GLOBAL FINANCING FACILITY

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The Global Financing Facility for Women, Children and Adolescents

2018-2019 ANNUAL REPORT

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Muhammad Pate

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. Buffet 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

"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 low-income countries and US$135 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:

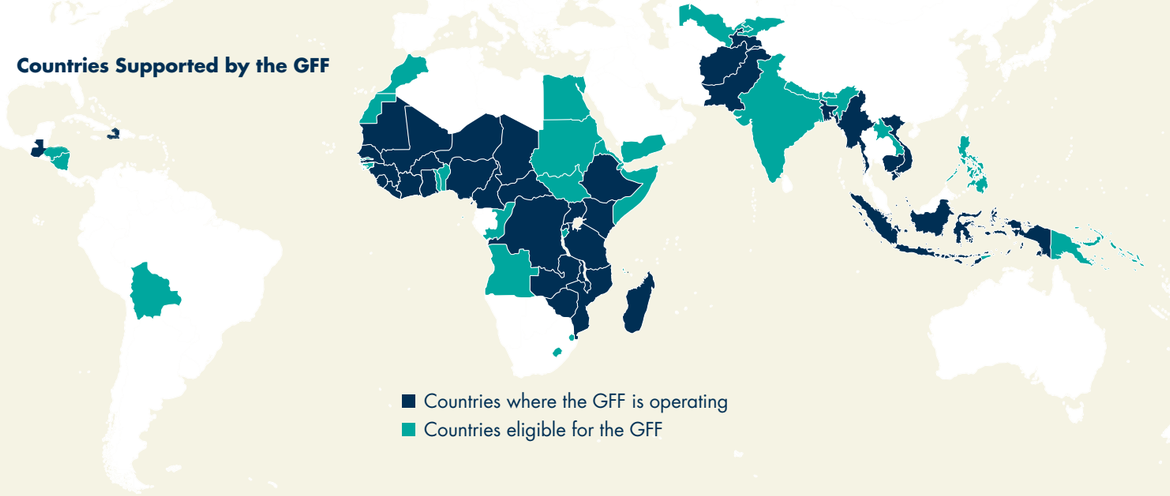
1 World Health Organization, "Primary Health Care on the Road to Universal Health Coverage," *Global Monitoring Report* (Geneva: 2019).

2 United Nations Inter-Agency Group for Child Mortality Estimation (UN IGME), *Levels and Trends in Child Mortality, Trends in Maternal Mortality* (2019); and 2019 estimates by WHO, UNICEF, UNFPA, World Bank Group and the UN Population Division.

3 World Bank Group, *High-Performance Health Financing for Universal Health Coverage: Driving Sustainable, Inclusive Growth in the 21st Century* (Washington, DC: 2019).

4 In April 2019, the GFF expanded its support to nine new countries—Chad, Ghana, Mauritania, Niger, Pakistan, Somalia, Tajikistan, Zambia, and Zimbabwe.

5 The 10 new donors that joined the GFF Trust Fund at the replenishment event are the European Commission, Laerdal Global Health, and the Susan T. Buffett Foundation, along with the governments of Burkina Faso, Côte d'Ivoire, Denmark, Germany, Japan, the Netherlands, and Qatar.

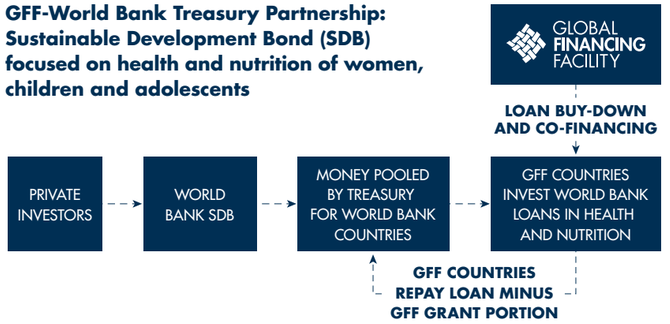


+ **Increasing domestic resource use and mobilization:** Per-capita health expenditure financed by domestic sources has increased in 19 of the 27 GFF countries highlighted in this report, according to the most recent available data. The impact of these increases is translating into more resources for 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 2018, 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 2018.[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.

GFF-World Bank Treasury Partnership: Sustainable Development Bond (SDB) focused on health and nutrition of women, children and adolescents



6 *RMNCAH Bulletin* 2019.

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 **Cote 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 packages 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, child, and adolescent health and nutrition 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.

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 multi-stakeholder platforms, as well as to improve coordinated advocacy and accountability activities.

Increasing Access to Primary Health Care to Underserved Communities

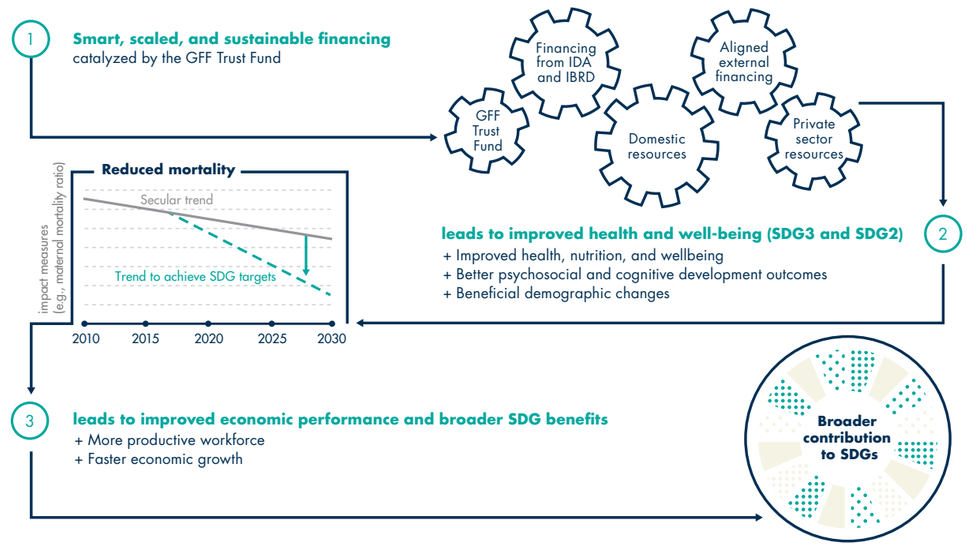
Mozambique's investment case was developed through a consultative process that included adolescent girls in underserved communities. In response, the GFF and partners are supporting the government's Primary Health Care Strengthening Program, a transformational effort to achieve predefined results for

How the GFF works

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 Case:** 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



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 lagging 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 Initiatives, Country Opportunities

Several global developments in 2018–19 provide a solid foundation for the GFF partnership to increase 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 linking 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 some of the highest rates of child stunting and wasting, fertility, and adolescent pregnancy in the world.

A second development is the adoption of the UHC Political Declaration at the September 2019 United Nations General Assembly. This declaration commits all UN member states to take action to accelerate progress toward SDG Targets 3.8.1 and 3.8.2[8]—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.

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.*[9] 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 (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population); Target 3.8.2 is proportion of population with large household expenditures on health as a share of total household expenditure or income.

9 For more information on the Global Action Plan, visit: https://www.who.int/sdg/global-action-plan


Photo: Dominic Chavez

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 around a country-led plan, prioritizing high-impact but underinvested areas of health, such as primary health care, nutrition, and sexual and reproductive health and rights.

The GFF partnership supports countries by:

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.

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.


Photo: Dominic Chavez


Photo: Dominic Chavez

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 Zitenga, 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.


Photo: Dominic Chavez


Photo: Dominic Chavez

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.

"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.


Photo: Evolving Communications


Photo: Scott Wallace/ World Bank

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.

"It's important to have registration to enter school, for employment and travel," says Ayodele, 35. At the Comprehensive Health Centre in Arakale, 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.


Photo: Arina Astvatsatryan

Case Studies & Country Profiles

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*)

CASE STUDY

Democratic Republic of Congo

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.

Box 1: **Trends in key RMNCAH-N indicators (2007-2013/14)**

+ **Maternal mortality ratio:** Rose from 549 to 846 deaths per 100,000 live births
+ **Under-five mortality rate:** Declined from 148 to 140 deaths per 1,000 live births
+ **Neonatal mortality rate:** Declined from 42 to 28 deaths per 1,000 live births
+ **Stunting prevalence among children under five:** Declined from 45.5 percent to 42.7 percent
+ **Wasting prevalence among children under five:** Declined from 10 percent to 7.9 percent

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.

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.[1] 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) using innovative financing mechanisms, including strategic purchasing, direct-facility financing, and single-contract pooled funding. The GFF partnership, 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.

Supporting the PNDS using innovative financing mechanisms

In 2015, the Health Systems Strengthening for Better Maternal and Child Health Results Program (or PDSS, 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 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.

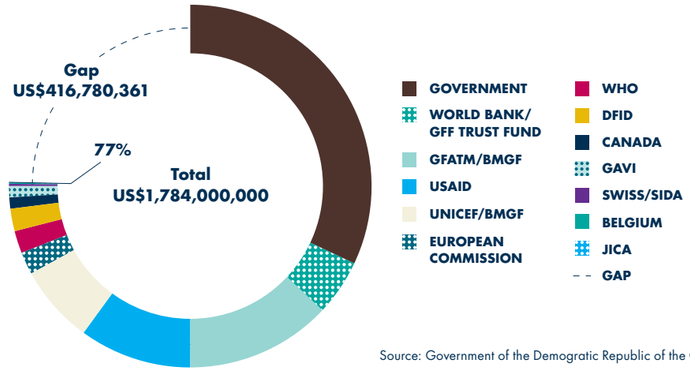
Lastly, the single-contract mechanism is a contract between the Ministry of Health at the provincial level, the provincial health authority, and development partners. All financial resources for the given province are pooled to support one integrated health action plan, reducing the fragmentation of 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).

