency for International Development (USAID); the Power of Nutrition; the US President’s Emergency Plan for AIDS Relief (PEPFAR); GAVI, the Global Fund to Fight AIDS, Tuberculosis and Malaria; and the United Nations Population Fund.

2 Partner organizations: the governments of Canada, Denmark, Ireland, and Switzerland; KOICA; UNICEF; and the World Bank and the GFF—two financial funds directly through Tanzania’s Health Basket Fund. The fund is a pooled funding mechanism that finances local government authorities’ annual plans, whose performance is tracked with the scorecard, using indicators aligned with One Plan II.
Financial support to One Plan II through the results-based Primary Health Care for Results (PHCforR) program

The GFF Trust Fund is co-financing One Plan II through the PHCforR program, which seeks funding to improved health outcomes at all levels of service delivery using DLIs. USAID, the Power of Nutrition, and the World Bank and GFF Trust Fund all provide financing through the PHCforR up to the facility level through innovative approaches, such as output-based payment modalities, to improve RMNCAH-N outcomes.

The DLIs are indicators used in scorecards to measure the performance of local government authorities, which helps inform their joint annual planning, which is also supported by the Health Basket Fund. Twelve criteria are featured in the scorecard, corresponding to key challenges or bottlenecks that affect the quality of care in Tanzania, as identified by the government. These 12 criteria include six criteria covering maternal, neonatal, and child health and nutrition service delivery outputs, and another six that cover quality of care. The local government authority scorecards support local-level accountability while also promoting a systematic and continuous monitoring of achievements and gaps for RMNCAH coverage indicators aligned with One Plan II.

Midterm review of One Plan II

Tanzania will be the first GFF country to complete a midterm review of its investment case. The objective of this review is to track progress, learn from successes as well as failures, and identify strategies to realign activities so that One Plan II better achieves the objectives laid out in its results framework. Specific focus areas of the review include understanding the bottlenecks that hinder progress, identifying highly vulnerable populations that are not being reached, and mapping out a clear path for the way forward. In parallel, support is provided for Tanzania to conduct a new resource mapping and tracking activity to identify financial gaps in One Plan II financing. Results from the resource mapping and the midterm review will be critical to informing the realignment of the plan.

Results

The results in One Plan II are partially financed through DLIs in the PHCforR program, as such, expected results in both documents are in direct alignment. Results in both the investment case and the PHCforR focus on all levels of the health system, with the end goal of improving the quality and availability of RMNCAH-N services to reduce morbidity and mortality.

To date, Tanzania has experienced significant improvements in many of the coverage, quality, and service improvement indicators that are central to the One Plan II and the PHCforR results frameworks. These results have been routinely monitored through the local government authority scorecards and Star Ratings Initiative, and demonstrate improvements in many indicators, among them: coverage of antenatal care, facility-based births, presence of a skilled staff member, and quality of services delivered during antenatal care visits. Quality of care is ultimately represented in the types of services received at the health facility, but improvements in star ratings under the Star Rating Initiative further attest to this progress.

Antenatal care improved in all 26 regions, from an average of 35.8 percent of pregnant women receiving at least four antenatal care visits in 2014 to 64.1 percent in 2018 (Figure 1). Increases are in response to some regions seeing more than 70 percent attendance in ANC (Dar es Salaam, Geta, Katavi, Kigoma, Mbeya, Pwani, Rukwa, and Shinyanga). Nevertheless, many regions remain below 50 percent coverage of ANC+4, highlighting the need for efforts on both the demand and supply side to increase coverage. Alongside improvements in ANC4+ coverage were increases in the regional averages for the share of births at a health facility, which rose from 67 percent in 2014 to 70.6 percent in 2017, and to 79.4 percent in 2018 (Figure 2) (RMNCAH Bulletin 2019).

Parallel increases in coverage of intermittent preventive treatment (IPT) of malaria and in the administering of iron and folic acid signal improvements not only in the coverage of ANC services but also in the quality of those services. The proportion of pregnant women who received IPT2 between 2014 and 2018 climbed from 36.4 percent to 82.8 percent. IPT3 was introduced in 2016, to use reached 59 percent by 2018 (data not presented). As shown in Figure 3, the average share of pregnant women receiving iron and folic acid at ANC visits increased from 57 percent in 2014 to 73 percent in 2018, with a large majority of regions achieving coverage of iron and folic acid distribution during ANC above 70 percent.

Further attesting to quality improvements is the increase in the number of facilities that achieved at least a 3-star rating between 2016 and 2018 (Figure 4). In 2016, in almost one-third of Tanzania’s regions, at least 70 percent of pregnant women are reached with ANC4+, but in many other regions coverage is under 50%.
More than 70% of pregnant women in a majority of regions in Tanzania received iron and folic acid in 2018.

Note: The sharp reduction in coverage in 2017 resulted from the large increase in uptake that led to a country-wide stockout. Upon identification of the problem, the government of Tanzania purchased iron and folic acid, which stabilized uptake and coverage in 2018.

Source: DHIS2

The increases in the number of facilities with three-star ratings reflect how both RMNCAH-N coverage and quality of care have increased in Tanzania over the past two years. However, district and regional results still reflect variations in performance, which highlight the need to learn from regions that are making the greatest progress and apply those lessons, where relevant, to poorer performing regions.
Uganda has achieved steady improvements on several key maternal and child health indicators over the past 20 years (Box 1). However, significant challenges remain, and public expenditure on health remains low, at just 7 percent of the national budget, equivalent to US$14 per capita, according to the Uganda National Health Financing Strategy 2016. Under the leadership of the Government of Uganda, the GFF, in collaboration with a diverse array of technical and financial partners, joined the effort to identify shared priorities in the health sector, advocate for increased investment, determine ways to make more effective use of existing funds, and target these resources to achieve greater coverage of high-impact interventions.

Among the outputs of this collaboration, the government implemented a prioritized package of services for women, children, and adolescents using several approaches to results-based financing and service purchasing. The implementation of these approaches has progressed rapidly, and positive results have begun to emerge, as presented in this case study. Of note are increases in the coverage and quality of antenatal care services and facility-based deliveries, as well as substantial shifts in the mix of contraceptive methods that may reflect improved access to and availability of long-acting contraceptive methods.

Country Priorities: The Sharpened Plan

Uganda’s investment case, called the Sharpened Plan, focuses on building and maintaining the momentum of key improvements in reproductive, maternal, newborn, child, and adolescent health [RMNCAH] through five strategic shifts. Operationally, the shifts are:

- **Shift 1**: Expanding access to a package of high-impact RMNCAH interventions
- **Shift 2**: Including expanded access to high-burden populations, and
- **Shift 3**: Keeping a focus on geographic sequencing (prioritizing the 40 highest burden districts).
- These operational shifts are complemented by two changes in focus:
  - **Shift 4**: Addressing the social determinants of health outcomes, and
  - **Shift 5**: Ensuring accountability through investments in systems such as civil registration and vital statistics (CRVS) capabilities.

The GFF process and financial contributions aim to support the effective implementation of these strategic shifts.

**Strengthening operations of the national country platform to improve accountability and coordination**

Among the GFF partnership’s key areas of focus in Uganda is supporting the efforts of the Ministry of Health to coordinate the implementation and financing of the Sharpened Plan. This is being done in collaboration with more than 20 dozen partners, including international and Ugandan civil society organizations, international development agencies, UN agencies, and the private sector. A unified investment case

**Expansion of strategic purchasing of an essential package of health services to improve value for money in the health sector**

Uganda has a history of experimentation with supply and demand-side financing approaches to increase the utilization and quality of high-priority health services. In 2016, this experience culminated in the development of the national Results-Based Financing Framework for the Health Sector, which was identified as a key strategy for advancing the strategic shifts outlined in the Sharpened Plan. The Uganda Reproductive Maternal and Child Health Services Improvement Project (URMCHIP), cofinanced by the GFF Trust Fund, the Swedish International Development Cooperation Agency (SIDA), and the International Development Association (IDA), is a major source of financing for putting this strategy into action.

This emphasis on strategic purchasing is well aligned with the GFF approach, as it focuses on a prioritized package of services for women, children, and adolescents that includes immunization, family planning, antenatal care, emergency obstetric care, postnatal care for mothers and children, and treatment for common conditions among children under age.
five. Given the multiple financiers, geographies, and schemes that are involved, the strategy also requires a high degree of coordination with partners to ensure that all priority districts are covered, that synergies between schemes are exploited, and that unintentional duplication is avoided.

Results

The government’s strategic purchasing of the package of essential health services has been rapidly expanding. In the first half of 2019, 341 health facilities were participating, with another 395 health centers in 51 districts having completed the prequalification assessments and training needed for implementation. As of July 1, 2019, 79 districts were implementing the program at scale (Figure 2).

Initial results suggest that priority interventions in the Sharpened Plan, such as health worker mentorship, vouchers, and the results-based financing approach, are all creating conditions for improved coverage of services where they are being delivered—notably in the Northern Region—a positive sign as these approaches are expanded to places like the Central Region. For example, the number of women attending one and four antenatal care visits (ANC1 and ANC4, respectively) has increased in most regions, especially in the Northern Region, where there was an increase in ANC4+ of 11 percentage points over a two-year period (Figure 3).

Despite improvements in ANC1 over the same two-year period, much work remains to be done to promote the use of these services early in pregnancy, given that the utilization rates in all regions remain below 20 percent (data not shown). Promotion would be especially valuable, since data on the services that women are receiving signal improvements in quality. For example, all women receiving ANC1, the proportion of them that were receiving iron folate in 2018 was between 80 and 90 percent in all regions except one (the Central Region, where it was just over 70 percent) (Figure 4). Similarly, the proportion of women receiving a third dose of intermittent preventive treatment for malaria in pregnancy (IPT3) has been rising in all regions (Figure 5). These improvements may also reflect a 2017 policy change, which affected protocols and reporting, as well as the support of development partners to improve stock monitoring and capacity building in the reporting system.

There are also indications that more women now have access to facility-based childbirth services through the formal health system (Figure 6). In the first quarter of 2018, an estimated 59.5 percent of births took place in health units. By the last quarter of that year, that number had risen by 5 percentage points. The Northern Region experienced a 10-percentage point increase; at 71 percent, it had the highest rate of institutional delivery in the country. The improvement coincides with investment from partners in maternal health vouchers in recent years as well as with supply-side investments going back several years.

There have also been notable shifts in the method mix in family planning services delivered in Uganda between 2017 and 2018: the use of long-acting

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2 Coverage estimates in this section come from national HMIS service statistics. They are not directly comparable to coverage estimates from household surveys.

3 Between 2017 and 2018, there was no change in the indicator used for safe delivery. Skilled birth attendance was replaced by the percentage of deliveries in a health unit. For the sake of indicator consistency, only 2018 data are presented here.

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contraceptives soared, while use of shorter-term methods declined (Figure 7). The number of implant insertions, for example, increased by 73 percent, from about 65,000 in the first quarter of 2017 to nearly 113,000 in the fourth quarter of 2018. This shift in method mix reflects increases in method choice in the public sector, which may have implications for overall contraceptive use, contraceptive continuation, and health outcomes for women and girls in Uganda.

Improving Birth Registrations

The 2016 Uganda Demographic and Health Survey indicated that only 32 percent of Ugandan children under the age of five had a registered birth. In part, this reflected a backlog of 4.6 million birth notifications at the start of the Sharpened Plan period. Since mid-2018 to present, the National Identification and Registration Authority (NIRA) has been working closely with the Ministry of Health, with technical support from the GFF, to address this backlog using a modified mobile vital records system (MVRS) to expedite birth registrations. In addition, systems investments and the efforts of this multisectoral collaboration have contributed to increases in birth registrations, from 37,694 in FY 2016/17 to more than 600,000 in FY 2018/19.

Conclusion

The results presented here from Uganda’s Sharpened Plan highlight the urgency of accelerating the plan’s implementation. Trends in national data also reveal successes at the subnational level and demonstrate the will of a diverse set of partners to align and coordinate on approaches to strategic purchasing. These insights suggest enormous potential for further improvements in health outcomes deriving from the Sharpened Plan’s strategic shifts and this partnership in the years ahead.
Afghanistan

**Country Focus Areas**

- Achieve efficiency gains by better managing contracts with NGOs (moving from contract management to performance management).
- Reduce fragmentation of external resources by mapping and tracking of off-budget and on-budget resources to complement BPHS and EPHS contracts in a more aligned and coordinated manner.
- Adopt innovations to reduce material wastage and stunting and increase access to and quality of RMNCAH-N interventions such as family planning services.

**RMNCAH-N Core Indicators**

- Maternal mortality ratio: Not available
- Neonatal mortality ratio: 39 per 1,000 live births
- Under-five mortality ratio: 68 per 1,000 live births
- Adolescent birth rate: 62 per 1,000 women
- Percent of births ≤24 months after the preceding birth: 32.4%
- Stunting among children under 5 years of age: 36.6%
- Moderate to severe wasting among children under 5 years of age: 5%

**Health Financing Core Indicators**

- Health expenditure per capita financed from domestic sources: US$2.94
- Ratio of government health expenditure to total government expenditures: 2.01%
- Percent of current health expenditures on primary/outpatient health care: 60.34%
- Incidence of catastrophic and impoverishing health expenditures: 14.63% catastrophic and 4.52% impoverishing

**Resource Mapping**

Resource mapping is currently underway in Afghanistan. The first phase of resource mapping focused on external financing for the health sector, and preliminary results have been analyzed. The second phase will focus on inclusion of external financing at the sub-national level. Additionally, the expanded version of the investment case is in development and the second phase will also focus on identifying the financing gap for the investment case.