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.

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

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



Source: Government of the Demographic Republic of the Congo.

1 The GFF trust fund is providing up to $60 million in co-financing for the PNDS 2019–22. The World Bank is co-financing the program through four operations. Also aligned with the PNDS 2019–22 are the US Agency for International Development (USAID); GAVI; the Global Fund to Fight AIDS, Tuberculosis and Malaria; the European Union; the UK Department for International Development (DFID); the government of Canada; and various UN agencies. GAVI, the Global Fund, and USAID are pooling resources through the Projet de Development du Système de Santé (PDSS) platform in 15 of 26 provinces (Central-Kasai, Equateur, Haut-Lomami, Haut Kasai, Katanga, Kwango, Kwilu, Lualaba, Mai-Ndombe, Maniema, Mongala, North Kivu, South Kivu, South Ubangi, Tshuapa).

Table 1 **Use of antenatal care services and availability of related drugs and medical supplies in the DRC, 2016 and 2018**

	Percentage of strategic purchasing facilities (PDSS) providing service	
	Baseline (2016)	**Midline (2018)**
Provides antenatal care (ANC) services	99	100
Days per week ANC provided	1.24 days	1.94 days
Always prescribes iron	70	74
Iron supplies available	40	60
Vitamin A supplies available	19	58
Always prescribe antimalarials	76	82
Malaria rapid tests supplies available	56	82
Always prescribe deworming pills	65	72
Provides antenatal care card	96	94
Provides family planning services	32	74
Contraceptive pills (progesterone) available	2	22
Contraceptive pills (combined) available	10	41
Injectables available	14	57
Implants available	12	46
Intrauterine device (IUD) supplies available	13	22

Source: Midline Assessment

a more explicit connection between the budget's purposes and its results, enabling better monitoring of increases in domestic and external resources to ensure that they match the commitments stated in the health financing strategy. Because it can also 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

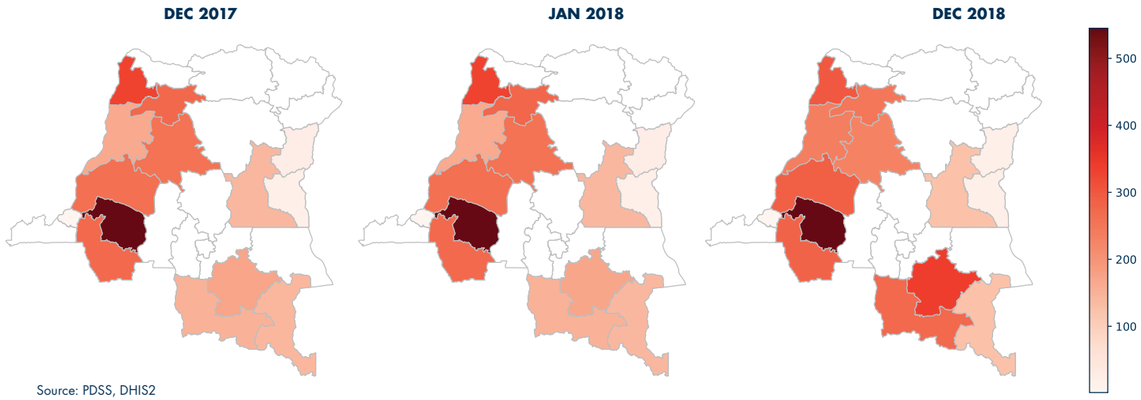
The Government of the DRC has demonstrated progress in increasing its domestic health funding: the 2019 national health accounts show that the share of the national budget allocated to health increased from 7.0 percent to 8.5 percent between 2016 and 2018, putting the country on track to reach the target 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.

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

Figure 2 **Number of health facilities enrolled in the strategic purchasing mechanism in the DRC, by province, December 2017, January 2018, and December 2019**

The strategic purchasing mechanism under the PDSS now reaches more than 2,800 facilities, including health centers and hospitals in 13 districts.



Source: PDSS, DHIS2

Note: Figures shows the number of facilities reporting verified data into the program platform. Facilities in Kasai and Central Kasai are not colored on the maps, as they only began scaling up in 2019.

Figure 3 **Share of birth-related services financed through the strategic purchasing mechanism in the DRC, by Province, 2017–2019**

Between 2017 and 2019, large increases were seen in the share of birth-related services delivered through the strategic purchasing mechanism.

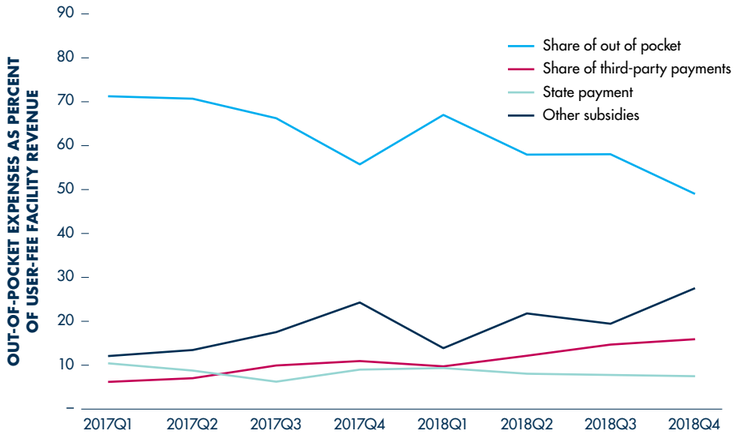
Source: PDSS and DHIS2

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 injectibles and implantables.

Figure 4 **Out-of-pocket and third-party payments as share of total health facility revenue, DRC, Q1 2017 to Q4 2018**

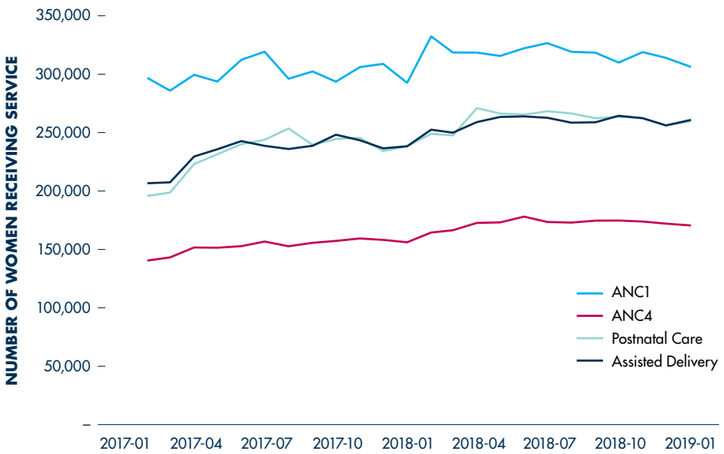
With the introduction of new facility-level funding modalities (e.g., results-based financing) the share of revenue from out-of-pocket payments has declined and the share from third-party payments has risen.



Source: DHIS2

Figure 5 **Investments in service delivery and access in targeted regions have begun to show results at the regional level**

Use of ante-natal care, assisted delivery, and post-natal care services in regions participating in innovative financing mechanisms in the Democratic Republic of Congo, 2017–18.



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 challenge that remains 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.

CASE STUDY

Ethiopia

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 efforts are needed to strengthen the nation's health system to achieve the objectives of its investment case. That investment case, called the Health Sector Transformation Plan (HSTP), aims to increase the equitable coverage of, access to, and use of essential health services.

Box 1: **Trends in key RMNCAH-N indicators (2000–2019, DHS)**

+ **Maternal mortality ratio:** Declined from 871 to 412 per 100,000 live births
+ **Under-five mortality rate:** Declined from 166 to 55 per 1,000 live births
+ **Age-specific fertility rate for adolescents (15-19 yrs):** Declined from 100 to 80 per 1,000 live births

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 and geographic, 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.

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 government is now seeking to increase health spending as a share of the national budget from 6 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,[1] 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.

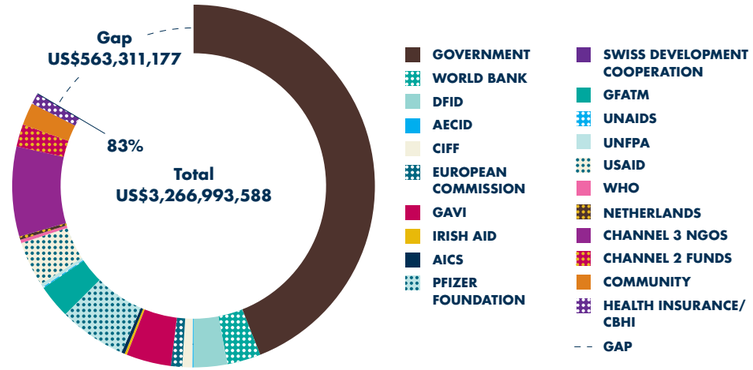
The GFF partnership is committed to supporting the government's efforts to close this financial gap through improved domestic resource use and mobilization. It is also committed to supporting the achievement of HSTP objectives through (1) policy dialogue to track, mobilize, and align resources (both 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.

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.

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.

Figure 1 **Mapping of resources contributing to Ethiopia's Health Sector Transformation Plan for 2018/2019**



1 The 11 development partners pooling funding through the SDG Fund are the European Union, Gavi, IrishAid, Italian Cooperation, the Netherlands, the Spanish Agency for International Development Cooperation (AECID), the U.K. Department for International Development (DFID), UNICEF, the United Nations Population Fund (UNFPA), the World Bank, and the World Health Organization (WHO). KOICA is also joining the pooled fund, pending signature of the joint financing agreement.