**Monitoring the Country-Led Process**

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Investment case for RMNCAH-N or equivalent (e.g., national health plan) not developed</td>
</tr>
<tr>
<td>1</td>
<td>Results monitoring strategy and framework not in support of IC*</td>
</tr>
<tr>
<td>2</td>
<td>Country-led multi-stakeholder platform (e.g., new or established from an existing platform) not yet established</td>
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<tr>
<td>3</td>
<td>Government focal point not yet identified</td>
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<tr>
<td>4</td>
<td>Government focal point identified but not yet integrated into IC</td>
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<tr>
<td>5</td>
<td>CDS not included in the process</td>
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<tr>
<td>6</td>
<td>Health financing reforms not identified</td>
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<tr>
<td>7</td>
<td>World Bank-funded project in support of the IC not under preparation</td>
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<tr>
<td>8</td>
<td>Private sector not identified at this time</td>
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<tr>
<td>9</td>
<td>Civil registration and vital statistics (CRVS) not identified at this time</td>
</tr>
<tr>
<td>10</td>
<td>Management of medicines and supplies / supply chain not identified as a priority</td>
</tr>
<tr>
<td>11</td>
<td>Supply chain / commodity management not identified as a priority</td>
</tr>
</tbody>
</table>

**Notes:**

- * Both included in the IC document or a separate document
- ** Country platform (or other country led entity) uses country platform (e.g., new or established from an existing platform) to discuss results arising from implementing the IC and corrective action
- *** ANC4 = four antenatal care visits
- ** Meaning that funding was allocated, disbursed and released – payment done
- *** Meaning that funding was allocated, disbursed and released – payment done
- ART = antiretroviral therapy; ARV = antiretroviral; DTP3 = vaccination for Diphtheria, Tetanus, and Pertussis; ORS = oral rehydration solution; PMTCT = prevention of mother-to-child transmission; PNC = postnatal care
Investment Case being Developed but not Project approved and Developed. Initial efforts are under way to develop an investment case for RMNCAH-N or equivalent (e.g., national healthplan) based on prioritized monitoring and results framework in support of IC.

Set of evidence based priorities financed

Results monitoring strategy and framework in support of IC

Country-led multi-stakeholder platform (e.g., new or established from an existing platform)

Government focal point

An inclusive country platform processes with CSO engagement

Health financing reforms identified

World Bank-funded project in support of the IC

Private sector engagement

Civil registration and vital statistics (CRVS) made a priority

Management of medicines and supplies / supply chain interventions

Resource Mapping

Bangladesh

Country Focus Areas

- Build capacity on health financing to support evidence generation and advocacy on the need to increase the share of the government budget allocated to health.
- Increase spending on primary care targeting the poor by increasing the availability of midwives and increasing the operational budget at the level of the Upazila (subdistrict).
- Support the development of health system governance, management, and service delivery capacities.
- Implement an essential service package that includes key RMNCAH-N measures, particularly in vulnerable areas of Sylhet and Chittagong.
- Reduce adolescent pregnancy rate by keeping girls in school and increasing access to adolescent-friendly health and nutrition services.
- Strengthen private sector engagement and collaboration in the delivery of health care services.

RMNCAH-N Core Indicators

- Maternal mortality ratio: 169 per 100,000 live births
- Neonatal mortality ratio: 16 per 1,000 live births
- Under-five mortality rate: 29 per 1,000 live births
- Adolescents birth rate: 73.1 per 1,000 women
- Percent of births ≤ 24 months after the preceding birth: 11.3%
- Stunting among children under 5 years of age: 36%
- Moderate to severe wasting among children under 5 years of age: 14%
- Incidence of catastrophic and impoverishing health expenditures: 10.3% catastrophic, 2.6% impoverishing

Health Financing Core Indicators

- Health expenditure per capita financed from domestic sources: US$6.14
- Ratio of government health expenditure to total government expenditures: 3.38%
- Percent of current health expenditures on primary/outpatient health care: Not available
- Incidence of catastrophic and impoverishing health expenditures: 10.3% catastrophic, 2.6% impoverishing

The resource mapping for Bangladesh covers FY2018 to 2023. This chart includes use of the two World Bank projects, and is focused specifically on health and nutrition. The second project, which is co-funded by the GFF Trust Fund, is a standalone project focused on keeping girls in school in an effort to reduce adolescent health. However, it is not included in the resource mapping because currently there is only an 8% gap in financing for the IC.

GAP

Total

US$51,00,00,000

US$56,00,00,000

92%

GOVERNMENT

WORLD BANK

GFF TRUST FUND

Netherlands

Private sector

Civil society engaged

Country does not have a priority

Off priority identified

Not identified at this time

CRVS identified as a priority in the investment case

Not included in the process

Country platform holds regular country meetings to discuss results arising from implementing the IC and corrective action

Government focal point not yet identified

Government focal point identified

Government focal point identified with contact available online (GFF website)

IDR, other)

**Priorities fully funded

* Both included in the IC document or a separate document

*** Meaning that funding was allocated, disbursed and released – payment done

** MHSA = mother, newborn and child health and nutrition strategy; ANM = accredited nurse midwife; ASH = auxiliary silu health worker; ASH = auxiliary silu health worker; CRS = charcoal; FHS = family health service; MCH = maternal and child health; RMNCH = reproductive, maternal, newborn, Child Health; SDG = sustainable development goal; WHA = World Health Assembly; WSS = water supply and sanitation; WHS = World Health Statistics; WHP = world health report.
Burkina Faso has completed a preliminary analysis of the resources available for the Investment case. Domestic resources from the government account for 48 percent of financing available for the investment case, which is on par with external resources that are equivalent to 45 percent of investment case financing. Out-of-pocket spending from households is approximately 7 percent of expenditure on the investment case, while less than 1 percent of spending is from private sources.

Resource Mapping

Burkina Faso has completed a preliminary analysis of the resources available for the Investment case. Domestic resources from the government account for 48 percent of financing available for the investment case, which is on par with external resources that are equivalent to 45 percent of investment case financing. Out-of-pocket spending from households is approximately 7 percent of expenditure on the investment case, while less than 1 percent of spending is from private sources.

Health Financing Core Indicators

Health expenditure per capita financed from domestic sources: $US16.42

Ratio of government health expenditure to total government expenditures: 11.03%

Percent of current health expenditures on primary/outpatient health care: 78.34%

Incidence of catastrophic and impoverishing health expenditures: catastrophic, Not available, 1.92% impoverishing
Cambodia

Country Focus Areas

- Focus on reducing child undernutrition, neonatal mortality, and adolescent fertility, in seven priority provinces with large percentages of ethnic minorities.
- Support quality improvement and community health initiatives to increase coverage of good-quality RMNCAH-N services.
- Increase community awareness and demand for preventive, promotive, and curative health services.
- Address supply-side bottlenecks including low provider training and capacity, limited accountability for delivering health and nutrition services in adherence to clinical guidelines; and insufficient availability of necessary equipment, commodities, and supplies.
- Defragment RMNCAH-N financing and integrate service delivery within mainstream government systems and reforms to improve the coordination and sustainability of RMNCAH-N activities and interventions.

RMNCAH-N Core Indicators

Maternal mortality ratio: 170 per 100,000 live births
Neonatal mortality ratio: 18 per 1,000 live births
Under-five mortality ratio: 35 per 1,000 live births
Adolescent birth rate: 57 per 1,000 women
Percent of births <24 months after the preceding birth: 13.3%
Stunting among children under 5 years of age: 32.4%
Moderate to severe wasting among children under 5 years of age: 9.6%

Resource Mapping

Cambodia’s investment case is focused on three key issues: reducing newborn mortality, reducing child undernutrition, and decreasing adolescent fertility. The aim is to finalize the investment case by the end of 2019. Collaboration with the SUN Donor Network and the United Nations agencies is being established to link the ongoing initiatives on resource mapping with the investment case resource mapping exercise. The investment case identified a funding gap of US$53.56 million over five years, of which 80% will be funded by a US$3 million project, Cambodia Nutrition project (2019-2024) financed by the Royal Government of Cambodia (US$12m), IDD (US$ 15m), GFF (US$10m), German KfW (US$9m), Australian DFAT (US$5m) and Health Equity and Quality Improvement Project MDTF with financing from Australian Aid, German KfW and KOICA (US$2m). A funding gap for adolescent health, pre-service and in-service training, EmONC, and other issues remains. Further investments from donors to align their work to reduce the remaining funding gap are pending.

Health Financing Core Indicators

Health expenditure per capita financed from domestic sources: US$16.94
Ratio of government health expenditure to total government expenditures: 6.16%
Percent of current health expenditures on primary/health patient care: 67.37%
Incidence of catastrophic and impoverishing health expenditures: 19.97% catastrophic, 2.99% impoverishing

Monitoring the Country-Led Process

- Investment case for RMNCAH-N or equivalent (e.g., national health plan)
- Results monitoring strategy and framework in support of IC
- Core Indicators
  - ODF not included in the process
  - ODF representation identified
  - ODF accountability in resource mobilization and implementation
- Health financing reforms identified
- Government focal point
  - Government focal point not yet identified
  - Government focal point identified
- World Bank-funded project in support of the IC
  - Project under preparation
  - Project approved and available online
- Private sector engagement
  - Private sector engagement not identified at this time
  - Private sector engagement identified as a priority
- Civil registration and vital statistics (CRVS) made a priority
  - CRVS not identified as a priority
  - CRVS identified as a priority in the investment case
  - CRVS priority funded (for example GFF Trust Fund, IDA, other)
- Management of medicines and supplies / supply chain interventions
  - Supply chain / commodity management not identified as a priority
  - Supply chain / commodity management identified as a priority

Scores

<table>
<thead>
<tr>
<th>Category</th>
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<tbody>
<tr>
<td>ODF</td>
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<td>Health financing reforms</td>
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<td>1</td>
</tr>
<tr>
<td>Management of medicines and supplies / supply chain interventions</td>
<td>1</td>
</tr>
</tbody>
</table>
**Investment Case being Developed but not Established and initial Country Focus Areas**

- Incentivize birth registration
- Focus on adolescent and preterm infants.
- Strengthen Kangaroo Mother Care and neonatal health care
- Scale up results-based financing in disadvantaged regions
- Support Government in increasing its budget share for health: from 3.9 percent in 2018 to 3.97 percent in 2019 and the share of the health budget going to primary and secondary care from 8 percent in 2017 to 21 percent in 2019
- 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.

### RMNCAH-N Core Indicators

- **Maternal mortality ratio:** 596 per 100,000 live births
- **Neonatal mortality ratio:** 28 per 1,000 live births
- **Under-five mortality ratio:** 79 per 1,000 live births
- **Adolescent birth rate:** 123 per 1,000 women
- **Percent of births ≤24 months after the preceding birth:** 21.3%
- **Stunting among children under 5 years of age:** 28.9%
- **Moderate to severe wasting among children under 5 years of age:** 4.3%

### Health Financing Core Indicators

- **Health expenditure per capita financed from domestic sources:** US$8.60
- **Ratio of government health expenditure to total government expenditures:** 2.93%
- **Percent of current health expenditures on primary/outpatient health care:** Not available
- **Incidence of catastrophic and impoverishing health expenditures:** 10.78% catastrophic; 1.86% impoverishing

### Monitoring the Country-Led Process

**Investment Case for RMNCAH-N or equivalent (e.g., national health plan)**
- Not prioritized within available funding
- Not developed
- Not yet established
- Not available
- Not yet developed
- Not available

**Set of evidence-based priorities identified**
- Not prioritized within available funding
- Not developed
- Not yet established
- Not available

**Results monitoring strategy and framework in support of IC**
- Not developed
- Not available
- Not yet developed
- Not available

**Country-led multi-stakeholder platform (e.g., new or established from an existing platform)**
- Not established and initial meeting held
- Not available
- Not established
- Not available

**Government focal point**
- Government focal point not yet identified
- Government focal point identified
- Government focal point identified with contact available online

**An inclusive country platform process with CSO engagement**
- CSOs not included in the process
- CSO representatives identified
- CSOs not included identified
- CSO representatives identified

**Health financing reforms identified**
- Not considered at this time
- Not considered, but not integrated into IC
- CSOs not included identified
- CSOs representatives identified

**World Bank-funded project in support of the IC**
- Project under preparation
- Project approved and available online
- Project disbursing

**Private sector engagement**
- Private sector engagement not identified at this time
- Country has either included or identified a private sector intervention
- Country has started implementing a private sector intervention
- Private sector engagement not identified at this time
- Country has started implementing a private sector intervention

**Civil society and civil society actors (COSA) involved in IC**
- COSA not identified as a priority
- COSA identified as a priority in the investment case
- COSA identified as a priority in the investment case

**Management of medicines and supplies / supply chain interventions**
- Supply chain / commodity management not identified as a priority
- Supply chain / commodity management identified as a priority
- Supply chain / commodity management not identified as a priority
- Supply chain / commodity management identified as a priority

**Scores**
- **Investment Case in Development:**
  - Score: 4
- **Investment Case complete:**
  - Score: 7
- **Investment Case being implemented:**
  - Score: 5

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Other indicators that might be relevant include:

**Health Financing Indicators:**
- **Maternal mortality ratio:** 596 per 100,000 live births
- **Neonatal mortality ratio:** 28 per 1,000 live births
- **Under-five mortality ratio:** 79 per 1,000 live births
- **Adolescent birth rate:** 123 per 1,000 women
- **Percent of births ≤24 months after the preceding birth:** 21.3%
- **Stunting among children under 5 years of age:** 28.9%
- **Moderate to severe wasting among children under 5 years of age:** 4.3%

**Country Focus Areas:**

- Support Government in increasing its budget share for health: from 3.9 percent in 2018 to 3.97 percent in 2019 and the share of the health budget going to primary and secondary care from 8 percent in 2017 to 21 percent in 2019
- Scale up results-based financing in disadvantaged regions, in order to improve equity in spending.
- 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.
- 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.
- 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.

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**Resource Mapping**

- **Gap US$11,000,746**
  - **98%**
  - **Total US$65,625,530**

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**CAMEROON**

**Country Focus Areas**

- Support Government in increasing its budget share for health: from 3.9 percent in 2018 to 3.97 percent in 2019 and the share of the health budget going to primary and secondary care from 8 percent in 2017 to 21 percent in 2019
- Scale up results-based financing in disadvantaged regions, in order to improve equity in spending.
- 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.
- 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.
- 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.

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**Investment Case for RMNCAH-N or equivalent (e.g., national health plan)**
- Not prioritized within available funding
- Not developed
- Not yet established
- Not available
- Not yet developed
- Not available

**Set of evidence-based priorities identified**
- Not prioritized within available funding
- Not developed
- Not yet established
- Not available

**Results monitoring strategy and framework in support of IC**
- Not developed
- Not available
- Not yet developed
- Not available

**Country-led multi-stakeholder platform (e.g., new or established from an existing platform)**
- Not established and initial meeting held
- Not available
- Not established
- Not available

**Government focal point**
- Government focal point not yet identified
- Government focal point identified
- Government focal point identified with contact available online

**An inclusive country platform process with CSO engagement**
- CSOs not included in the process
- CSO representatives identified
- CSOs not included identified
- CSO representatives identified

**Health financing reforms identified**
- Not considered at this time
- Not considered, but not integrated into IC
- CSOs not included identified
- CSOs representatives identified

**World Bank-funded project in support of the IC**
- Project under preparation
- Project approved and available online
- Project disbursing

**Private sector engagement**
- Private sector engagement not identified at this time
- Country has either included or identified a private sector intervention
- Country has started implementing a private sector intervention
- Private sector engagement not identified at this time
- Country has started implementing a private sector intervention

**Civil society and civil society actors (COSA) involved in IC**
- COSA not identified as a priority
- COSA identified as a priority in the investment case
- COSA identified as a priority in the investment case

**Management of medicines and supplies / supply chain interventions**
- Supply chain / commodity management not identified as a priority
- Supply chain / commodity management identified as a priority
- Supply chain / commodity management not identified as a priority
- Supply chain / commodity management identified as a priority

**Scores**
- **Investment Case in Development:**
  - Score: 4
- **Investment Case complete:**
  - Score: 7
- **Investment Case being implemented:**
  - Score: 5
Investment Case being Project approved and Developed and initial Established and initial COUNTRY PLATFORM Developed but not

Strengthen health information reducing fragmentation focusing on increasing access development financing.

integrating humanitarian and health information system reforms.

Case results framework with ongoing systems RMNCAH-N services of a high-impact package of and improving the quality based violence.

breastfeeding women, children under five, and victims of gender

Free services for pregnant and improving rates of a high-impact package of

performance-based financing and to ensure that external partners are aligned.

in CAR is to use existing resources more efficiently accounts for 5% of total IC needs. The main focus defending in the IC. Government financing

who are aligned with and committed to Central African Republic (CAR) over 5 external partners in the 2020-22. There are currently

63% of the IC

multi-stakeholder platform (e.g., new or established from an existing platform)

Government focal point

An inclusive country platform process with CSO engagement

Health financing reforms identified

World Bank-funded project in support of the IC

Private sector engagement

Health expenditure per capita financed from domestic sources: US$2.43

Ratio of government health expenditure to total government expenditures: 5.06%

Percent of current health expenditures on primary/outpatient health care: Not available

Incidence of catastrophic and impoverishing health expenditures: 6.75% catastrophic, 1.06% impoverishing

The resource mapping presented here covers the years 2020-22. There are currently 23 external partners in the Central African Republic (CAR) who are aligned with and committed to investing in the IC. Government financing accounts for 5% of total IC needs. The main focus in CAR is to use existing resources more efficiently while ensuring that external partners are aligned.

HIV/AIDS

Health financing

Other areas of interest

Health Financing Core Indicators

Maternal mortality ratio: 882 per 100,000 live births

Neonatal mortality ratio: 41.5 per 1,000 live births

Under-five mortality ratio: 121.3 per 1,000 live births

Adolescent birth rate: 105.8 per 1,000 women

Percent of births <24 months after the preceding birth: No Data

Stunting among children under 5 years of age: 39.6%

Moderate to severe wasting among children under 5 years of age: 7.6%

Health Financing Core Indicators

Health expenditure per capita financed from domestic sources: US$2.43

Ratio of government health expenditure to total government expenditures: 5.06%

Percent of current health expenditures on primary/outpatient health care: Not available

Incidence of catastrophic and impoverishing health expenditures: 6.75% catastrophic, 1.06% impoverishing

Monitoring the Country-Led Process

Investment Case being

Set of evidence based priorities financed

Results monitoring strategy and framework in support of IC

Country-led multi-stakeholder platform (e.g., new or established from an existing platform)

Government focal point

An inclusive country platform process with CSO engagement

Health financing reforms identified

World Bank-funded project in support of the IC

Private sector engagement

Civil registration and vital statistics (CRVS) made a priority

Private sector engagement identified

Country has aCRVS priority funded (for IDA, other)

Project under preparation

Project approved and available online

Project disbursement

Country has either included or identified a private sector intervention

Civil registration and vital statistics (CRVS) not identified as a priority

Civil registration and vital statistics (CRVS) not identified as a priority in the investment case

Management of medicines and supplies / supply chain interventions

Supply chain / commodity management not identified as a priority

Supply chain / commodity management identified as a priority

SCORES

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SCORES

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Resource Mapping

Cote d’Ivoire has completed the first phase of resource mapping by estimating the total resources available for Investment Case implementation. Since the Investment Case has not yet been costed, there is no financing gap identified. We expect to have final results, including the financing gap, available by March 2020. Preliminary results for FY 2016-2018 (including commitment) indicate that their domestic government resources account for over 60% of financing for the Investment Case with external partners accounting for the rest. There are currently over 15 external partners in Cote d’Ivoire who are aligned with and committed to investing in the Investment Case.

Country Focus Areas

- Operationalize the government’s commitment, made at the first National Dialogue on Health Financing held April 15–18, 2019, to increase the health budget share by 15 percent a year.
- Increase public health spending on primary health care, including community health services, through decentralization, nationwide scale-up of strategic purchasing, and linking of the universal health insurance scheme.
- Involve private sector service providers in strategic purchasing reforms through regulation, accreditation, and contracting mechanisms.

RMNCAH-N Core Indicators

Maternal mortality ratio: 614 per 100,000 live births
Neonatal mortality ratio: 33 per 1,000 live births
Under-five mortality ratio: 96 per 1,000 live births
Adolescent birth rate: 124 per 1,000 women
Percent of births <24 months after the preceding birth: 16.9%
Stunting among children under 5 years of age: 21.6%
Moderate to severe wasting among children under 5 years of age: 6%

Health Financing Core Indicators

Health expenditure per capita financed from domestic sources: US$17.41
Ratio of government health expenditure to total government expenditures: 4.88%
Percent of current health expenditures on primary/ outpatient health care: 77.78%
Incidence of catastrophic and impoverishing health expenditures: 8.22% catastrophic, 1.73% impoverishing

Health Financing

Cote d’Ivoire

Monitoring the Country-Led Process

Resource Mapping

Cote d’Ivoire has completed the first phase of resource mapping by estimating the total resources available for Investment Case implementation. Since the Investment Case has not yet been costed, there is no financing gap identified. We expect to have final results, including the financing gap, available by March 2020. Preliminary results for FY 2016-2018 (including commitment) indicate that their domestic government resources account for over 60% of financing for the Investment Case with external partners accounting for the rest. There are currently over 15 external partners in Cote d’Ivoire who are aligned with and committed to investing in the Investment Case.

Country Focus Areas

- Operationalize the government’s commitment, made at the first National Dialogue on Health Financing held April 15–18, 2019, to increase the health budget share by 15 percent a year.
- Increase public health spending on primary health care, including community health services, through decentralization, nationwide scale-up of strategic purchasing, and linking of the universal health insurance scheme.
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RMNCAH-N Core Indicators

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Health Financing

Cote d’Ivoire

Monitoring the Country-Led Process

Resource Mapping

Cote d’Ivoire has completed the first phase of resource mapping by estimating the total resources available for Investment Case implementation. Since the Investment Case has not yet been costed, there is no financing gap identified. We expect to have final results, including the financing gap, available by March 2020. Preliminary results for FY 2016-2018 (including commitment) indicate that their domestic government resources account for over 60% of financing for the Investment Case with external partners accounting for the rest. There are currently over 15 external partners in Cote d’Ivoire who are aligned with and committed to investing in the Investment Case.
Democratic Republic of Congo

Country Focus Areas

- The Investment case corresponds to the updated national health development plan 2019-2022 which is a prioritized version of the previous National Health Development Plan (NHDP).
- Align the government’s health budget with the new NHDP, in order to monitor increases in domestic and external spending on priority areas, such as including RMNCAH.
- Provide technical support on public financial management, in order to address the low budget execution rate (below 60 percent nationally and below 20 percent in several provinces).
- Reduce the fragmentation of donor support through single contracts.
- Provide a package of RMNCAH services through result-based financing.
- Undertake a comprehensive assessment of civil registration and vital statistics (CRVS), develop a costed national CRVS strategy and implementation plan, and support catch-up registration campaigns through schools.
- Conduct discussions with the private sector on developing capacity and public-private dialogue platforms.

RMNCAH-N Core Indicators

- Maternal mortality ratio: 846 per 100,000 live births
- Neonatal mortality ratio: 28 per 1,000 live births
- Under-five mortality ratio: 138.1 per 1,000 women
- Adolescent birth rate: 138.1 per 1,000 live births
- Stunting among children under 5 years of age: 43%
- Moderate to severe wasting among children under 5 years of age: 8%
- 27.1% of births <24 months after the preceding birth
- 28 per 1000 live births

Health Financing Core Indicators

- Health expenditure per capita financed from domestic sources: US$2.51
- Ratio of government health expenditure to total government expenditures: 3.73%
- Percent of current health expenditures on primary/outpatient health care: 65.39%
- Incidence of catastrophic and impoverishing health expenditures: 4.82% catastrophic; 0.87% impoverishing

The resource mapping shown here is for FY 2019. Presently there are more than 10 country platforms aligned with and committed to financing the IC. The government only accounts for 22% of total needs for the IC. There is a funding gap of 22% for FY 2019. The resource mapping has been completed for the Plan National de Developpement (PNDE) and the Plan National de Developpement (PNDE), World Bank, and the World Bank-funded project in support of the IC. The resource mapping is available online.

Monitors the Country-Led Process

Investment Case being
COUNTRY PLATFORM
Democratic Republic of Congo
Country Focus Areas
 Undertake a comprehensive supply of RMNCAH and external spending on priority areas, such as including RMNCAH.
 Reduce the fragmentation of donor support through single contracts.
 Provide a package of RMNCAH services through result-based financing.
 Undertake a comprehensive assessment of civil registration and vital statistics (CRVS), develop a costed national CRVS strategy and implementation plan, and support catch-up registration campaigns through schools.
 Conduct discussions with the private sector on developing capacity and public-private dialogue platforms.

Country-led multi-stakeholder platform (e.g., new or established from an existing platform)

Governance focal point

An inclusive country platform process with CSO engagement

Civil registration and vital statistics (CRVS) identified as a priority

Management of medicines and supplies / supply chain interventions

Supply chain / commodity management not identified as a priority

Project under preparation

Not yet identified

Country platform holds regular country meetings to discuss results arising from implementing the IC and corrective action

Government focal point not identified

Health financing reforms identified

Not considered at this time

World Bank-funded project in support of the IC

Project approved and available online

Country platform has started implementing a private sector intervention

Private sector engagement

Not identified at this time

Civil registration/vital statistics (CRVS) identified as a priority

CRVS not included as a priority in the investment case

Project disbursing

Project disbursement as a priority identified from the IC

Government focal point identified with current online activity (GPF network)

GFF Trust Fund

Not prioritized within available funding

Program determined, but financial gap remains

Donor support campaigns through schools.

Private sector engagement

Not identified at this time

Civil registration/vital statistics (CRVS) identified as a priority

CRVS not included as a priority in the investment case

Country platform has started implementing a private sector intervention

Health financing reforms identified

Not considered at this time

World Bank-funded project in support of the IC

Project approved and available online

Country platform has started implementing a private sector intervention

Private sector engagement

Not identified at this time

Civil registration/vital statistics (CRVS) identified as a priority

CRVS not included as a priority in the investment case

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Project disbursement as a priority identified from the IC

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Donor support campaigns through schools.

Private sector engagement

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Civil registration/vital statistics (CRVS) identified as a priority

CRVS not included as a priority in the investment case

Project disbursing

Project disbursement as a priority identified from the IC

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GFF Trust Fund

Not prioritized within available funding

Program determined, but financial gap remains

Donor support campaigns through schools.

Private sector engagement

Not identified at this time

Civil registration/vital statistics (CRVS) identified as a priority

CRVS not included as a priority in the investment case

Project disbursing

Project disbursement as a priority identified from the IC

Government focal point identified with current online activity (GPF network)

GFF Trust Fund

Not prioritized within available funding

Program determined, but financial gap remains

Donor support campaigns through schools.

Private sector engagement

Not identified at this time

Civil registration/vital statistics (CRVS) identified as a priority

CRVS not included as a priority in the investment case

Project disbursing

Project disbursement as a priority identified from the IC

Government focal point identified with current online activity (GPF network)
Country Focus Areas

- Add GFF and World Bank resources into SDG Pool funds with 10 other partners that the Ministry of Health can use to purchase drugs and medical supplies for health facilities at regional levels and implement the HSTP / Investment Case and support improvement of RMNCAH results.
- Support the government’s efforts to increase the budget share for health from 7 percent in 2015 to 11 percent in 2020.
- Improve equity in public spending by increasing the proportion of functioning community-based health insurance schemes from 23 percent in 2017 to 53 percent in 2021.
- Support public financial management reforms to improve budget execution and increase domestic resource mobilization.
- Strengthen private sector engagement, support public-private sector dialogues, and build capacity and opportunities for collaboration.
- Strengthen monitoring, supervision, and safe storage of civil registration documents, and support advocacy and awareness campaigns.