Note: There are currently over 15 external partners, in addition to the Ministry of Health, who are aligned with and invested in financing the Ethiopia's Investment Case. Ethiopia has conducted a thorough resource mapping, including community contributions that have been converted into monetary value. Additionally, they have estimated the contributions of Community Based Health Insurance (CBHI) scheme, which subsidizes the primary health care package. Ethiopia also has two additional funding flows that are not typically documented in other countries; Channel 2 funds refer to financing that is on-plan, but not on-budget, while Channel 3 funds refer to financing from NGOs to the health sector that do not flow through the government system.

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 annual 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 respond to: (1) the lack of a comprehensive mechanism to regularly monitor whether the priorities of the investment case are being invested in; and (2) challenges in the current government's system of budget and expenditure classification and reporting in the IBEX system, which only permit 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 preventing full use of 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 performance of the health care system. This is in response to results of a midterm review of the HSTP, which identified more than 200 challenges 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 strategic purchasing mechanism could address these challenges. The study, which is intended to inform the planning process for the next five-year health plan, included discussions with key stakeholders, focusing 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 contributed to the observed increase in the incidence of catastrophic health expenditures for the poor in Ethiopia, which rose from 2 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 HSTP to increase the proportion of *woredas* with established CBHI schemes from 15 percent in 2015 to 80 percent by 2020; reaching this target is incentivized through a disbursement-linked indicator under the Health Sustainable Development Goals Program for Results.

2 Estimates are based on the Ethiopia Socioeconomic Survey (ESS), 2011 and 2015. The variable used to measure financial protection was the rate of catastrophic (CATA) health payments. Financial catastrophe is defined as out-of-pocket exceeding 10% of a household's total spending.

Increasing private sector engagement in the health sector

The Ethiopian government has identified private sector engagement in the equitable delivery of RMNCAH-N 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 the opportunities for and challenges to leveraging the private sector for health;
+ 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 for Ethiopia's private health sector, which has already resulted in the creation of a federation 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 (84 percent) exceeded the initial target of 80 percent, and an annual data quality assessment of HMIS was conducted. The coverage and the completeness of civil registration have also increased, with the proportion of *kebeles* (subdivisions of *woreda* districts) providing civil registration service increased to 89 percent in 2018. From 2017 to 2018, the number of registered births increased by 20 percent, and the number of registered deaths increased by 19 percent (data not shown).

Table 1 **Health and Nutrition outcomes in Ethiopia, 2016 and 2019**

Outcome	**Baseline (2016) (percent)**	**Baseline date**	**July 2019 (percent)**
Deliveries attended by skilled birth providers	28	October 13, 2016	50[a]
Deliveries attended by skilled birth providers in the three bottom-performing regions (Afar, Oromia, and Somali)	19 (average)	October 13, 2016	41 (average)
Contraceptive prevalence rate	32	October 13, 2016	41
Pregnant women receiving at least four antenatal care visits	32	October 13, 2016	43[a]
Woredas in nonemerging regions delivering vitamin A supplements to children through routine systems	48	October 13, 2016	69
Children 0–23 months participating in growth monitoring and promotion	27	December 30, 2016	44
Primary care facilities having available all drugs from the Ministry of Health's list of drugs	42	December 30, 2016	48
Health centers reporting HMIS data on time	50	March 30, 2012	84
Pregnant women taking iron folic acid tablets	42	October 31, 2016	60
Woredas with functional community-based health insurance schemes	21	June 19, 2017	43

Source: Data from the Ethiopia Demographic Health Survey; the Mini-Demographic and Health Survey; the Nutrition Data Verification Joint Review Mission Report (December 2018); the 2012 HMIS Data Quality Assessment (DQA) Report; the 2014 HMIS DQA; and the 2018 Service Availability and Readiness Assessment report.

a. Preliminary results from mini-DHS.

Conclusion

The GFF partnership will continue supporting 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[1] 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.

Box 1: **Trends in key RMNCAH-N indicators (1998–2014)**

+ **Maternal mortality ratio:** Declined from 590 to 362 per 100,000 live births
+ **Under-five mortality rate:** Declined from 111 to 52 deaths per 1,000 live births
+ **Share of women who had another child less than 24 months after their previous child:** Declined from 23.1 to 17.9 percent

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 review and discuss scorecard outcomes and agree on specific activities to drive course correction through an action tracker that is linked to the scorecard.

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).

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." Both the Transforming Health Systems for Universal Health Care Project and the RMNCAH Multi Donor Task Fund (MDTF) support health workers' use of the scorecard and action tracker through workshops and training.

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 GFF Trust Fund, is encouraging county governments to shift from a health-inputs model to a health-results model. In Kenya, county governments are primarily responsible for planning and budgeting for health service delivery. Every year, they receive funding that is tied directly to their performance on four indicators: coverage of antenatal care services, skilled birth attendance, child immunization, and use of modern contraceptives. This creates an incentive to prioritize both the delivery and the utilization of these essential health services.

Other focus areas of the THS-UCP, which aim 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. By removing out-of-pocket payments for hospital-based services, the goal is to increase the use of hospital health services while reducing the financial burden on lower-income individuals. Third, those four Phase I UHC counties are also receiving support for primary care services through the provision of commodities and equipment.

Technical assistance to support RMNCAH services

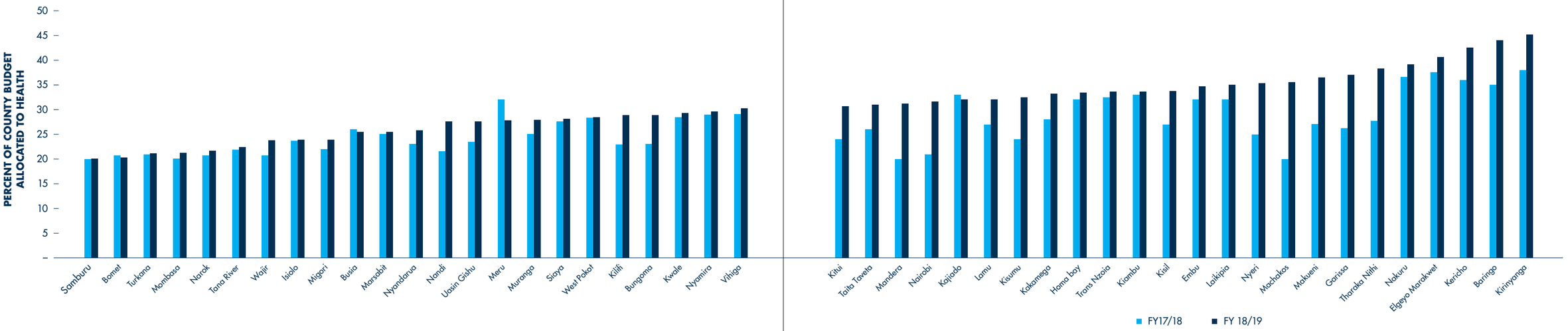
The RMNCAH Technical Assistance Multi-Donor Trust Fund (MDTF), cofinanced by the U.S. Agency for International Development (USAID), the Department for International Development (DFID), and the Danish International Development Agency (Danida), complements the THS-UCP and the investment framework by providing 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 making 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

1 Specifically, the US Agency for International Development (USAID), the UK Department for International Development (DFID), and the Danish International Development Agency (Danida).

Figure 1 **Percent of budget allocated to health in Kenya, by county, FY17/18 and FY18/19**

In FY 2018/19, 43 of Kenya's 47 counties increased their health budgets



supply-chain management in 5 counties; (3) for coordinating stakeholders in 22 counties; (4) for RMNCAH-focused monitoring and evaluation in 8 counties; and (5) for mapping and tracking resources to ensure that all health investments (on-budget, off-budget, and in-kind) are reflected in the health sector's annual work plan and that resources are linked with planning and reporting processes. More specifically, concerning area (5), the aim is to ensure that resources are linked with annual Medium-Term Expenditure Framework's (MTEF's) planning and annual sector reporting processes.[2]

The MDTF has encouraged health leaders to share experiences and lessons learned, with the goal of working together in a more coordinated way, both among donors and within and across government sectors. It has also supported revisions of the tools government uses for performance review and planning and has helped develop a public financial management framework that allows county governments to "ring-fence" the funds allocated to health.

Results

In 2017, Kenya's health system suffered a severe crisis in its health workforce that 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.

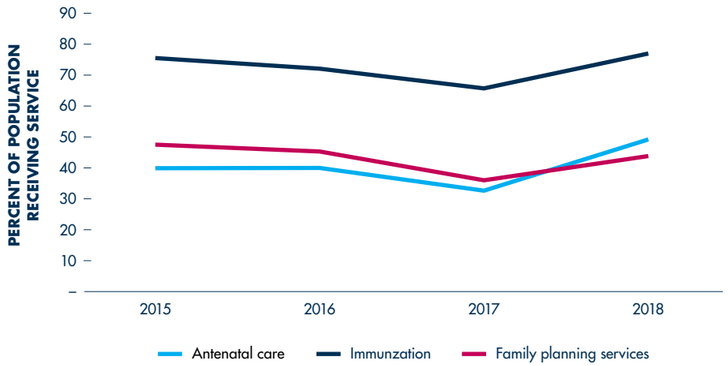
In summary, the introduction of high-impact, cost-effective RMNCAH interventions, the promotion of joint learning, and the monitoring of progress toward the core health goals have helped Kenya make measurable progress in its four focus indicators of antenatal care, skilled birth attendance, immunization,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

2 The resource mapping system that is linked to annual MTEFs is supported with technical assistance from the Clinton Health Access Initiative (CHAI).