RMNCAH-N Core Indicators

Maternal mortality ratio: 412 per 100,000 live births
Neonatal mortality ratio: 30 per 1,000 live births
Under-five mortality ratio: 55 per 1,000 live births
Adolescent birth rate: 80 per 1,000 women
Percent of births <24 months after the preceding birth: 21.7%
Stunting among children under 5 years of age: 37%
Moderate to severe wasting among children under 5 years of age: 7%

Health Financing Core Indicators

Health expenditure per capita financed from domestic sources: US$10.60
Ratio of government health expenditure to total government expenditures: 8.1%
Percent of current health expenditures on primary/ outpatient health care: 89%
Incidence of catastrophic and impoverishing health expenditures: 4.91% catastrophic
0.93% impoverishing

Monitoring the Country-Led Process

Investment Case for RMNCAH or equivalent (e.g., national health plan)
Set of evidence based priorities financed
Results monitoring strategy and framework in support of IC
Country-led multi-stakeholder platform (e.g., new or established from an existing platform)
Government focal point
An inclusive country platform process with CSO engagement
Health financing reforms identified
World Bank-funded project in support of the IC
Private sector engagement
Civil registration and vital statistics (CRVS) made a priority
Management of medicines and supplies / supply chain interventions

Resource Mapping

<table>
<thead>
<tr>
<th>Category</th>
<th>Total US$3,266,993,588</th>
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<tbody>
<tr>
<td>GOVERNMENT</td>
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<tr>
<td>WORLD BANK</td>
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<td>GFF</td>
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<td>AECDF</td>
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<td>GAVI</td>
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<td>UNICEF</td>
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<td>UNFPA</td>
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<td>WHO</td>
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<td>NETHERLANDS</td>
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<td>CHANNEL 3 NGOs</td>
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<tr>
<td>COMMUNITY HEALTH INSURANCE / CBHI</td>
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<td>... GAP</td>
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</tbody>
</table>

GAP
US$63,311,177
83%
Guatemala

Country Focus Areas

- Improve efficiency by providing technical assistance on strategic planning and public financial management, integrated service delivery networks, and data and evidence-based policy making.
- Free up domestic resources from debt payments through the GFF buy-down. A conditionality to receive the buy-down is for the Ministry of Finance to secure and guarantee double the amount of the buy-down (US$188 million), for the national conditional cash transfer program that has suffered from budgetary shortfalls in the past.
- Reduce stunting and chronic malnutrition through multisectoral approaches, focusing on increasing the quality of and demand for health and nutrition services, social safety nets, and sanitation.

RMNCAH-N Core Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Data</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal mortality ratio</td>
<td>140 per 100,000 live births</td>
<td>Health and population</td>
</tr>
<tr>
<td>Neonatal mortality ratio</td>
<td>17 per 1,000 live births</td>
<td>Health and population</td>
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<tr>
<td>Under-five mortality ratio</td>
<td>35 per 1,000 live births</td>
<td>Health and population</td>
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<tr>
<td>Adolescent birth rate</td>
<td>93 per 1,000 women</td>
<td>Health and population</td>
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<tr>
<td>Percent of births &lt;24 months after the preceding birth: 18.8%</td>
<td>Health and population</td>
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<tr>
<td>Stunting among children under 5 years of age: 47%</td>
<td>Health and population</td>
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</tr>
<tr>
<td>Moderate to severe wasting among children under 5 years of age: 1%</td>
<td>Health and population</td>
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</tbody>
</table>

Health Financing Core Indicators

- Health expenditure per capita financed from domestic sources: US$89.82
- Ratio of government health expenditure to total government expenditures: 17.94%
- Percent of current health expenditures on primary/secondary health care: 65.32%
- Incidence of catastrophic and impoverishing health expenditures: 1.36% catastrophic; 0.29% impoverishing

Resource Mapping

Although resource mapping has not yet been undertaken in Guatemala, Public Expenditure Reviews (PERs), health sector assessments and expenditure tracking using National Health Accounts (NHAs) have been completed in 2012, 2015, and 2017. Guatemala is not dependent on external financing, with less than 2 percent of total financing for the health sector from external sources.

Guatemala is on-track to implement efforts to improve efficiencies and public financial management systems, which is the main goal of conducting resource mapping. 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.

Health Financing

Results monitoring strategy and framework in support of IC

Country-led multi-stakeholder platform (e.g., new or established from an existing platform)

Government focal point

An inclusive country platform process with CSO engagement

Health financing reforms identified

World Bank-funded project in support of the IC

Private sector engagement

Civil registration and vital statistics (CRVS) made a priority

Management of medicines and supplies / supply chain interventions

CRVS not included in the process

CRVS identified as a priority in the investment case

CRVS identified as a priority in the investment case

Government focal point not yet identified

Government focal point identified

Government focal point identified with contact information

CDOs not included in the process

CDOs identified

CDOs identified as a priority in the investment case

CDOs identified

Supply chain / commodity management not identified as a priority

Supply chain / commodity management identified as a priority

Supply chain / commodity management identified as a priority

Supply chain / commodity management identified as a priority

*COS = cost of service, **COS = core organizational services, ***ANC4 = fourth antenatal care visit

Monitoring the Country-Led Process

Investment Case

- Investment Case in development
- Investment Case complete
- Investment Case being implemented

Evidence based priorities

- Not prioritized within available funding
- Priorities determined, but financial gaps remain
- Priorities likely funded

Results monitoring

- Not developed
- Developed and initial assessment of results monitoring capacity available
- Country platform for overall country strategy

Country-led multi-stakeholder platform

- Not yet established
- Established and initial meeting held
- Country platform holds regular country meetings to discuss results from implementing the IC and corrective action

Government focal point

- Government focal point not yet identified
- Government focal point identified
- Government focal point identified with contact information

Country platform

- CDOs not included in the process
- CDOs identified
- CDOs identified as a priority in the investment case

Civil registration and vital statistics

- CRVS not identified as a priority in the investment case
- CRVS identified as a priority
- CRVS identified as a priority in the investment case

Private sector engagement

- Private sector engagement not identified as a priority
- Country has either included or identified a private sector incentive
- Country has started implementing a private sector incentive

Supply chain / commodity management

- Supply chain / commodity management not identified as a priority
- Supply chain / commodity management identified as a priority
- Supply chain / commodity management identified as a priority

* Both included in the IC document or a separate document
** Meaning that funding was allocated, disbursed and released – payment done
***AHED = a four antenatal care visit
ART = antiretroviral therapy, ARV = antiretroviral, DPT3 = vaccination for Diphtheria, Tetanus, and Pertussis, ORS = oral rehydration solution, PMTCT = prevention of mother-to-child transmission, PVC = postnatal care.
Guinea

Country Focus Areas

- Align the government’s strategy on RMNCAH-N with a newly elaborated investment case.
- Support the Rural Pipeline Strategy and the Community Health Strategy, which brings health personnel to rural health centers.
- Support the integration of birth and death notification and recording of causes of death into the District Health Information System 2 (DHIS2), improve the quality and security of forms and registers, and build capacity in civil registration.

RMNCAH-N Core Indicators

Maternal mortality ratio: 550 per 100,000 live births
Neonatal mortality ratio: 32 per 1,000 live births
Under-five mortality ratio: 120 per 1,000 women
Adolescent birth rate: 120 per 1,000 women
Percent of births <24 months after the preceding birth: 16%
Stunting among children under 5 years of age: 30.3%
Moderate to severe wasting among children under 5 years of age: 9.2%

Health Financing

Core Indicators

Health expenditure per capita financed from domestic sources: US$4.61
Ratio of government health expenditure to total government expenditures: 4.11%
Percent of current health expenditures on primary/outpatient health care: 78.12%

Incidence of catastrophic and impoverishing health expenditures: 6.97% catastrophic, 2.48% impoverishing

Health Financing Inclusive Community Platform

Investment Case completion
Set of evidence based priorities financed

Results monitoring strategy and framework in support of IC

Country-led multi-stakeholder platform (e.g., new or established from an existing platform)
Government focal point

Government focal point not yet identified

An inclusive country platform process with CSO engagement

COs not included in the process

Health financing reforms identified

Not considered at this time

World Bank-funded project in support of the IC

Project under preparation

Private sector engagement

Civil registration and vital statistics (CRVS) made a priority

CRVS not identified as a priority

Management of medicines and supplies / supply chain interventions

CRVS management not identified as a priority

Other areas of priority

Civil registration and vital statistics (CRVS) made a priority

Not considered at this time

CRVS not identified as a priority

Management of medicines and supplies / supply chain interventions

CRVS management not identified as a priority

Other areas of priority

- Both included in the IC document or a separate document
- Meaning that funding was allocated, disbursed and released – payment done
- ** Meaning that funding was still available to the government
- *** Meaning that funding was still available to the government
- ART = Antiretroviral Therapy, ARV = Antiretroviral, DTP = Diphtheria, Tetanus, and Pertussis, EPI = Expanded program on Immunization, PMTCT = prevention of mother-to-child transmission, PMC = Preventive Medicine and Community Health

<table>
<thead>
<tr>
<th>Year</th>
<th>Gap</th>
<th>Total</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>US$42,332,154</td>
<td>US$129,626,300</td>
<td>67%</td>
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</tbody>
</table>

The resource mapping pie shown here is for FY 2018. There are currently over 10 donors aligned with and committed to the investment case in Guinea. While there remains a financing gap of over 35%, Guinea has made a strong commitment to reducing external morbidity by 15% and maternal and infant mortality by 25% over the next 5 years. While these goals are ambitious, they are supported by a comprehensive strategy for the IC and improvements in allocative efficiencies.

** Resource Mapping**

Gap

- **GOVERNMENT**
- **WORLD BANK**
- **GFF TRUST FUND**
- **GAVI**
- **UNICEF**
- **EUROPEAN COMMISSION**

Total

- **GOVERNMENT**
- **WORLD BANK**
- **GFF TRUST FUND**
- **GAVI**
- **UNICEF**
- **EUROPEAN COMMISSION**
**Country Focus Areas**

- Introduce a paradigm shift to improve donor coordination and enhance effectiveness of foreign aid, in support of efforts to improve utilization and impact of available resources.
- Develop a community health strategy and implementation plans to increase the efficiency and scale of service delivery and use.
- Improve the efficiency of available resources in the health sector using program-based budgeting and a transition towards managing by results.
- Develop 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.
- Map and track resources in order to improve the coordination and efficiency of external resources for health, which have shrunk.
- Improve the national supply and distribution system for medical commodities (SNAD) to guarantee an ongoing availability and accessibility to essential medicines at each health service delivery point across the country.

**RMNCAH-N Core Indicators**

- Maternal mortality ratio: 529 per 100,000 live births
- Neonatal mortality ratio: 32 per 1,000 live births
- Under-five mortality ratio: 81 per 1,000 live births
- Adolescent birth rate: 5.5 per 1,000 women
- Percent of births <24 months after the preceding birth: 17.8%
- Stunting among children under 5 years of age: 21.9%
- Moderate to severe wasting among children under 5 years of age: 3.6%
- Incidence of catastrophic and impoverishing health expenditures: 11.54% catastrophic, 2.62% impoverishing

**Health Financing Core Indicators**

- Health expenditure per capita financed from domestic sources: US$3.79
- Ratio of government health expenditure to total government expenditures: 4.42%
- Percent of current health expenditures on primary/ outpatient health care: 74.26%
- Incidence of catastrophic and impoverishing health expenditures: 11.54% catastrophic, 2.62% impoverishing

**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 plans to complete its resource mapping by 2020.

**Monitoring the Country-Led Process**

<table>
<thead>
<tr>
<th>Investment Case for RMNCAH-N or equivalent (e.g., national health plan)</th>
<th>Investment Case complete</th>
<th>Investment Case being implemented</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not prioritized within available funding</td>
<td>Priorities determined, but financial gap remains</td>
<td>Priorities likely funded***</td>
</tr>
</tbody>
</table>

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**Results monitoring strategy and framework in support of IC**

- Not developed
- Developed and initial assessment of results monitoring capacity available
- Country platform for effective country led entity case results framework review progress in a regular basis

---

**Country-led multi-stakeholder platform**

- Not yet established
- Established and initial meeting held
- Country platform holds regular country meetings to discuss results arising from implementing the IC and corrective action

---

**Government focal point**

- Government focal point not yet identified
- Government focal point identified
- Government focal point identified with contact available online (IC implementation website)

---

**An inclusive country platform process with CSO engagement**

- CSOs not included in the process
- CSO representative identified
- Civil society represented at inclusive country platform meetings to discuss IC implementation and results

---

**Health financing reforms identified**

- Not considered at this time
- Developed but not integrated in IC
- Health financing in progress

---

**World Bank-funded project in support of the IC**

- Project under preparation
- Project approved and available online
- Project disbursing

---

**Private sector engagement**

- Private sector engagement not identified at this time
- Country has either included or identified a private sector intervention
- Country has started implementing a private sector intervention

---

**Civil registration and vital statistics (CRVS) made a priority**

- CRVS not identified as a priority
- CRVS identified as a priority in the investment case
- CRVS priority funded for example GFF Trust Fund, CIA, others

---

**Management of medicines and supplies / supply chain interventions**

- Supply chain / commodity management not identified as a priority
- Supply chain / commodity management identified as a priority
- Supply chain / commodity management interventions funded
Investment Case being Project approved and established but not developed and initial Country Platform Developed but not developed and initial Country Focus Areas

- Establish a management and accountability system to implement the Vice President’s National Strategy to Accelerate Stunting Prevention through a multisectoral convergence approach, including improving services at the community level and strengthening citizen engagement.
- Improve the effectiveness of public resources by introducing performance assessment of fiscal transfers to districts and villages.
- Develop tools for tracking government expenditures on priority nutrition interventions, in order to enhance accountability for results.
- Support the roll-out of innovative technology solutions to deliver services and improve citizen engagement at scale, such as village convergence scorecard, child-length mat, and mobilization of Human Development Worker (HDW) to empower 70,000+ villages to converge services and use fiscal transfers for stunting reduction.
- Support sustainable public awareness and behavior change among communities through targeted and locally-adjusted interpersonal communication, continued advocacy to the decision makers, and capacity building.
- Support agenda-setting analytics in strategic emerging areas, such as private sector engagement, civil engagement and vital statistics, digital applications for HDW, and adolescent nutrition.

RMNCAH-N Core Indicators

- Maternal mortality ratio: 305 per 100,000 live births
- Neonatal mortality ratio: 13 per 1,000 live births
- Under-five mortality ratio: 32 per 1,000 live births
- Adolescent birth rate: 36 per 1,000 women
- Percent of births >24 months after the preceding birth: 9%
- Stunting among children under 5 years of age: 30.8%
- Moderate to severe wasting among children under 5 years of age: 10.2%

Health Financing Core Indicators

- Health expenditure per capita financed from domestic sources: US$49.90
- Ratio of government health expenditure to total government expenditures: 8.31%
- Percent of current health expenditures on primary/outpatient health care: Not available
- Incidence of catastrophic and impoverishing health expenditures: 3.61% catastrophic, 0.31% impoverishing

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 multisectoral expenditure tracking assessment with support from the World Bank and GFF. This exercise also includes multisectoral resource mapping. Results were completed in early 2019.