Figure 2 **Percent of population in Kenya receiving antenatal care, immunizations, and family planning services, annually, 2015–2018**

Increases in antenatal care, family planning, and child immunizations took place in Kenya from 2015 to 2018, including an impressive recovery in 2018 from severe health service disruptions that occurred in 2017



Source: DHIS2

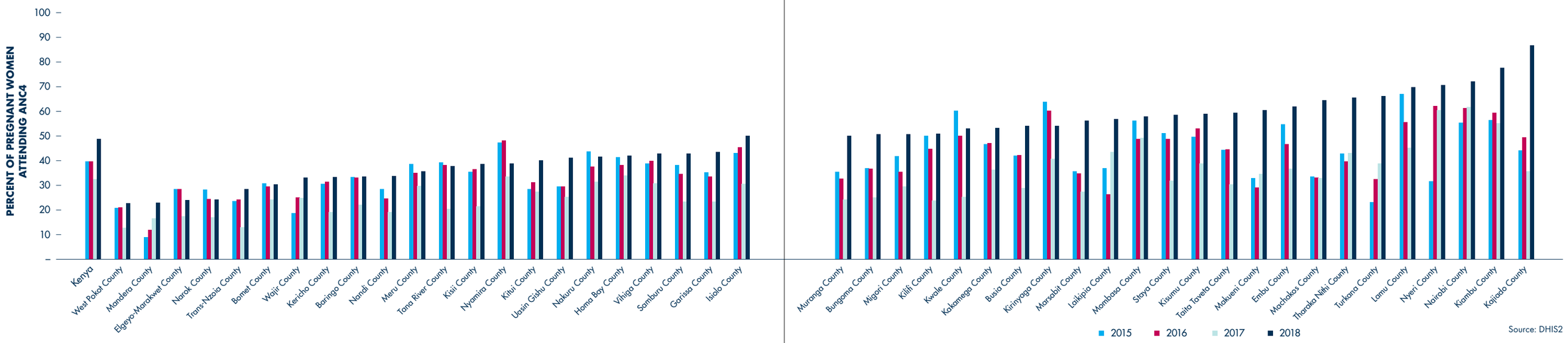
attendants also rose between 2015 and 2018, from 56.9 to 65.0 percent.

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 75.5 percent in 2018. As with ANC4 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 countries 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-UCP 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.

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

All except 10 counties have shown increases in women's antenatal 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.



Source: DHIS2

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 KHSSP, with specific action plans that are tailored and responsive to the particular needs of each county.

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

Kenya Counties	**2015** (dot shows high point)	**2018**
Kenya	75.7	76.8
Baringo County	67.8	63.6
Bomet County	73.6	56.9
Bungoma County	84.2	82.8
Busia County	82.2	73
Elgeyo-Marakwet County	83.1	61.9
Embu County	77.5	92
Garissa County	64.5	78.5
Homa Bay County	78.9	72.7
Isiolo County	73.3	65.9
Kajiado County	85.7	85
Kakamega County	88.6	77
Kericho County	64.9	63.1
Kiambu County	85.2	109.2
Kilifi County	92.3	75.4
Kirinyaga County	87.4	83.6
Kisii County	75.5	72.1
Kisumu County	82.3	79.9
Kitui County	72.7	81.1
Kwale County	114.5	80.1
Laikipia County	81.9	77.2
Lamu County	92.3	79.8
Machakos County	72.6	86.9
Makueni County	70.6	89.5

Kenya Counties	**2015** (dot shows high point)	**2018**
Mandera County	27.1	46.3
Marsabit County	80.8	83
Meru County	71.4	70.2
Migori County	77.5	85.3
Mombasa County	84.2	89.5
Muranga County	68.2	80.7
Nairobi County	86	86.7
Nakuru County	85.8	83.1
Nandi County	71.7	66.6
Narok County	67.5	58.9
Nyamira County	92.3	74.4
Nyandarua County	72	83.3
Nyeri County	37.4	77.5
Samburu County	59.2	64.7
Siaya County	85.2	82.3
Taita Taveta County	71.9	73.4
Tana River County	69.5	68.1
Tharaka Nithi County	60.5	73.9
Trans-Nzoia County	67.1	68.9
Turkana County	45.1	84.5
Uasin Gishu County	82.8	75.1
Vihiga County	83.3	69.2
Wajir County	59.8	62
West Pokot County	69.7	52.8

Almost all countries saw increases in coverage since 2017

Source: DHIS2

CASE STUDY

Mozambique

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).

Box 1: **Trends in key RMNCAH-N indicators (1997–2011, DHS)**

+ **Maternal mortality ratio:** Declined from 692 to 408 deaths per 100,000 live births
+ **Under-five mortality rate:** Declined from 201 to 97 per 1,000 live births
+ **Neonatal mortality rate:** Declined from 54 to 30 deaths per 1,000 live births
+ **Stunting prevalence among children under five:** Rose from 42.4% to 42.6%
+ **Wasting prevalence among children under age five:** Declined from 10.5% to 5.9%
+ **Age-specific fertility rate for adolescent girls (ages 15–19):** Declined from 179 to 167 live births per 1,000 women*

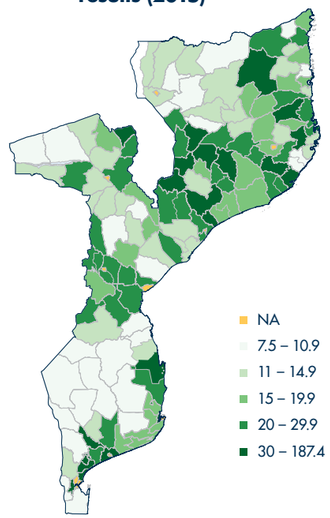
*Data for this indicator show change from 2003 to 2015.

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 (PESS) 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.

Figure 1 **Mozambique districts graded by potential for achieving RMNCAH-N results (2015)**



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

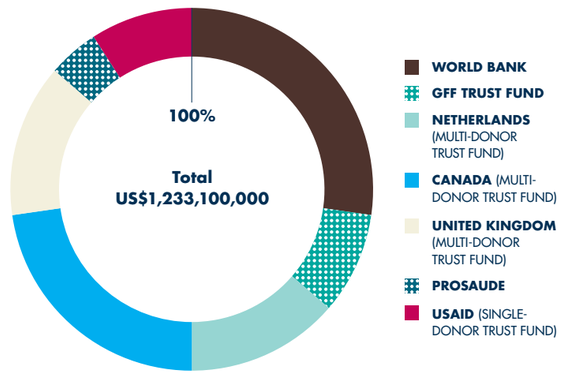
The investment case defines three priorities for strengthening the National Health Service:

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

Figure 2 **Resource mapping of the Mozambique investment case (percent distribution)**



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 (MGDH) 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.

Table 1 **Selected disbursement-linked indicators from December 2017 to December 2018**

Results indicators	**December 2017 (baseline)**	**2018 targets**	**December 2018 achievements**
Percentage of institutional deliveries in 42 lagging districts	66.10%	66.80%	80%[2]
Number of couple-years of protection (CYPs)	1,722,692	2,135,012	3,238,928
Number of women and children who have received basic nutrition services	0	Training of health workers completed, M&E system developed	Training of health workers completed, M&E system developed
Number of trained and active community health workers (APEs)	3,380	4,723	4,789
Number of technical health personnel assigned to the primary health care network	11,970	12,205	14,344

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.

1 These results were reported by the government but are yet to be verified by an independent verifier.

2 As of 1-Oct-18.

CASE STUDY

Nigeria

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.

Box 1: **Trends in key RMNCAH-N indicators (2008-2013, DHS)**

+ **Maternal mortality ratio:** Rose from 545 to 576 per 100,000 live births
+ **Under-five mortality rate:** Rose from 38 to 120 per 1,000 live births*
+ **Neonatal mortality rate:** Declined from 40 to 37 per 1,000 live births
+ **Stunting prevalence among children under five:** Rose from 34.3 to 44 percent**
+ **Wasting prevalence among children under five:** Rose from 10.8 to 11 percent**
+ **Age-specific fertility rate for adolescents (15-19 yrs):** Declined from 126 to 122 per 1,000 live births***

* Data covers 2007 to 2017, MICS.
**Data covers 2007 to 2017, DHS.
***Data covers 2003 to 2013.

In an effort to increase funding for health and deliver a universal Basic Minimum Package of Health Services (BMPHS) 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 that continues to exist and is particularly serious in the Northern regions of the country. The continued scale-up of the NSHIP, as well as the government's introduction of the Accelerating Nutrition Results in Nigeria (ANRIN) project, will support further expansion of the BMPHS while addressing the nutritional needs of mothers and children in the country's most vulnerable regions.

Country Priorities: The National Health Act

The National Health Act served as a significant catalyst for domestic resource mobilization in Nigeria, triggering an initial allocation of domestic resources for geographically and programmatically prioritized work on key health and nutrition services. The National Health Act was signed into law in 2014, pledging that all Nigerians were entitled to a free, universal Basic Minimum Package of Health Services (BMPHS). This package of high-impact services includes the equitable provision of family planning, antenatal care, facility-based delivery, screening for non-communicable diseases, malaria prevention and treatment, and prevention of and treatment of illnesses 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.

1 The investment case in Nigeria is supported with advocacy and financial resources from the Government of Nigeria; the Aliko Dangote Foundation; the Bill and Melinda Gates Foundation; GAVI; Global Affairs Canada; the Norwegian Ministry of Foreign Affairs; Power of Nutrition; the United Kingdom's Department for International Development (DFID); UNICEF; the United Nations Population Fund (UNFPA); the United States Agency for International Development (USAID); and the World Bank and GFF Trust Fund.