Investment Case for RMNCAH-N or equivalent (e.g., national health plan)
- Investment Case is in development
- Investment Case complete
- Investment Case being implemented

Set of evidence based priorities financed
- Not prioritized within available funding
- Priorities determined, but financial gap remains
- Priorities fully funded**

Results monitoring strategy and framework in support of IC*
- Not developed
- Developed but initial assessment of results accountability capacity available
- Country platform for effect country level entity: case results framework by review progress on a regular basis

Country-led multi-stakeholder platform (e.g., new or established from an existing platform)
- Not yet established
- Established and initial meeting held
- Country platform holds regular country meetings to discuss results arising from implementing the IC and corrective action

Government focal point
- Government focal point not yet identified
- Government focal point identified
- Government focal point identified with contact available (e.g., IC advisor)

An inclusive country platform process with CSO engagement
- CSOs not included in the process
- CSO representative identified
- Civil society represented in inclusive country platform meetings to discuss IC implementation and results

Health financing reforms identified
- Not considered at this time
- Developed but not integrated in IC
- Health financing is progress

World Bank-funded project in support of the IC
- Project under preparation
- Project approved and available online
- Project disbanding

Private sector engagement
- Private sector engagement not identified at this time
- Country has either included or identified a private sector intervention
- Country has started implementing a private sector intervention

Civil registration and vital statistics (CRVS) made a priority
- CRVS not identified as a priority
- CRVS identified as a priority in the investment case
- CRVS included in example GFF Trust Fund, GIA, other

Management of medicines and supplies / supply chain interventions
- Supply chain / commodity management not identified as a priority
- Supply chain / commodity management identified as a priority
- Supply chain / commodity management interventions funded

SCORES

- Both included in the IC document or a separate document
- Meaning that funding was allocated, disbursed and released – payment done
- ANGIE = four annualized care visits
- ART = antiretroviral therapy, ARV = antiretroviral, OUPS = vaccination for Diphtheria, Tetanus, and Pertussis, ORS = oral rehydration solution, PMTCT = prevention of mother-to-child transmission, PNC = postnatal care.
Kenya

Country Focus Areas

- Provide financial incentives for counties to allocate at least 20 percent of their budgets to health.
- Reduce fragmentation and improve the efficiency of spending at the county level by providing Multi Donor Trust Fund technical support to counties’ annual work plans.
- Support platforms for strategic private sector dialogue and engagement.
- Scale up birth registration with maternal and child health services, build the capacity of registration officials in monitoring and supervision and health officials in cause of death certification and coding, and incentivize birth registration.

RMNCAH-N Core Indicators

Maternal mortality ratio: 362 per 100,000 live births
Neonatal mortality ratio: 22 per 1,000 live births
Under-five mortality ratio: 52 per 1,000 live births
Adolescent birth rate: 96.3 per 1,000 women
Percent of births <24 months after the preceding birth: 17.9%
Stunting among children under 5 years of age: 26%
Moderate to severe wasting among children under 5 years of age: 84% moderate, 1% severe

Health Financing Core Indicators

Health expenditure per capita financed from domestic sources: US$23.95
Ratio of government health expenditure to total government expenditures: 6.06%
Percent of current health expenditures on primary/outpatient health care: 62.98%
Incidence of catastrophic and impoverishing health expenditures: 5.83% catastrophic, 1.8% impoverishing

Resource Mapping

Resource mapping informs and supports the implementation of the RMNCAH investment case. The financial requirement for RMNCAH investments for the 20 priority counties was estimated at US$999 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 slow but steady trend toward an increased government share of funding and a decreased share from external partners. Major 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.

Monitoring the Country-Led Process

Investment Case for RMNCAH-N or equivalent (e.g., national health plan)

Set of evidence-based priorities financed

Country-led multi-stakeholder platform (e.g., new or established from an existing platform)

Results monitoring strategy and framework in support of IC

Health financing reforms identified

World Bank-funded project in support of the IC

Private sector engagement

Civil registration and vital statistics (CRVS) made a priority

Management of medicines and supplies / supply chain interventions

SCORES

** Both included in the IC document or a separate document
*** Meaning that funding was allocated, disbursed and released – payment done
* ART = antiretroviral therapy, ATV = atazanavir, DFO = dolutegravir, EFV = efavirenz, KACS = Kivumbi Antiretroviral, OIs = opportunistic infections, PEPFAR = prevention of mother-to-child transmission, PNC = postnatal care.
Liberia

Country Focus Areas

- Reduce fragmentation and better align financial support through improved resource mapping and tracking.
- Build resilience, improve capacity, and strengthen policies and system to reduce maternal and neonatal mortality and increase adolescent access to health services.
- Improve the quality of care in hospitals and the utilization of primary care while building the capacity of county health teams.
- Expand civil registration service delivery points, revise registration forms, develop registration manuals, and better utilize civil registration management.

RMNCAH-N Core Indicators

Maternal mortality ratio: 1,072 per 100,000 live births
Neonatal mortality ratio: 26 per 1,000 live births
Under-five mortality ratio: 94 per 1,000 live births
Adolescent birth rate: 149 per 1,000 women

Health Financing Core Indicators

Health expenditure per capita financed from domestic sources: US$9.73
Ratio of government health expenditure to total government expenditures: 3.86%
Percent of current health expenditures on primary/outpatient health care: 67.71%

Incidence of catastrophic and impoverishing health expenditures: Not available catastrophic. Not available impoverishing

The resource mapping presented here covers FY 2016-2020. There are approximately 10 donors in Liberia that are aligned with and committed to investing in the IC. Domestic government resources account for approximately 28% of total financing for the IC. Liberia is committed to reducing the financing gap for the IC, both through resource mobilization and better use of existing financing. Liberia is focusing on how to improve efficiency of spending and strategic purchasing.

Monitoring the Country-Led Process

Investment Case being established and initial Country Platform developed and initial Project approved and launched.

Country-led multi-stakeholder platform (e.g., new or established from an existing platform) Government focal point

An inclusive country platform process with CSO engagement

Country has either included CRVS as a priority in the investment case or identified a private sector intervention.

Private sector engagement

Supply chain / commodity management identified as a priority

Management of medicines and supplies / supply chain interventions

Civil registration and vital statistics (CRVS) made a priority

Health financing reforms identified

World Bank-funded project in support of the IC

Private sector engagement

Supply chain / commodity management identified as a priority

Management of medicines and supplies / supply chain interventions

The resource mapping presented here covers FY 2016-2020. There are approximately 10 donors in Liberia that are aligned with and committed to investing in the IC. Domestic government resources account for approximately 28% of total financing for the IC. Liberia is committed to reducing the financing gap for the IC, both through resource mobilization and better use of existing financing. Liberia is focusing on how to improve efficiency of spending and strategic purchasing.

The resource mapping presented here covers FY 2016-2020. There are approximately 10 donors in Liberia that are aligned with and committed to investing in the IC. Domestic government resources account for approximately 28% of total financing for the IC. Liberia is committed to reducing the financing gap for the IC, both through resource mobilization and better use of existing financing. Liberia is focusing on how to improve efficiency of spending and strategic purchasing.
Investment Case being developed and initial project approved and committed to investing in the investment case from FY 2018 to 2020. However, since the investment case is being revised, costing will be completed to identify the funding gap. There are approximately 10 donors in Madagascar who are aligned with and committed to investing in the investment case.

**Country Focus Areas**
- Increase the allocation of resources to frontline providers by improving the distribution and availability of qualified people in underserved areas and increasing the decentralization of the health budget.
- Increase demand for high-impact services by vulnerable populations.
- Improve access to financial protection mechanisms by vulnerable populations.
- Strengthen the service delivery network, in order to ensure the provision of a high-impact RMNCH-N service package.
- Support implementation of the national civil registration and vital statistics strategic plan, as part of support to strengthening information systems and improving accountability for results.

**RMNCAH-N Core Indicators**
- Maternal mortality ratio: 498 per 100,000 live births
- Neonatal mortality rate: 24 per 1,000 live births
- Under-five mortality rate: 72 per 1,000 live births
- Adolescent birth rate: 123 per 1,000 women
  - Percent of births <24 months after the preceding birth: 39.7%
  - Stunting among children under 5 years of age: 48.9%
  - Moderate to severe wasting among children under 5 years of age: 7.9%

**Health Financing Core Indicators**
- Health expenditure per capita financed from domestic sources: US$11.49
- Ratio of government health expenditure to total government expenditure: 17.83%
- Percent of current health expenditures on primary/ outpatient health care: Not available
- Incidence of catastrophic and impoverishing health expenditures: 1.64% catastrophic / 0.39% impoverishing

**Resource Mapping**
Madagascar has completed a preliminary analysis of resources available for implementation of the investment case. There are approximately 10 donors in Madagascar who are aligned with and committed to investing in the investment case.

**Monetizing the Country-Led Process**

<table>
<thead>
<tr>
<th>Score</th>
<th>Investment case for RMNCAH-N or equivalent (e.g., national health plan)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not available</td>
<td>Investment case in development</td>
</tr>
<tr>
<td>Priority determined, but financial gap remains</td>
<td>Investment Case being implemented</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Score</th>
<th>Set of evidence based priorities financed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Country-led multi-stakeholder platform (e.g., new or established from an existing platform)</td>
<td></td>
</tr>
<tr>
<td>Not developed</td>
<td>Country platform for effect country-led multi-stakeholder platform (e.g., new or established from an existing platform)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Score</th>
<th>Results monitoring and evaluation strategy and framework in support of IC*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Analytical/monitoring capacity available</td>
<td>Country platform holds regular country meetings to discuss results arising from implementing the IC and consequent action</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Score</th>
<th>Country has either included or identified a private sector intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not applicable</td>
<td>Country has started implementing a private sector intervention</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Score</th>
<th>Health financing reforms identified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not considered at this time</td>
<td>Developed but not integrated in IC</td>
</tr>
<tr>
<td>Health financing in progress</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Score</th>
<th>World Bank-funded projects in support of the IC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project under preparation</td>
<td>Project approved and available online</td>
</tr>
<tr>
<td>Project disbursing</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Score</th>
<th>Private sector engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private sector engagement not identified at this time</td>
<td>Country has either included or identified a private sector intervention</td>
</tr>
<tr>
<td>Country has started implementing a private sector intervention</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Score</th>
<th>Civil registration and vital statistics (CRVS) made a priority</th>
</tr>
</thead>
<tbody>
<tr>
<td>CRVS priority not funded (for RMNCAH-N)</td>
<td>CRVS priority funded (for RMNCAH-N)</td>
</tr>
<tr>
<td>CRVS priority identified</td>
<td>Civil society represented in multi-sector platform meetings to discuss core IC implementation and results</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Score</th>
<th>Management of medicines and supplies / supply chain interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supply chain / commodity management not identified as a priority</td>
<td>Supply chain / commodity management identified as a priority</td>
</tr>
<tr>
<td>Country platform holds meetings to discuss results arising from implementing the IC and consequent action</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Score</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supply chain / commodity management not identified as a priority</td>
<td></td>
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</tbody>
</table>

* Both included in the IC document or a separate document
** Meaning that funding was allocated, disbursed and released – payment done
*** ANC4 = four antenatal care visits
**** ART = antiretroviral therapy; ARV = antiretroviral; DTP3 = vaccination for Diphtheria, Tetanus, and Pertussis; ORS = oral rehydration solution; PMTCT = prevention of mother to child transmission; PNC = postnatal care.

**Notes:**
- 1st Score: Inclusive country platform process with CSO engagement
- 2nd Score: Health financing in progress
- 3rd Score: Health financing reforms identified
- 4th Score: Country has either included or identified a private sector intervention
- 5th Score: Civil registration and vital statistics (CRVS) made a priority
- 6th Score: Management of medicines and supplies / supply chain interventions
- 7th Score: Results monitoring and evaluation strategy and framework in support of IC*
Investment Case being Developed but not Established and initial Project approved and COUNTRY PLATFORM Developed and initial Project approved.

Country Focus Areas
- Increase capacity for planning at sub-national level.
- Improve governance at district facility and community levels.
- Develop and implement strategies to motivate and retain health workers in the health system, particularly in hard-to-reach areas.
- Strengthen implementation of a national civil registration system and the generation of vital statistics.
- Increase the utilization of health information at the point of care.

RMNCAH-N Core Indicators

- Maternal mortality ratio: 439 per 100,000 live births
- Neonatal mortality ratio: 27 per 1,000 live births
- Under-five mortality rate: 136 per 1,000 women
- Adolescent birth rate: 136 per 1,000 women
- Percent of births <24 months after the preceding birth: 11.5%
- Stunting among children under 5 years of age: 37.1%
- Moderate to severe wasting among children under 5 years of age: 2.7%

Health Financing Core Indicators

- Health expenditure per capita financed from domestic sources: US$8.30
- Ratio of government health expenditure to total government expenditures: 9.83%
- Percent of current health expenditures on primary/outpatient health care: Not available
- Incidence of catastrophic and impoverishing health expenditures: 1.3% catastrophic, 0.02% impoverishing

Resource Mapping

Malawi has conducted extensive resource mapping for the health sector. The investment case is under development, and once it is completed and a costing is undertaken, the health-sector-wide resource mapping will be linked to resource mapping focused on investment case implementation. There are over 180 donors and implementing partners in Malawi who contribute to health financing, with external financing accounting for 75 percent of funding. Each of these have separate budgets, priorities, and decision-making processes. As such, the need for improved aid coordination has been identified as a priority to be addressed in the investment case.

Monitoring the Country-Led Process

1. Investment case for RMNCAH-N or equivalent (e.g., national health plan) identified with contact (e.g., WHO, national health agency).
2. Health financing reforms identified.
3. Health financing in progress.
4. Project disbursing.
5. Country has either included or identified a private sector intervention.
6. Government focal point identified with contact available online (GFF website).
7. Country platform holds regular country meetings to discuss results arising from implementing the IC and country action plan.

LMIC Core Indicators

- Child mortality rate: 11.5 per 1,000 live births
- Maternal mortality ratio: 37.1 per 1,000 live births
- Under-five mortality rate: 11.5 per 1,000 live births
- Adolescent birth rate: 11.5 per 1,000 live births
- Stunting among children under 5 years of age: 37.1%
- Moderate to severe wasting among children under 5 years of age: 2.7%
Investment Case being Project approved and Developed but not COUNTRY PLATFORM

Established and initial Developed and initial

Mali

88

Country Focus Areas

- 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.
- Expand performance-based financing, in order to improve the flow of funds and access to good-quality front-line health services.