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 BMPHS 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 scorecard 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 scorecard 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 BMPHS, 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 elicit areas of duplication and gaps in financing and activities.[1] The resource mapping highlighted that the investment case remains underfunded (58 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.

Figure 1 **Example of a BHCPF quality scorecard**

	ASSESSMENTS		
Priority Areas	**Baseline**	**2nd**	**3rd**
Administrative Systems and Infrastructure	High	High	High
Financial Systems	Moderate	High	High
Human Resources	Moderate	Moderate	Moderate
Patient Care Management	Moderate	High	High
Essential Drugs and Commodities	Low	High	High
Laboratory	Moderate	High	High
Maternal and Child Health Services	High	High	High
Health Management Information Systems	Low	Low	Low
Utilization and Clinical Outcomes	Low	High	High
Community / Clients Views	High	High	Moderate

Low Moderate High

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 requested from 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 to objectively monitor and benchmark quality systems in resource-restricted settings, strengthen drug revolving funds, and strengthen the capacity of frontline health workers; 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, a program that brings new attention to critical issues such as chronic malnutrition. The NSHIP uses a performance-based financing approach that creates incentives to improve maternal and child health outcomes. In other words, financing is provided to preselected public and private primary health care centers directly, based on facilities' achievement of pre-agreed results on health outcomes. Decision-making is also decentralized to the facility level, giving facilities more autonomy and flexibility to innovate and adopt their own locally focused solutions to achieve results.

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 BMPHS 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, for 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).

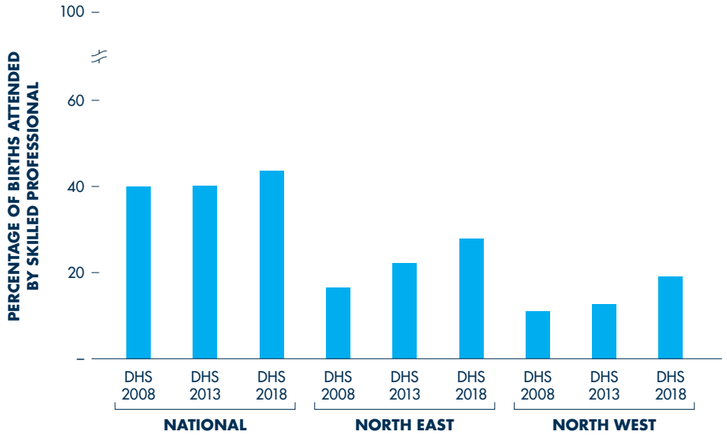
Drastic improvements in malaria prevention, a key intervention under the BMPHS and at the core of funding provided by external partners such as the Global Fund and the World Bank, have also been observed in Nigeria over time. This is reflected in large increases in bed net use among both children and 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 far exceeding both 2013 and 2008 numbers.

The national and regional increases in the proportion of women who had access to two and three or more doses of IPT (IPT 2+ 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 IPT 2+ 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

Figure 2 **Rate of skilled birth attendance in Nigeria, nationwide and northern regions, 2008, 2013, and 2018**

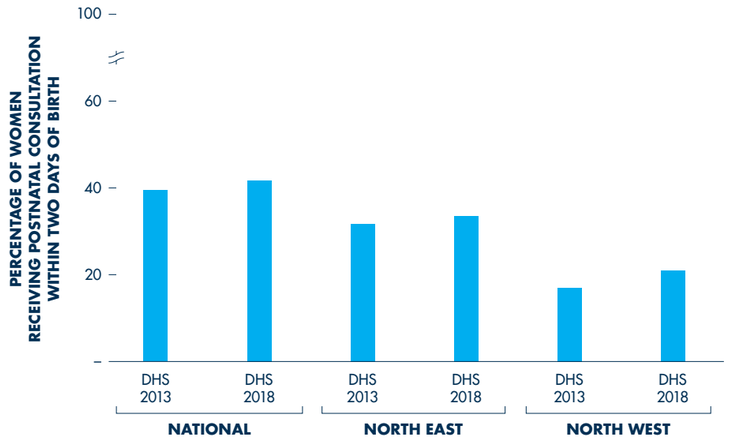
The percent of skilled birth attendance in the Northern regions of Nigeria is lower than the national average, but improvements there over the last decade far surpass those seen at the national level



Source: DHIS2

Figure 3 **Postnatal consultation within 1-2 days of birth in Nigeria, nationwide and northern regions, 2013 and 2018**

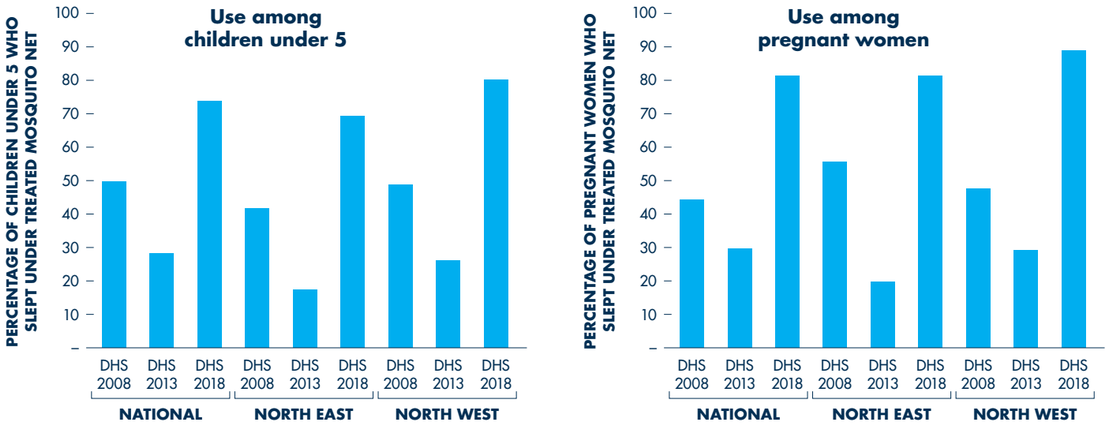
The percentage of women receiving postnatal consultations increased over the last 5 years, with increases in the Northern regions equivalent to or greater than those seen at the national level



Source: DHIS2

Figure 4 **Use of treated mosquito nets among children under 5 and pregnant women in Nigeria, nationwide and northern regions, 2008, 2013, and 2018**

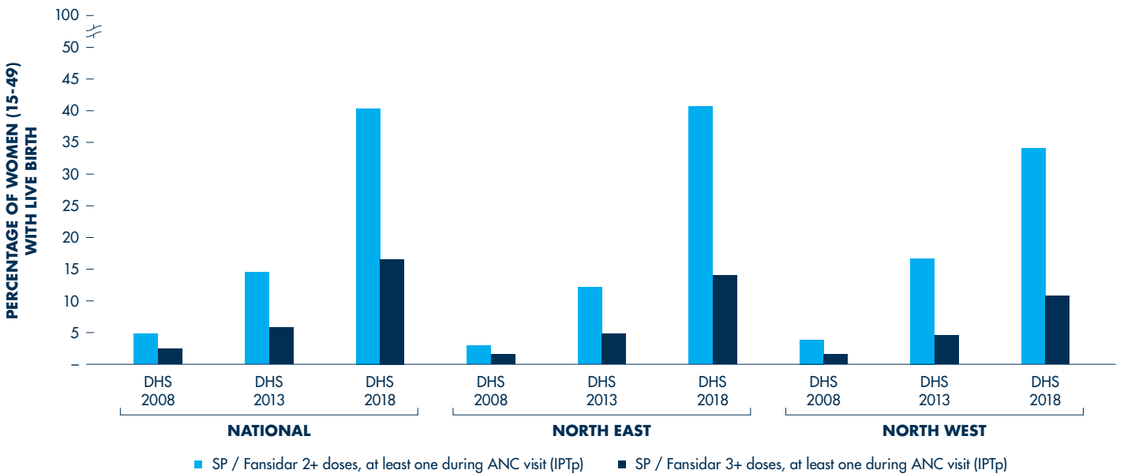
Drastic increases in bed net usage were observed at both national and regional levels in Nigeria, especially from 2013-2018



Source: DHIS2

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**

National and regional increases in the coverage of IPT2+ and IPT3+ signal important improvements in the quality of service delivery in Nigeria over time



Source: DHIS2

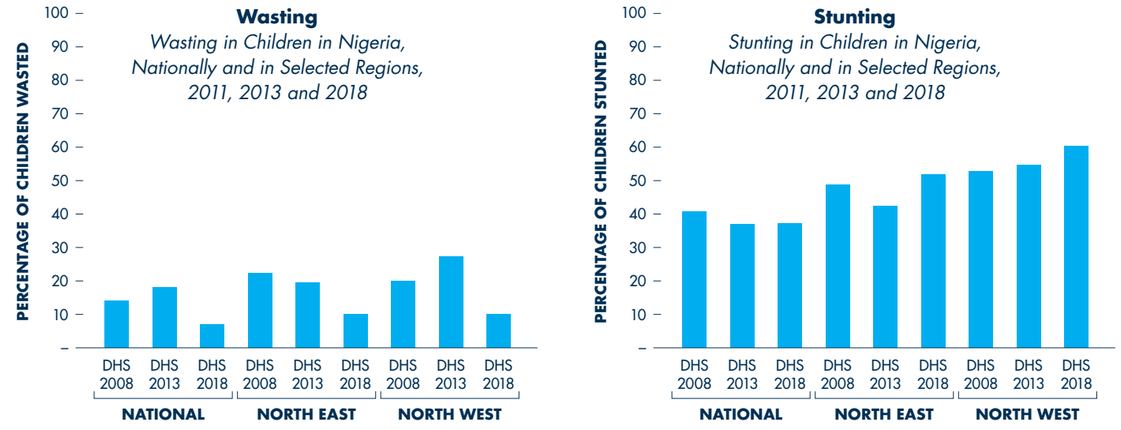
reductions in wasting, however, were increases in the prevalence of stunting, including in Northern regions of the country. This indicates—as recognized by the Government of Nigeria through its ANRIN project—the need to go beyond financing the "nutrition emergency" (i.e., severe acute malnutrition), to address the "nutrition crisis" (i.e., child stunting, maternal malnutrition, and micronutrient deficiencies) that affects far larger numbers of women and children.

Conclusion and Work Going Forward

With the expansion of the NSHIP into Northern, conflict-affected regions of the country, 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 National Health Act—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.

Figure 6 **Prevalence of wasting and stunting among children under five in Nigeria, nationwide and northern regions, 2008-2013**

Drastic improvements in child wasting were seen both nationally and regionally, while child stunting rose



Source: DHIS2

CASE STUDY

Tanzania

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.[1] 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 (ANC4+, 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.

Box 1: **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

1 Partners include the governments of Canada, Denmark, Ireland, and Switzerland; the Korea International Cooperation Agency (KOICA); UNICEF; 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.

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 (PHCforR) 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 Sector-Wide 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 strengthen this effort.

2 Partner organizations—the governments of Canada, Denmark, Ireland, and Switzerland; KOICA; UNICEF; and the World Bank and the GFF—are flowing 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 ties 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 DLI indicators are 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.[2] 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.

To improve facilities' performance in terms of quality of service delivery, the Star Rating initiative has been used. The Star Rating system is a nationwide ranking of health facilities whose scoring ranges from 0 to 5 stars and includes criteria that correspond to improvements in the conditions for the provision of quality care and that facilitate the achievement of maternal, neonatal and child health service delivery outcomes. The Star Rating Initiative includes a quality improvement plan as well as efforts to help health facilities achieve improved structural quality of care. Criteria included in the rating include human resources for health, availability of essential drugs, social accountability, and completeness of data entry.

Using Social Media to Improve Health Outcomes in Tanzania

To overcome data and communication gaps, the Government of Tanzania is using social messaging platforms, such as WhatsApp groups. These are enabling communication and linkages between service providers at the primary to tertiary levels. The groups provide a forum for support to address life-threatening conditions, as group members share knowledge and experiences in real time, by using diverse medical expertise to manage emergencies, improve the quality of referrals and sharing of resources, and enhance coordination among programs, regional authorities, district authorities, faith-based organizations, and private hospitals and health centers. The existence of maternity WhatsApp groups has contributed to saving lives in complicated, "near miss" cases for both pregnant women and newborns.

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

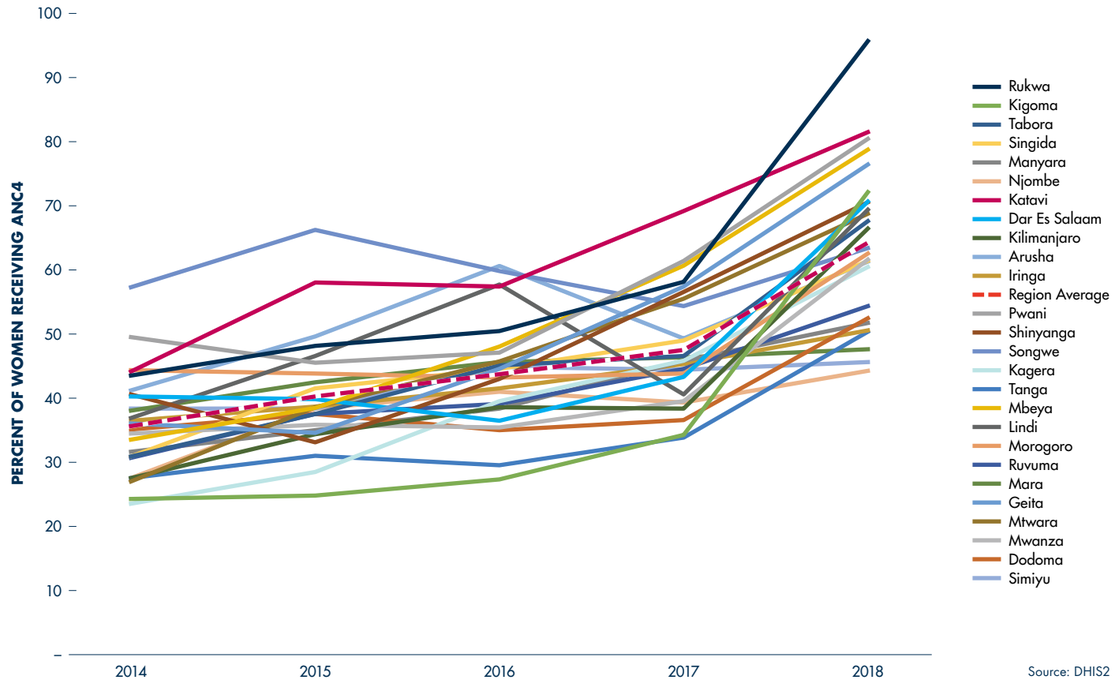
The results in One Plan II are partially financed through DLIs in the PHCforR program; as such, expected results in both documents are in direct alignment. Results in both the investment case and the PHCforR focus on all levels of the health system, with the end goal of improving the quality and availability 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, Geita, Katavi, Kigoma, Mbeya, Pwani, Rukwa, and Shinyanga). Nevertheless, many regions remain below 50 percent coverage of ANC4+, 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 67.0 percent in 2014 to 70.6 percent in 2017, and to 79.6 percent in 2018 (Figure 2) (RMNCAH Bulletin 2019).

Figure 1 **Percent of women in Tanzania receiving at least four antenatal visits, by region, 2014–18**

In almost one-third of Tanzania's regions, at least 70% of pregnant women are reached with ANC4+, but in many other regions coverage is under 50%



Source: DHIS2

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; its 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 75 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,

Figure 2 **Percent of facility-based births in Tanzania, by region, 2014–18**

region	**2015** (dot shows high point)	**2018**
Manyara Region	47.6	54.0
Kilimanjaro Region	56.9	56.5
Dar Es Salaam Region	50.2	60.5
Tanga Region	53.2	61.8
Arusha Region	60.1	67.6
Lindi Region	58.6	68.3
Dodoma Region	70.7	69.2
Simiyu Region	53.8	69.7
Mtwara Region	60.8	70.6
Morogoro Region	62.6	71.5
Njombe Region	79.2	71.7
Mara Region	64.4	72.4
Singida Region	70.5	75.0

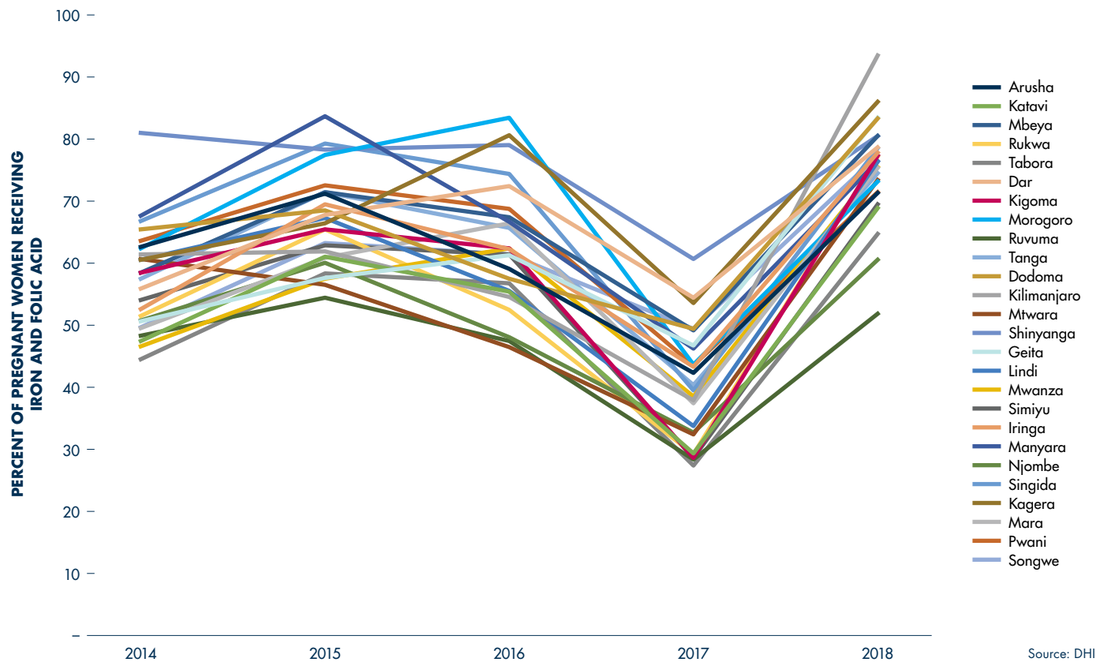
region	**2015** (dot shows high point)	**2018**
Iringa Region	85.7	75.7
Songwe Region	85.8	75.8
Kagera Region	52.5	77.7
Mbeya Region	63.8	82.1
Ruvuma Region	77.1	82.2
Katavi Region	76.4	94.0
Tabora Region	65.9	96.8
Mwanza Region	67.5	97.6
Kigoma Region	56.7	100.3
Geita Region	51.9	103.7
Pwani Region	88.3	107.0
Shinyanga Region	64.1	109.6
Rukwa Region	91.5	109.6

Source: DHIS2

More than 80 percent of Tanzania's 26 regions saw an increase in facility-based births from 2017 to 2018