RMNCAH-N Core Indicators

- Maternal mortality ratio: 325 per 100,000 live births
- Neonatal mortality ratio: 33 per 1,000 live births
- Under-five mortality ratio: 54 per 1,000 live births
- Adolescent birth rate: 164 per 1,000 women
- Percent of births <24 months after the preceding birth: 28.8%
- Stunting among children under 5 years of age: 27%
- Moderate to severe wasting among children under 5 years of age: 9%

Health Financing Core Indicators

- Health expenditure per capita financed from domestic sources: US$9.27
- Ratio of government health expenditure to total government expenditures: 5.34%
- Percent of current health expenditures on primary/outpatient health care: 81.60%
- Incidence of catastrophic and impoverishing health expenditures: 6.5% catastrophic, 1.91% impoverishing

Resource Mapping

The Government of Mali joined the GFF in 2018 and launched the GFF process in March 2019. Mali’s investment case is being developed in line with the country’s next health sector plan (PRODESS) and with a view to supporting the recently announced reforms (gratuité) to provide free care for pregnant women and children under 5. The investment case is also expected to support the expansion of the community health workers nationally to ensure stronger service delivery at the frontlines.

Monitoring the Country-Led Process
Country Focus Areas

- Improve coverage of RMNCAH-N services.
- Support the government's commitment to keep the share of government health expenditures in total expenditure stable initially (at 79 percent) and increase it to 9.5 percent by 2021.
- Increase the number of technical health staff and community health workers, the availability of essential drugs in primary care facilities, and spending in underserved provinces and districts.
- Reduce fragmentation through Multi Donor Trust Fund support of the investment case.
- Incentivize death registration, certification, and coding of the cause of death for deaths in health facilities.
- Implement reforms of the private sector supply chain.

RMNCAH-N Core Indicators

- Maternal mortality ratio: 408 per 100,000 live births
- Neonatal mortality ratio: 30 per 1,000 live births
- Under-five mortality ratio: 97 per 1,000 live births
- Adolescent birth rate: 194 per 1,000 women
- Percent of births <24 months after the preceding birth: 18.8%
- Stunting among children under 5 years of age: 42.6%
- Moderate to severe wasting among children under 5 years of age: 5.0%

Health Financing Core Indicators

- Health expenditure per capita financed from domestic sources: US$10.25
- Ratio of government health expenditure to total government expenditures: 8.33%
- Percent of current health expenditures on primary/outpatient health care: Not available
- Incidence of catastrophic and impoverishing health expenditures: 1.61% catastrophic; 0.23% impoverishing

Resource Mapping

- Total US$1,233,100,000

Monitoring the Country-Led Process

- Investment Case for RMNCAH-N or equivalent (e.g., national health plan)
- Set of evidence-based priorities financed
- Results monitoring strategy and framework in support of IC
- Country-led multi-stakeholder platform (e.g., new or established from an existing platform)
- Government focal point
- An inclusive country platform process with CSO engagement
- Health financing reforms identified
- Private sector engagement
- Civil registration and vital statistics (CRVS) made a priority
- Management of medicines and supplies / supply chain interventions
- Supply chain / commodity management identified as a priority

SCORES

- Investment Case in development
- Not prioritized within available funding
- Priorities determined, but financial gap remains
- Country platform for all country led entities: results framework to review progress on a regular basis
- Not yet established
- Established and initial meeting held
- Country platform holds regular country meetings to discuss results arising from implementing the IC and corrective action
- Government focal point not yet identified
- Government focal point identified
- Government focal point identified with contact available online (GFT website)
- OSS not included in the process
- OSS representation identified
- Civil society represented at routine country platform meetings to discuss IC implementation and results
- World Bank-funded project in support of the IC
- Project under preparation
- Project approved and available online
- Project disbanding
- Private sector engagement
- Country has either included or identified a private sector intervention
- OSS not identified as a priority
- OSS identified as a priority in the investment case
- OSS priority funded by example GFT Trust Fund, GFF, other
- Supply chain / commodity management identified as a priority
- Supply chain / commodity management identified as a priority
- Supply chain / commodity management identified as a priority

* Both included in the IC document or a separate document
** Meaning that funding was allocated, disbursed and released – payment done
*** AHC + 4 maternal care visits
**** ART + tuberculosis therapy, ART + antiretroviral, OFS + association for Diphtheria, Tetanus, and Pertussis, OED + vaccination solution, PMTCT = prevention of mother-to-child transmission, PNC = postnatal care

Country has started implementing a private sector intervention

Private sector engagement

Country has either included or identified a private sector intervention

Civil registration and vital statistics (CRVS) made a priority

Management of medicines and supplies / supply chain interventions

Supply chain / commodity management identified as a priority
Investment Case being Developed but not COUNTRY PLATFORM Established and initial Project approved and Developed and initial Project on a budgeting tool for the National Health Plan.

Country Focus Areas
- Provide technical support to the Health Financing Strategy formulation process, specifically on a budgeting tool for the National Health Plan.
- Strengthen public financial management, in order to improve budget execution, and support advocacy for a larger health share of the rapidly growing government budget.
- Increase institutional deliveries, in order to reduce maternal and neonatal mortality and create an entry point for broader health system reform.
- Engage with the government on a private sector action plan.

RMNCAH-N Core Indicators
- Maternal mortality ratio: 227 per 100,000 births
- Neonatal mortality ratio: 23 per 1,000 live births
- Under-five mortality ratio: 50 per 1,000 live births
- Adolescent birth rate: 36 per 1,000 women
- Percent of births <24 months after the preceding birth: 13.2%
- Stunting among children under 5 years of age: 29.2%
- Moderate to severe wasting among children under 5 years of age: 6.0%

Health Financing Core Indicators
- Health expenditure per capita financed from domestic sources: US$12.48
- Ratio of government health expenditure to total government expenditures: 4.79%
- Percent of current health expenditures on primary/outpatient health care: Not available
- Incidence of catastrophic and impoverishing health expenditures: 13.82% catastrophic, 2.25% impoverishing

Resource Mapping
Resource mapping process is being currently discussed with government officials. Resource mapping is expected to start by late 2018.
Investment Case being Developed but not Project approved and Established and initial NIGERIA

Country Focus Areas

- Support the Basic Health Care Provision Fund which has triggered an initial US$150 million allocation of government resources and the alignment of external resources.
- Improve efficiency by defining and delivering a universal, free, sharpened package of services through performance-based approaches, including a focus on forgotten priorities such as chronic malnutrition and adolescent health.
- Reestablish, through performance-based financing, basic health services in the fragile and conflict-affected North East regions.

RMNCAH-N Core Indicators

Maternal mortality ratio: 576 per 100,000 live births
Neonatal mortality ratio: 37 per 1,000 live births
Under-five mortality ratio: 120 per 1,000 live births
Adolescent birth rate: 120 per 1,000 women

Health Financing Core Indicators

Health expenditure per capita financed from domestic sources: US$10.33
Ratio of government health expenditure to total government expenditure: 5.01%
Percent of current health expenditures on primary/outpatient health care: Not available
Incidence of catastrophic and impoverishing health expenditures: 15.1% catastrophic, 3.5% impoverishing

Resource Mapping

Nigeria has completed the initial phase of resource mapping for the IC. The World Bank is financing 3 health projects with GFF co-financing in Nigeria. These projects are currently in varying stages of implementation, two of them being at very early stages. As such, the resource mapping data is incomplete. Considerable attention has been given to mapping the financing from GAVI and the Global Fund. The main focus of the IC is the provision of the Basic Minimum Package of Health Services (BMPHS) for national scale-up as well as the delivery and strengthening of a national nutrition program. While there is currently a significant financing gap, once all World Bank project disbursements have commenced and all financiers to the investment case have been mapped, we expect the gap to reduce significantly.

Other Areas of Interest

Civil registration and vital statistics (CRVS) not available
Management of medicines and supplies / supply chain interventions

Country-led process

- An inclusive country platform process with CSO engagement
- Results monitoring strategy and framework in support of IC
- Country-led multi-stakeholder platform (e.g. new or established from an existing platform)
- Development and initial assessment of results monitoring capacity available
- Government focal point
- Government focal point not yet identified
- Country platform for all country led entity case result framework to review progress on a regular basis
- ODA not included in the process
- Country platform holds regular country meetings to discuss results arising from implementing the IC and corrective action
- ODM not identified as priority
- Country has a focal point identified with contact available online (eg GF website)
- Health financing reforms identified
- Health financing in progress
- World Bank-funded project in support of the IC
- Project under preparation
- Project approved and available online
- Project disbursement
- Private sector engagement
- Private sector engagement not identified at this time
- Country has either included or identified a private sector intervent
- Public sector engaged under the IC
- ODM not identified as priority
- ODM identified as priority in the investment case
- ODM project funded (except GFF Trust Fund, GAVI, other)

Scores

1
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* Both included in the IC document or a separate document
** Meaning that funding was allocated, disbursed and released – payment done
*** ANC4 = four antenatal care visits
ART = antiretroviral therapy, ARV = antiretroviral, DPT3 = vaccination for Diphtheria, Tetanus, and Pertussis, ORS = oral rehydration solution, PMTCT = prevention of mother-to-child transmission, PNA = polio vaccine

Monitoring the Country-Led Process
Resource Mapping

Activity mapping for Rwanda’s investment case has been completed. 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 expects to undertake this activity in late-2019/early 2020. Multisectoral expenditure tracking for nutrition is currently ongoing.

RMNCAH-N Core Indicators

- Maternal mortality ratio: 210 per 100,000 live births
- Neonatal mortality ratio: 20 per 1,000 live births
- Under-five mortality ratio: 50 per 1,000 live births
- Adolescent birth rate: 43 per 1,000 women
- Percentage of births <24 months after the preceding birth: 14%
- Stunting among children under 5 years of age: 37.9%
- Moderate to severe wasting among children under 5 years of age: 2.2%

Health Financing Core Indicators

- Health expenditure per capita financed from domestic sources: US$16.29
- Ratio of government health expenditure to total government expenditures: 8.88%
- Percent of current health expenditures on primary/outpatient health care: Not available
- Incidence of catastrophic and impoverishing health expenditures: 1.2% catastrophic, 0.6% impoverishing

Monitoring the Country-Led Process

INVESTMENT CASE

- Investment Case for RMNCAH-N or equivalent (e.g., national health plan)
- Set of evidence based priorities financed
- Results monitoring strategy and framework in support of IC*
- Country-led multi-stakeholder platform (e.g., new or established from an existing platform)
- Government focal point

COUNTRY PLATFORM

- An inclusive country platform processes with CSO engagement
- Health financing reforms identified
- World Bank-funded project in support of the IC
- Private sector engagement
- Management of medicines and supplies / supply chain interventions

* CCS: not included in the process
* CRVS: not identified as a priority
* Government focal point not identified
* CSO representative identified
* Government focal point identified
* GOV: not identified as priority in the investment case
* Country platform holds regular country meetings to discuss results arising from implementing the IC and corrective action

FINANCING

- Government focal point not yet identified
- Government focal point identified
- Government focal point identified with contact available online (e.g., website)
- Country platform for IC established (e.g., IC focal point), or established from an existing platform
- Country platform holds regular country meetings to discuss results arising from implementing the IC and corrective action
- GOV: not identified as a priority
- GOV: identified as a priority
- GOV: identified as a priority in the investment case
- Country platform holds regular country meetings to discuss results arising from implementing the IC and corrective action
- Government focal point identified
- Government focal point identified with contact available online (e.g., website)

SCORES

1. Country platform
2. Government focal point
3. Health financing reforms identified
4. World Bank-funded project in support of the IC
5. Private sector engagement
6. Management of medicines and supplies / supply chain interventions
7. Health financing reforms identified
8. Government focal point
9. Country platform holds regular country meetings to discuss results arising from implementing the IC and corrective action
10. GOV: not identified as priority
11. GOV: identified as a priority
12. GOV: identified as a priority in the investment case
13. Country platform holds regular country meetings to discuss results arising from implementing the IC and corrective action
14. Government focal point identified
15. Government focal point identified with contact available online (e.g., website)

** Meanings that funding was allocated, disbursed and released – payment done
* Both included in the IC document or a separate document
1. Education
2. Health
3. Food and Agriculture
4. Water, sanitation and hygiene
5. Social protection
6. Energy
7. Transport
8. Other

**Meaning that funding was allocated, disbursed and released – payment done
1. Education
2. Health
3. Food and Agriculture
4. Water, sanitation and hygiene
5. Social protection
6. Energy
7. Transport
8. Other

**Meaning that funding was allocated, disbursed and released – payment done
1. Education
2. Health
3. Food and Agriculture
4. Water, sanitation and hygiene
5. Social protection
6. Energy
7. Transport
8. Other
**Country Focus Areas**

- Support implementation of the government's commitment to increase the share of its budget going to health from 4 percent to 10 percent by 2022.
- Strengthen public financial management, in order to better track resources going to the health sector, improve budget and planning, and increase budget execution.
- Support implementation of the universal health insurance scheme by consolidating the community-based health insurance schemes while effectively exempting the poor.