Figure 3 **Percent of pregnant women in Tanzania receiving iron and folic acid, by region, 2014–18**

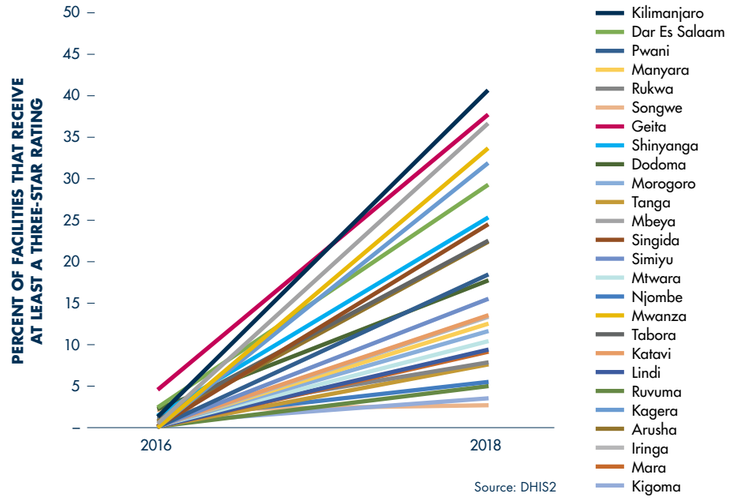
More than 70% of pregnant women in a majority of regions in Tanzania received iron and folic acid in 2018



Source: DHIS2

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

Figure 4 **Percent of facilities in Tanzania that received at least a 3-star rating, by region, 2014–18**



Source: DHIS2

137 facilities achieved a 3-star rating or higher; this number climbed to 1,370 facilities by 2018. This is equivalent to an increase in the average proportion of facilities achieving at least a 3-star rating from 0.9 percent in 2016 to 18 percent in 2018. In 2018, the highest-performing region saw 41.1 percent of its facilities achieving a 3-star rating, while the lowest-performing region saw just 2.8 percent of its facilities perform at this level.

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.

CASE STUDY

Uganda

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.

Box 1: **Trends in key RMNCAH-N indicators (1995–2016, DHS)**

+ **Maternal mortality ratio:** Declined from 506 to 336 deaths per 100,000
+ **Under-5 mortality rate:** Declined from 147 to 64 deaths per 1,000 live births
+ **Age-specific fertility rate for adolescent girls:** Declined from 204 to 132 births per 1,000 15-to-19-year-olds
+ **Share of women who had another child less than 24 months after their previous child:** Declined from 27.9 to 24.3 percent
+ **Prevalence of stunting among children under five years:** Declined from 45% to 28.9%

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:

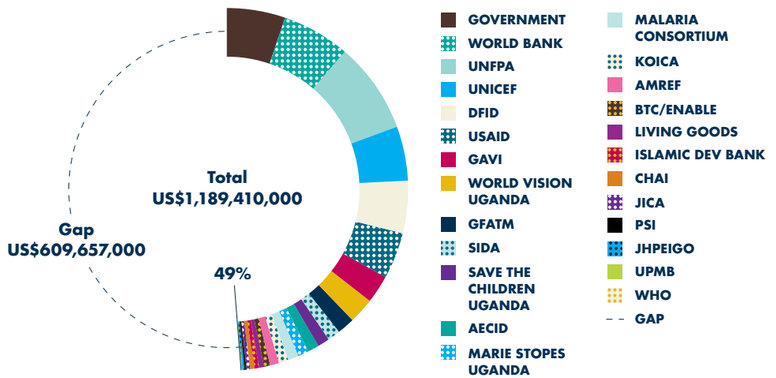
+ **Shift 1:** Expanding access to a package of high-impact RMNCAH interventions
+ **Shift 2:** Including expanded access to high-burden populations, and
+ **Shift 3:** Keeping a focus on geographic sequencing (prioritizing the 40 highest burden districts).
+ These operational shifts are complemented 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 two dozen partners, including international and Ugandan civil society organizations, international development agencies, UN agencies, and the private sector.[1] A unified investment case (namely, the Sharpened Plan), systematic resource mapping (Figure 1), routine coordination meetings, and a shared results framework have all helped the government and partners better plan their activities to reduce duplication, fill gaps, and craft a long-term sustainable vision for the health system.

Figure 1 **Resource mapping for The Sharpened Plan, 2018-2021**



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, post-abortion care, and treatment for common conditions among children under age

1 Partners include the Government of Uganda; the African Development Bank; Amref Health Africa; the Bill & Melinda Gates Foundation; BRAC; Belgian Technical Cooperation (BTC); the Clinton Health Access Initiative (CHAI); Doctors with Africa CUAMM; the Danish International Development Agency (DANIDA); the U.K. Department for International Development (DFID); GAVI; the Global Fund to Fight AIDS, Tuberculosis and Malaria; the Islamic Development Bank; the Japan International Cooperation Agency (JICA); John Snow International (JSI); The Johns Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO); the Korea International Cooperation Agency (KOICA); Living Goods; Marie Stopes Uganda; the Maternal and Child Survival Program (MCSP); the Government of Norway; Population Services International (PSI); Save the Children Uganda; the Swedish International Development Cooperation Agency (SIDA); the Uganda Protestant Medical Bureau (UPMB); the United Nations Population Fund (UNFPA); the United Nations High Commissioner for Refugees (UNHCR); the United Nations Children's Fund (UNICEF); the United Nations Office for Project Services (UNOPS); the U.S. Agency for International Development (USAID); Wellshare; the World Health Organization (WHO); the World Bank; and World Vision Uganda.

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.

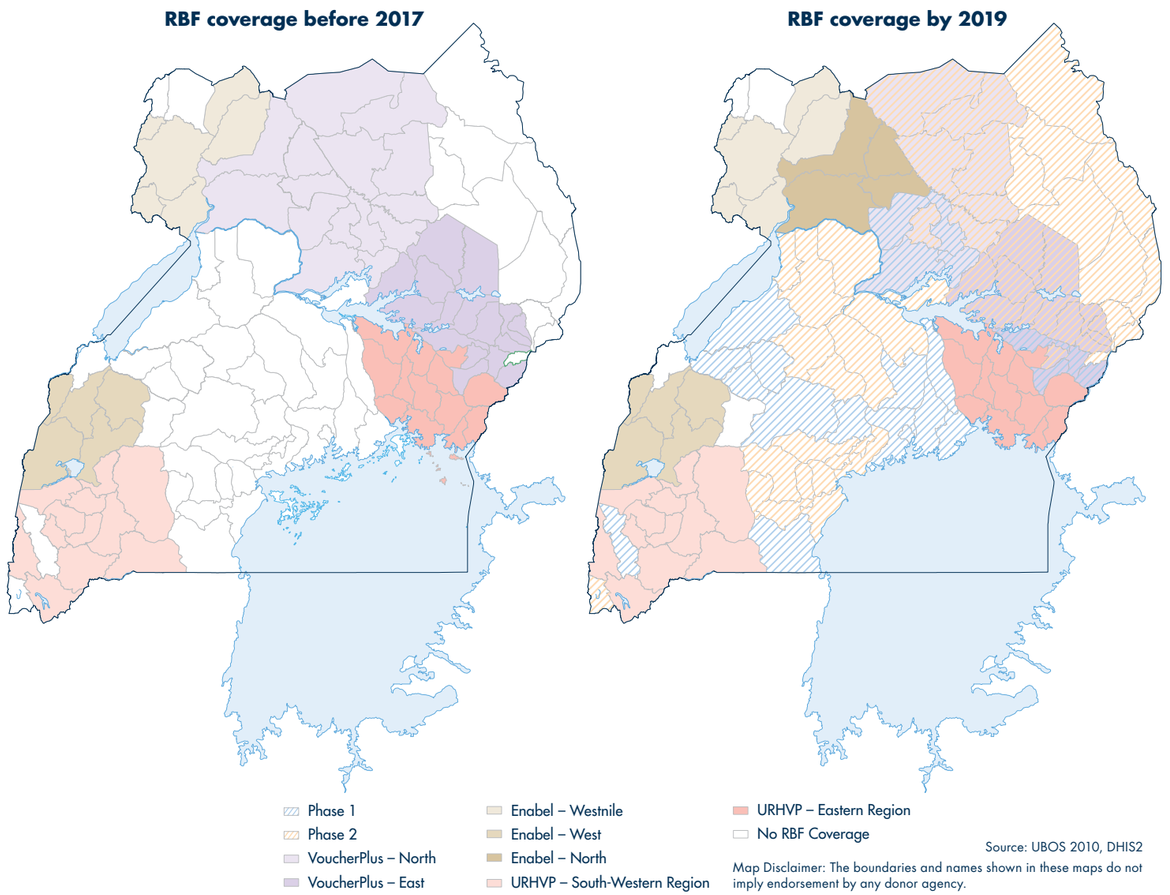
Results

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 in 28 districts 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[2] 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

Figure 2 **Coverage of results-based financing and voucher programs in Uganda, 2017 and 2019**



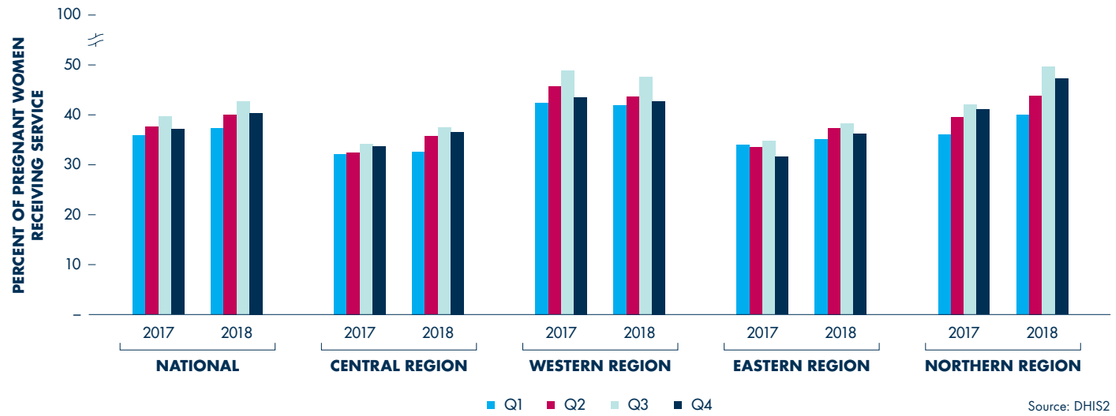
Source: UBOS 2010, DHIS2

Map Disclaimer: The boundaries and names shown in these maps do not imply endorsement by any donor agency.