**RMNCAH-N Core Indicators**

Maternal mortality ratio: 236 per 100,000 live births

Neonatal mortality ratio: 28 per 1,000 live births

Under-five mortality ratio: 56 per 1,000 live births

Adolescent birth rate: 78 per 1,000 women

Percent of births <24 months after the preceding birth: 15.8%

Stunting among children under 5 years of age: 16.5%

Moderate to severe wasting among children under 5 years of age: 8.0%

**Health Financing Core Indicators**

Health expenditure per capita financed from domestic sources: US$17.86

Ratio of government health expenditure to total government expenditures: 6.04%

Percent of current health expenditures on primary/ outpatient health care: Not available

Incidence of catastrophic and impoverishing health expenditures: 3.33% catastrophic, 1.10% impoverishing

**Monitoring the Country-Led Process**

- **Investment Case being implemented**: Investment Case in development
- **Set of evidence based priorities financed**: Not prioritized within available funding
- **Results monitoring strategy and framework in support of IC**: Not developed
- **Country-led multi-stakeholder platform (e.g., new or established from an existing platform)**: Not yet established
- **Government focal point**: Government focal point not yet identified
- **An inclusive country platform process with CSO engagement**: CSOs not included in the process
- **Health financing reforms identified**: Not considered at this time
- **World Bank-funded project in support of the IC**: Project under preparation
- **Private sector engagement**: Country has either included or identified a private sector intervention
- **Civil registration and vital statistics (CRVS) made a priority**: Not identified at this time
- **Management of medicines and supplies / supply chain interventions**: ONS not identified as a priority

**GAP**

- **US$320,661,465**
- **67%**

**Source**: Senegal, cartographie des ressources des partenaires 2018
Sierra Leone

Country Focus Areas

- Improve the efficiency of available resources by right-sizing the health sector, redesigning the performance-based financing program, improving the coordination and alignment of external resources, and pushing resources down to the frontlines.
- Support development of the health financing strategy and implementation plan.
- Strengthen the prioritization and monitoring system of the RMNCAH strategy, including the focus on adolescent health.

RMNCAH-N Core Indicators

- Maternal mortality ratio: 1,165 per 100,000 live births
- Neonatal mortality ratio: 20 per 1,000 live births
- Under-five mortality ratio: 94 per 1,000 live births
- Adolescent birth rate: 125 per 1,000 women
- Percent of births <24 months after the preceding birth: 28.1%
- Stunting among children under 5 years of age: 29%
- Moderate to severe wasting among children under 5 years of age: 5%
- Under-five mortality ratio: 20 per 1,000 live births

Health Financing Core Indicators

- Health expenditure per capita financed from domestic sources: US$9.64
- Ratio of government health expenditure to total government expenditures: 7.91%
- Percent of current health expenditures on primary/outpatient health care: Not available
- Incidence of catastrophic and impoverishing health expenditures: 10.42% catastrophic, 2.56% impoverishing

Monitoring the Country-Led Process

1. Country platform holds regular country meetings to discuss results arising from implementing the IC and corrective action.
2. Government focal point not yet identified
3. Country platform for IC established and initial assessment of results monitoring framework in support of IC.
4. No prioritization within available funding
5. Country platform for IC not established, but financial gap remains
6. Not developed
7. Country platform for IC not yet established
8. Government focal point identified
9. Government focal point co-financing an IDA loan.
10. Country platform for IC established and initial assessment of results monitoring framework in support of IC.

Resource Mapping

- Total US$283,632,917
- Gap US$143,177,494

SCORES

- **: Not considered at this time
- ***: Developed and not yet integrated into IC
- **: Not included in the process
- *: Identified at routine country platform meetings to discuss results arising from implementing the IC and corrective action.
- **: Identified at routine country platform meetings to discuss results arising from implementing the IC and corrective action.
- **: Identified at routine country platform meetings to discuss results arising from implementing the IC and corrective action.
- **: Identified at routine country platform meetings to discuss results arising from implementing the IC and corrective action.
Investment Case being Developed and initial Country platform developed but not project approved and established.

Tanzania

Country Focus Areas

- Improve efficiency by scaling up output-based payment mechanisms.
- Continue to strengthen the alignment of partners and reduce fragmentation through health basket funding.
- Preserve government budget allocations for health in addition to increased donor resources.
- 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.
- Track progress and help decision makers at all levels to reduce maternal and neonatal mortality by utilizing data from quarterly RMNCAH scorecard.

RMNCAH-N

Core Indicators

Maternal mortality ratio: 556 per 100,000 live births
Neonatal mortality ratio: 23 per 1,000 live births
Under-five mortality ratio: 67 per 1,000 live births
Adolescent birth rate: 123 per 1,000 women
Stunting among children under 5 years of age: 34%
Moderate to severe wasting among children under 5 years of age: 4.4%

Health Financing

Core Indicators

Health expenditure per capita financed from domestic sources: US$14.42
Ratio of government health expenditure to total government expenditures: 9.52%
Percent of current health expenditures on primary/outpatient health care: 46.89%
Incidence of catastrophic and impoverishing health expenditures: 3.79% catastrophic, 1.38% impoverishing

Monitoring the Country-Led Process

- Investment Case for RMNCAH or equivalent (e.g., national health plan)
- Set of evidence based priorities financed
- Results monitoring strategy and framework in support of IC*
- Government focal point
- Administrative Reform
- Health financing reforms identified
- World Bank-funded project in support of the IC
- Private sector engagement
- Civil registration and vital statistics (CRVS) made a priority
- Management of medicines and supplies / supply chain interventions

Resource Mapping

Gap
US$66,026,548

Total
US$368,010,429

82%

Governance
PEPFAR (INCLUDING USAID-PEPFAR)
USAID
WB/GFF/IDA, other)
BASKET FUND
GRANIN
GAVI
UNFPA

82%

82%
Uganda

Country Focus Areas

- Supporting the generation of evidence for the feasibility or potential of a series of tax-financed health trust funds in raising revenue for the health sector (including sin taxes and motor vehicle insurance taxes), in order to increase the public budget for health.
- Improve the quality and efficiency of health facilities through results-based financing, and increase access to services through demand-side vouchers.
- Expand access to a package of high-impact RMNCAH interventions by level, with a focus on high burden populations and the 40 highest burden districts.
- Improve the community-based services and functionality of health centers, in order to provide good-quality maternal, neonatal and child health services.
- Increase district-level capacity to drive improvements in RMNCAH outcomes and service provider capacity by establishing skills hubs.
- Address the broader context for health outcomes by focusing on the social determinants of health for adolescents.
- Scale up birth and death registration services at the health facility and community levels, and develop and disseminate a strategy and communication strategy for civil registration and vital statistics.

RMNCAH-N Core Indicators

Maternal mortality ratio: 336 per 100,000 live births
Neonatal mortality rate: 27 per 1,000 live births
Under-five mortality rate: 64 per 1,000 live births
Adolescent birth rate: 133 per 1,000 women
Percent of births >24 months after the preceding birth: 24.3%
Stunting among children under 5 years of age: 29.9%
Moderate to severe wasting among children under 5 years of age: 3.4%

Health Financing Core Indicators

Health expenditure per capita financed from domestic sources: US$6.23
Ratio of government health expenditure to total government expenditures: 5.14%
Percent of current health expenditures on primary/ outpatient health care: 58.26%
Incidence of catastrophic and impoverishing health expenditures: 13.27% catastrophic; 3.18% impairing

Monitoring the Country-Led Process

Investment case for RMNCAH-N or equivalent (e.g., national health plan)
Set of evidence based priorities financed
Results monitoring strategy and framework in support of IC
Country-led multi-stakeholder platform (e.g., new or established from an existing platform)
Government focal point
An inclusive country platform process with CSO engagement
Health financing reforms identified
World Bank-funded project in support of the IC
Private sector engagement
Civil registration and vital statistics (CRVS) made a priority
Management of medicines and supplies / supply chain interventions

SCORES

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* Both included in the IC document or a separate document
** Meaning that funding was allocated, disbursed and released – payment done
*** AFC = a four-year core visit
ART = antiretroviral therapy; AVR = antiretroviral; DTR = discussion, training and reorientation; DTR/EC = discussion of results and evaluation of progress; GFF = global fund for maternal, newborn and child health (GFP)
Vietnam

Country Focus Areas

- Increase health system efficiency by improving the quality of grassroots (commune-level) health system, including through strengthening infrastructure, equipment, training and developing new models of service delivery.
- Improve functioning of Social Health Insurance (SHI) through technical assistance to the revision of the SHI Law and its associated policies.
- Strengthen Civil Registration and Vital Statistics (CRVS) system through development of a CRVS Action Plan and tools to improve cause of death reporting.
- Improve understanding of options for Public-Private Partnerships that serve the public interest, through analysis and capacity-building.

RMNCAH-N Core Indicators

Maternal mortality ratio: 54 per 100,000 live births
Neonatal mortality rate: 11.5 per 1,000 live births
Under-five mortality rate: 21.6 per 1,000 live births
Adolescent birth rate: 29 per 1,000 women
Percent of births <24 months after the preceding birth: 13%
Stunting among children under 5 years of age: 24.6%
Moderate to severe wasting among children under 5 years of age: 6.4%

Health Financing Core Indicators

Health expenditure per capita financed from domestic sources: US$58.27
Ratio of government health expenditure to total government expenditures: 8.93%
Percent of current health expenditures on primary/outpatient health care: Not available
Incidence of catastrophic and impoverishing health expenditures: 9.81% catastrophic; 0.5% impoverishing

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 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$3 million from the Integrating Donor-Financed Health Programs Multi-Donor Trust Fund, with Australian support, a co-financing grant of US$3 million from the Tackling Non-Communicable Diseases Challenges in Low- and Middle-income Countries MOI (Pharmaceutical Governance Fund), and US$21.25 million from the Government of the United Kingdom to the success of the project. Vietnam in addition to the US$17 million GFF grant of US$3 million from the Tackling Non-Communicable Diseases Challenge (TDNCH) and the World Bank-funded project in support of the IC. The recently approved Grassroots Health Service Delivery project fills an important financing gap for Vietnam. This project is supported by an IDA-Transitional Support (IDA-TS) credit of US$80 million, a co-financing grant of US$3 million from the Integrating Donor-Financed Health Programs Multi-Donor Trust Fund, with Australian support, and a co-financing grant of US$3 million from the Tackling Non-Communicable Diseases Challenges in Low- and Middle-income Countries MOI (Pharmaceutical Governance Fund), and US$21.25 million from the Government of the United Kingdom.

Monitoring the Country-Led Process

**Investment Case for RMNCAH-N or equivalent (e.g., national health plan)**

- Investment Case in development
- Investment Case complete
- Investment Case being implemented

**Set of evidence-based priorities financed**

- Not prioritised within available funding
- Priorities determined, but financial gap remains
- Priorities fully funded*

**Results monitoring strategy and framework in support of IC**

- Not developed
- Developed and initial assessment of results monitoring capacity available
- Country platform for monitoring country-led initiatives

**Country-led multi-stakeholder platform (e.g., new or established from an existing platform)**

- Not yet established
- Established and initial meeting held
- Country platform holds regular meetings to discuss results arising from implementing the IC and corrective action

**Government focal point**

- Government focal point not yet identified
- Government focal point identified
- Government focal point identified with contact available (e.g., key IC focal point)

**An inclusive country platform process with CSO engagement**

- CSOs not included in the process
- CSO representatives identified
- Civil society represented in inclusive country platform meetings to discuss IC implementation and results

**Health financing reforms identified**

- Not considered at the time
- Developed but not integrated into IC
- Health financing in progress

**World Bank-funded project in support of the IC**

- Project under preparation
- Project approved and available online
- Project eliminated

**Private sector engagement**

- Private sector engagement not identified at this time
- Country has either included or identified a private sector intervention
- Country has started implementing a private sector intervention

**Civil registration and vital statistics (CRVS) made a priority**

- CRVS not identified as a priority
- CRVS identified as a priority in the investment case
- CRVS identified as a priority in the implementation framework
- CRVS prioritised for example GFF or IC, other

**Management of medicines and supplies / supply chain interventions**

- Supply chain / commodity management not identified as a priority
- Supply chain / commodity management identified as a priority
- Supply chain / commodity management interventions funded

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**SCORES**

- Not yet established
- Established and initial meeting held
- Country platform holds regular meetings to discuss results arising from implementing the IC and corrective action
Civil registration and vital statistics (CRVS) systems in most GFF-supported countries are weak, with only Guatemala having a fully functional electronic CRVS system to provide basic demographic and health data. In 20 of the 27 countries, less than 80 percent of children under the age of five are registered with civil registration authorities. Fourteen countries have no information on death registration, and 24 have no information on the cause of death (COD). Lack of these statistics undermines the basic human rights of women, children, and adolescents and has a negative impact on the availability of data at the national and subnational levels that are required for planning and monitoring of health outcomes.

### Percentage of Children under the Age of Five Registered with National Civil Registration Authorities in GFF-Supported Countries

<table>
<thead>
<tr>
<th>Country</th>
<th>Registered</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethiopia (DHS, 2016)</td>
<td>3</td>
<td>Source: Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS) conducted between 2000 and 2016.</td>
</tr>
<tr>
<td>Bangladesh (DHS, 2014)</td>
<td>30</td>
<td>Source: Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS) conducted between 2000 and 2016.</td>
</tr>
<tr>
<td>Liberia (DHS, 2013)</td>
<td>25</td>
<td>Source: Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS) conducted between 2000 and 2016.</td>
</tr>
<tr>
<td>Democratic Republic of Congo (DHS, 2013/14)</td>
<td>26</td>
<td>Source: Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS) conducted between 2000 and 2016.</td>
</tr>
<tr>
<td>Tanzania (DHS, 2010)</td>
<td>30</td>
<td>Source: Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS) conducted between 2000 and 2016.</td>
</tr>
<tr>
<td>Nigeria (DHS, 2013)</td>
<td>32</td>
<td>Source: Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS) conducted between 2000 and 2016.</td>
</tr>
<tr>
<td>Afghanistan (DHS, 2013)</td>
<td>32</td>
<td>Source: Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS) conducted between 2000 and 2016.</td>
</tr>
<tr>
<td>Mozambique (DHS, 2011)</td>
<td>42</td>
<td>Source: Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS) conducted between 2000 and 2016.</td>
</tr>
<tr>
<td>Rwanda (DHS, 2014)</td>
<td>48</td>
<td>Source: Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS) conducted between 2000 and 2016.</td>
</tr>
<tr>
<td>Central African Republic (MICS, 2010)</td>
<td>48</td>
<td>Source: Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS) conducted between 2000 and 2016.</td>
</tr>
<tr>
<td>Cameroon (MICS, 2014)</td>
<td>56</td>
<td>Source: Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS) conducted between 2000 and 2016.</td>
</tr>
<tr>
<td>Indonesia (DHS, 2015)</td>
<td>61</td>
<td>Source: Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS) conducted between 2000 and 2016.</td>
</tr>
<tr>
<td>Kenya (DHS, 2014)</td>
<td>66</td>
<td>Source: Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS) conducted between 2000 and 2016.</td>
</tr>
<tr>
<td>Malawi (MICS, 2014)</td>
<td>67</td>
<td>Source: Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS) conducted between 2000 and 2016.</td>
</tr>
<tr>
<td>Cote d’Ivoire (MICS, 2016)</td>
<td>72</td>
<td>Source: Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS) conducted between 2000 and 2016.</td>
</tr>
<tr>
<td>Cambodia (DHS, 2014)</td>
<td>73</td>
<td>Source: Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS) conducted between 2000 and 2016.</td>
</tr>
<tr>
<td>Guinea (MICS, 2016)</td>
<td>75</td>
<td>Source: Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS) conducted between 2000 and 2016.</td>
</tr>
<tr>
<td>Sierra Leone (DHS, 2013)</td>
<td>77</td>
<td>Source: Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS) conducted between 2000 and 2016.</td>
</tr>
<tr>
<td>Burkina Faso (DHS, 2015)</td>
<td>77</td>
<td>Source: Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS) conducted between 2000 and 2016.</td>
</tr>
<tr>
<td>Madagascar (MICS, 2014)</td>
<td>80</td>
<td>Source: Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS) conducted between 2000 and 2016.</td>
</tr>
<tr>
<td>Senegal (DHS, 2013)</td>
<td>80</td>
<td>Source: Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS) conducted between 2000 and 2016.</td>
</tr>
<tr>
<td>Myanmar (DHS, 2015/16)</td>
<td>81</td>
<td>Source: Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS) conducted between 2000 and 2016.</td>
</tr>
<tr>
<td>Mali (MICS, 2015)</td>
<td>84</td>
<td>Source: Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS) conducted between 2000 and 2016.</td>
</tr>
<tr>
<td>Haiti (DHS, 2012)</td>
<td>84</td>
<td>Source: Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS) conducted between 2000 and 2016.</td>
</tr>
<tr>
<td>Guatemala (DHS, 2014)</td>
<td>96</td>
<td>Source: Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS) conducted between 2000 and 2016.</td>
</tr>
<tr>
<td>Vietnam (MICS, 2013/14)</td>
<td>96</td>
<td>Source: Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS) conducted between 2000 and 2016.</td>
</tr>
</tbody>
</table>
In 2019, the GFF Trust Fund provided grants to 23 countries in Latin America and the Caribbean, 9 percent in East Asia, and 3 percent in South Asia, followed by 10 percent in South Asia, 9 percent in East Asia, and 3 percent in Latin America and the Caribbean (Figure 1). GFF-supported projects in 23 countries have been approved by the World Bank Board of Executive Directors. Fifteen countries are implementing GFB-World Bank financed projects, with a total of US$1.02 billion disbursed by these projects, of which US$120 million is from the GFF Trust Fund and US$901.5 million is from IDA/IBRD. Seventy-eight percent of the funding supports GFF countries in Africa, followed by 10 percent in South Asia, 9 percent in East Asia, and 3 percent in Latin America and the Caribbean.

As of June 30, 2019, contributions to the GFF Trust Fund total US$992.8 million equivalent, of which $659 million is committed for 33 projects in 27 countries and is combined with an additional $4.8 billion IDA/IBRD. Seventy-eight percent of the funding supports GFF countries in Africa, followed by 10 percent in South Asia, 9 percent in East Asia, and 3 percent in Latin America and the Caribbean (Figure 1). GFF-supported projects in 23 countries have been approved by the World Bank Board of Executive Directors. Fifteen countries are implementing GFB-World Bank financed projects, with a total of US$1.02 billion disbursed by these projects, of which US$120 million is from the GFF Trust Fund and US$901.5 million is from IDA/IBRD. The full list of Board-approved projects is provided in Table 1.

**Table 1: List of Board Approved Projects as of June 30, 2019**

<table>
<thead>
<tr>
<th>Project</th>
<th>GFF amount</th>
<th>IDA amount</th>
<th>IBRD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tanzania</td>
<td>$40</td>
<td>$200</td>
<td></td>
</tr>
<tr>
<td>DRC (AF-CRVS)</td>
<td>$10</td>
<td>$30</td>
<td></td>
</tr>
<tr>
<td>Cameroon</td>
<td>$27</td>
<td>$100</td>
<td></td>
</tr>
<tr>
<td>Nigeria (AF)</td>
<td>$60</td>
<td>$125</td>
<td></td>
</tr>
<tr>
<td>Kenya</td>
<td>$20</td>
<td>$50</td>
<td></td>
</tr>
<tr>
<td>Uganda</td>
<td>$20</td>
<td>$110</td>
<td></td>
</tr>
<tr>
<td>Liberia (AF)</td>
<td>$16</td>
<td>$50</td>
<td></td>
</tr>
<tr>
<td>Guatemala</td>
<td>$10</td>
<td>$100</td>
<td></td>
</tr>
<tr>
<td>DRC (AF)</td>
<td>$40</td>
<td>$320</td>
<td></td>
</tr>
<tr>
<td>Ethiopia</td>
<td>$20</td>
<td>$150</td>
<td></td>
</tr>
<tr>
<td>Bangladesh</td>
<td>$20</td>
<td>$50</td>
<td></td>
</tr>
<tr>
<td>Bangladesh (Education)</td>
<td>$10</td>
<td>$50</td>
<td></td>
</tr>
<tr>
<td>Mozambique</td>
<td>$25</td>
<td>$80</td>
<td></td>
</tr>
<tr>
<td>Rwanda (Health)</td>
<td>$20</td>
<td>$25</td>
<td></td>
</tr>
<tr>
<td>Afghanistan</td>
<td>$35</td>
<td>$140</td>
<td></td>
</tr>
<tr>
<td>Rwanda (AF-Social Protection)</td>
<td>$20</td>
<td>$80</td>
<td></td>
</tr>
<tr>
<td>Guinea</td>
<td>$20</td>
<td>$45</td>
<td></td>
</tr>
<tr>
<td>Indonesia</td>
<td>$20</td>
<td>$400</td>
<td></td>
</tr>
<tr>
<td>Nigeria (Nutrition)</td>
<td>$20</td>
<td>$25</td>
<td></td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>$20</td>
<td>$80</td>
<td></td>
</tr>
<tr>
<td>Nigeria (Part 2)</td>
<td>$20</td>
<td>$50</td>
<td></td>
</tr>
<tr>
<td>CAR</td>
<td>$20</td>
<td>$43</td>
<td></td>
</tr>
<tr>
<td>Malawi</td>
<td>$10</td>
<td>$50</td>
<td></td>
</tr>
<tr>
<td>Mali</td>
<td>$10</td>
<td>$50</td>
<td></td>
</tr>
<tr>
<td>Cote d’Ivoire</td>
<td>$20</td>
<td>$200</td>
<td></td>
</tr>
<tr>
<td>Cambodia</td>
<td>$10</td>
<td>$15</td>
<td></td>
</tr>
<tr>
<td>Haiti</td>
<td>$15</td>
<td>$55</td>
<td></td>
</tr>
<tr>
<td>DRC (Nutrition)</td>
<td>$10</td>
<td>$492</td>
<td></td>
</tr>
<tr>
<td>Vietnam</td>
<td>$17</td>
<td>$80</td>
<td></td>
</tr>
</tbody>
</table>
Investors Group Members

The Investors Group includes representatives of the following countries and organizations:

ABT Associates (representing the private sector constituency)

PARI (representing the civil society constituency)

PATH (representing the civil society constituency)

Bill & Melinda Gates Foundation

Education as a Vaccine (representing the civil society constituency)

Gavi, the Vaccine Alliance

Global Fund to Fight AIDS, Tuberculosis, and Malaria

Government of Canada

Government of Denmark

Government of Ethiopia

Government of Germany

Government of Japan

Japan International Cooperation Agency

Government of Kenya

Government of Liberia

Government of the Kingdom of the Netherlands

Government of the United States

Government of the World Health Organization

Government for Mothers (representing the private sector constituency)

Government of Norway

Trust Fund Contributors

As of June 30, 2019, the GFF Trust Fund is supported by the Governments of Canada, Denmark, Japan, the Netherlands, Norway, and the United Kingdom; the Bill & Melinda Gates Foundation; the Susan T. Buffett Foundation, Laerdal Global Health, and MSD for Mothers.

List of Acronyms

AFD Agence Francaise de Developpement (France)

BMZ Bundesministerium fuer Wirtschaftliche Zusammenarbeit und Entwicklung (Germany)

ANC antenatal care

ANC4 four antenatal care visits

BEmONC Basic Emergency Obstetric and Newborn Care

BHCFP Basic Health Care Provision Fund

ClemONC Comprehensive Emergency Obstetric and Newborn Care

CSO civil society organization

DFID Department for International Development (United Kingdom)

DHS Demographic Health Survey

DRC Democratic Republic of Congo

GFATM Global Fund for AIDS, Tuberculosis and Malaria

HDI Human Development Index

IRBD 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

PMNCH Partnerships for Maternal, Newborn, and Child Health

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

SDG Sustainable Development Goals

SIDA Swedish International Development Cooperation Agency

UNFPA UN Population Fund

USAID United States Agency for International Development

WHO World Health Organization

Acknowledgments

This report was written by the GFF Secretariat in collaboration with countries participating in the GFF that have been profiled in this report, under the guidance of Dr. Monique Vadrot, Program Manager. The GFF Secretariat would like to thank the contributors, who gave their time, expertise and energy, in particular, Anna Astrakhatyan, Julie Ruel Bergeron, Kimberly Boer, Maria Eugenia Bonilla-Chacin, Marlon Cis, Karin Lane Gichuki, Josine Karangwa, Toni Lee Kaguru, Luc Laviollette, Brandon Hayes, Vincenzo Menon, Segen Teklo Moges, Christine Nelson, Augustine Nikolova, Carolyn Noon, Genesis Samonte, Robert Walter Scherpber, Mirja Channa Sjoblom, Aissa Socorro, Meg Sommerfield, Maleleta Tuane-Nkhisi, Ellen Van De Poel and Petra Vegera.

APPENDIX A

Indicators Description

<table>
<thead>
<tr>
<th>Category</th>
<th>INDICATOR</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Mortality Rates</td>
<td>Number of female deaths (by any cause related to or aggravated by pregnancy or its management [including accidents or incidental causes]) occurring or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, expressed per 100,000 live births.</td>
<td></td>
</tr>
<tr>
<td>Under 5 Mortality Rate</td>
<td>Probability of a child born in a specific period or time of dying before reaching the age of 5 years, expressed per 1000 live births.</td>
<td></td>
</tr>
<tr>
<td>Neonatal Mortality Rate</td>
<td>Probability of a child born in a specific period of dying in the first month of life, expressed per 1000 live births.</td>
<td></td>
</tr>
<tr>
<td>Adolescent Birth Rate (15-19)</td>
<td>Number of births to females aged 15-19 years per 1000 females in the four years preceding the survey.</td>
<td></td>
</tr>
<tr>
<td>Percentage of births within 24 hours after the preceding birth*</td>
<td>Percentage of women giving birth in the four years preceding the survey who gave birth within 24 hours after the preceding birth.</td>
<td></td>
</tr>
<tr>
<td>Percentage of children under 5 years of age who are below -2 SD of height for age according to the WHO standard</td>
<td>Percentage of children under 5 years of age who are below -2 SD of height for age according to the WHO standard.</td>
<td></td>
</tr>
<tr>
<td>Incidence of catastrophic health expenditures</td>
<td>Proportion of households with out of pocket health expenditures that exceed 40% of total household expenditures.</td>
<td></td>
</tr>
<tr>
<td>Ratio of domestic government health expenditure to total government expenditure</td>
<td>Ratio of domestic government health spending to total government expenditure.</td>
<td></td>
</tr>
<tr>
<td>Proportion of health expenditures spent on primary health care</td>
<td>Proportion of health expenditures spent on primary health care.</td>
<td></td>
</tr>
<tr>
<td>Proportion of health expenditures spent on reproductive, maternal, newborn, child and adolescent health and nutrition</td>
<td>Proportion of health expenditures spent on reproductive, maternal, newborn, child and adolescent health and nutrition.</td>
<td></td>
</tr>
<tr>
<td>Number of household with all of productive health expenditures</td>
<td>Number of household with all of productive health expenditures.</td>
<td></td>
</tr>
<tr>
<td>Percentage of households with any household expenditure</td>
<td>Percentage of households with any household expenditure.</td>
<td></td>
</tr>
</tbody>
</table>

*The definitions for these indicators might vary slightly depending on the source of the data and/or the country.
## Data Sources

**APPENDIX B**

### INDICATOR / SOURCE TABLE

|------------------------|-------------|-------------|--------|----------|-------------------------|---------------|-----|---------|---------|----------|-----|-------|-------|--------|-------|--------|--------|----------|--------|--------|-------|---------|-------|-----------|-------|--------|-------|---------|-------|-----------|-------|--------|-------|---------|-------|-----------|-------|--------|-------|---------|-------|-----------|-------|--------|-------|---------|-------|-----------|-------|--------|-------|---------|-------|-----------|-------|--------|-------|---------|-------|-----------|-------|--------|-------|---------|-------|-----------|-------|--------|-------|---------|-------|-----------|-------|--------|-------|---------|-------|-----------|-------|--------|-------|---------|-------|-----------|-------|--------|-------|---------|-------|-----------|-------|--------|-------|---------|-------|-----------|-------|--------|-------|---------|-------|-----------|-------|--------|-------|---------|-------|-----------|-------|--------|-------|---------|-------|-----------|-------|--------|-------|---------|-------|-----------|-------|--------|-------|---------|-------|-----------|-------|--------|-------|---------|-------|-----------|-------|--------|-------|---------|-------|-----------|-------|--------|-------|---------|-------|-----------|-------|--------|-------|---------|-------|-----------|-------|--------|-------|---------|-------|-----------|-------|--------|-------|---------|-------|-----------|-------|--------|-------|---------|-------|-----------|-------|--------|-------|---------|-------|-----------|-------|--------|-------|---------|-------|-----------|-------|--------|-------|---------|-------|-----------|-------|--------|-------|---------|-------|-----------|-------|--------|-------|---------|-------|-----------|-------|--------|-------|---------|-------|-----------|-------|--------|-------|---------|-------|-----------|-------|--------|-------|---------|-------|-----------|-------|--------|-------|---------|-------|-----------|-------|--------|-------|---------|-------|----------- |