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

Figure 3 **Antenatal coverage from January 2017 to December 2018, by region, by quarter**

Antenatal coverage shows increases in all regions, most pronounced in the northern regions with 3rd quarter showing greatest gains.



Source: DHIS2

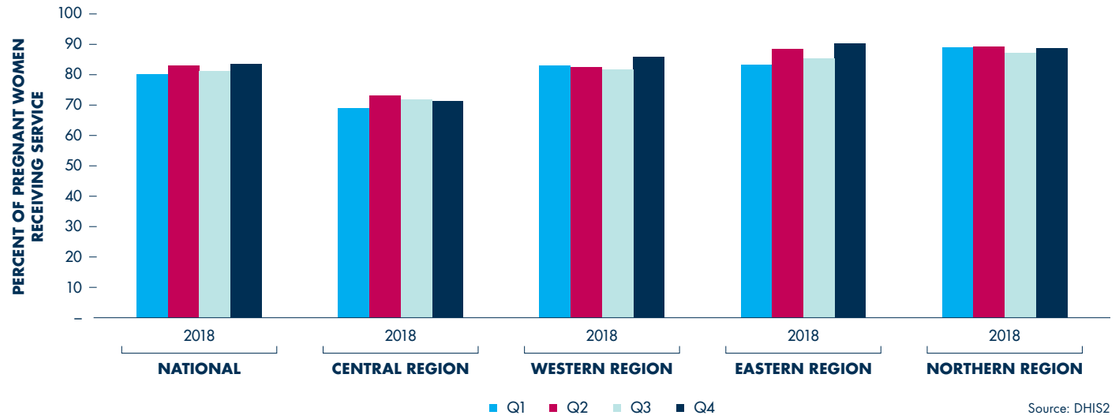
improvements in quality. For example, of all women receiving ANC1, the proportion of them that were receiving iron folate in 2018 was between 80 and 90 percent in all regions except one (the Central Region, where it was just over 70 percent) (Figure 4). Similarly, the proportion of women receiving a 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.[3] 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

Figure 4 **Women receiving iron folate during 1st antenatal visits, coverage from January 2018 to December 2018, by region and quarter**

No significant change in women receiving iron folate during 1st antenatal visit in all regions.

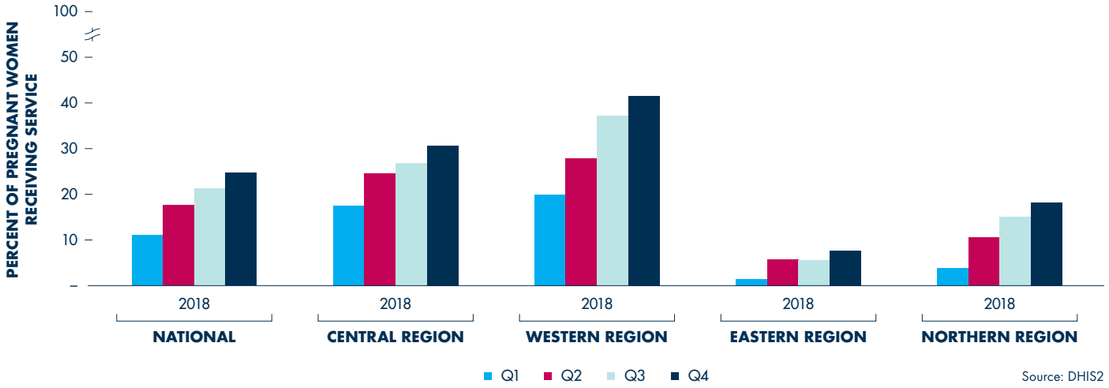


Source: DHIS2

3 Between 2017 and 2018, there was a 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.

Figure 5 **National intermittent preventive therapy, third dose (IPT3), for malaria, by region from January 2018 to December 2018**

Following a 2017 policy change and improved stock monitoring, the proportion of women receiving a third dose of intermittent preventive treatment for malaria in pregnancy (IPT3) increased in all regions.



Source: DHIS2

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.

Figure 6 **Coverage of facility-based deliveries in 2018, by region and by quarter**

Increase in facility-based deliveries in quarters 3 and 4 in 2018 across all regions.

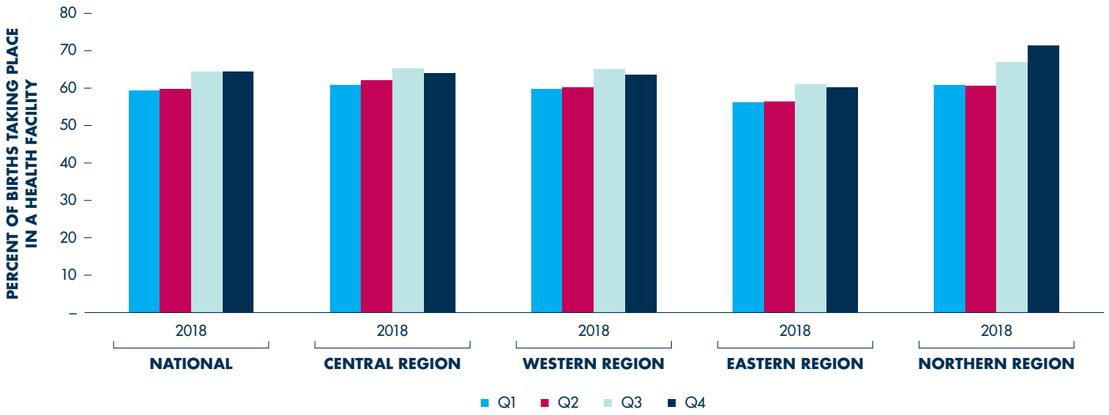
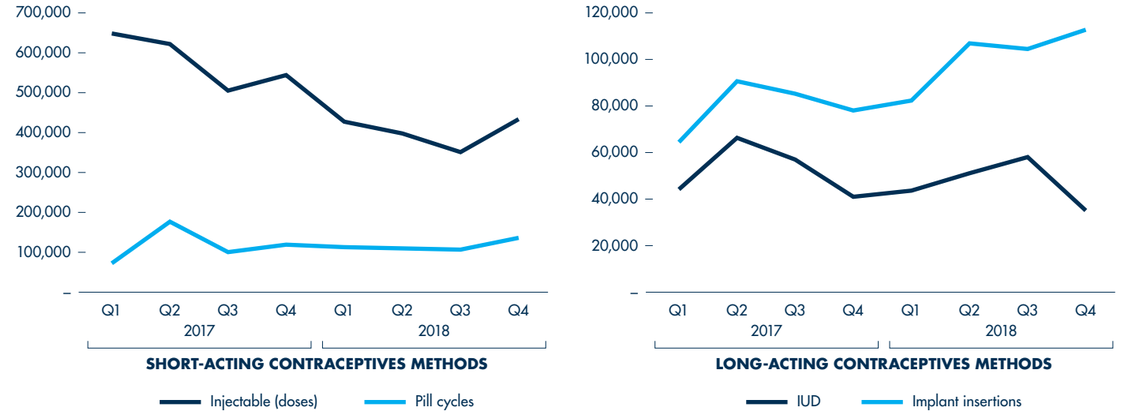


Figure 7 **There have been notable, national-level shifts in the method mix of family planning in Uganda over the last 2 years**

Between 2017 and 2018, the use of long-acting contraceptives soared, while use of shorter-term methods declined.



Source: DHIS2

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 maternal mortality 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
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

INVESTMENT CASE	Investment case for RMNCAH-N or equivalent (e.g., national healthplan)	2	Investment Case in development	Investment Case complete	Investment Case being implemented
	Set of evidence based priorities financed	4	Not prioritized within available funding	Priorities determined, but financial gap remains	Priorities fully funded**
	Results monitoring strategy and framework in support of IC*	1	Not developed	Developed and initial assessment of results monitoring capacity available	Country platform (or other country led entity) uses results framework to review progress on a regular basis
COUNTRY PLATFORM	Country-led multi- stakeholder platform (e.g., new or established from an existing platform)	6	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	7	Government focal point not yet identified	Government focal point identified	Government focal point identified with contact available online (GFF website)
	An inclusive country platform process with CSO engagement	7	CSOs not included in the process	CSO representative identified	Civil society represented at routine country platform meetings to discuss IC implementation and results
HEALTH FINANCING	Health financing reforms identified	7	Not considered at this time	Developed but not integrated in IC	Health financing in progress
	World Bank-funded project in support of the IC	7	Project under preparation	Project approved and available online	Project disbursing
OTHER AREAS OF INTEREST	Private sector engagement	2	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	2	CRVS not identified as 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	2	Supply chain / commodity management not identified as a priority	Supply chain / commodity management identified as a priority	Supply chain / commodity management interventions funded
				SCORES	

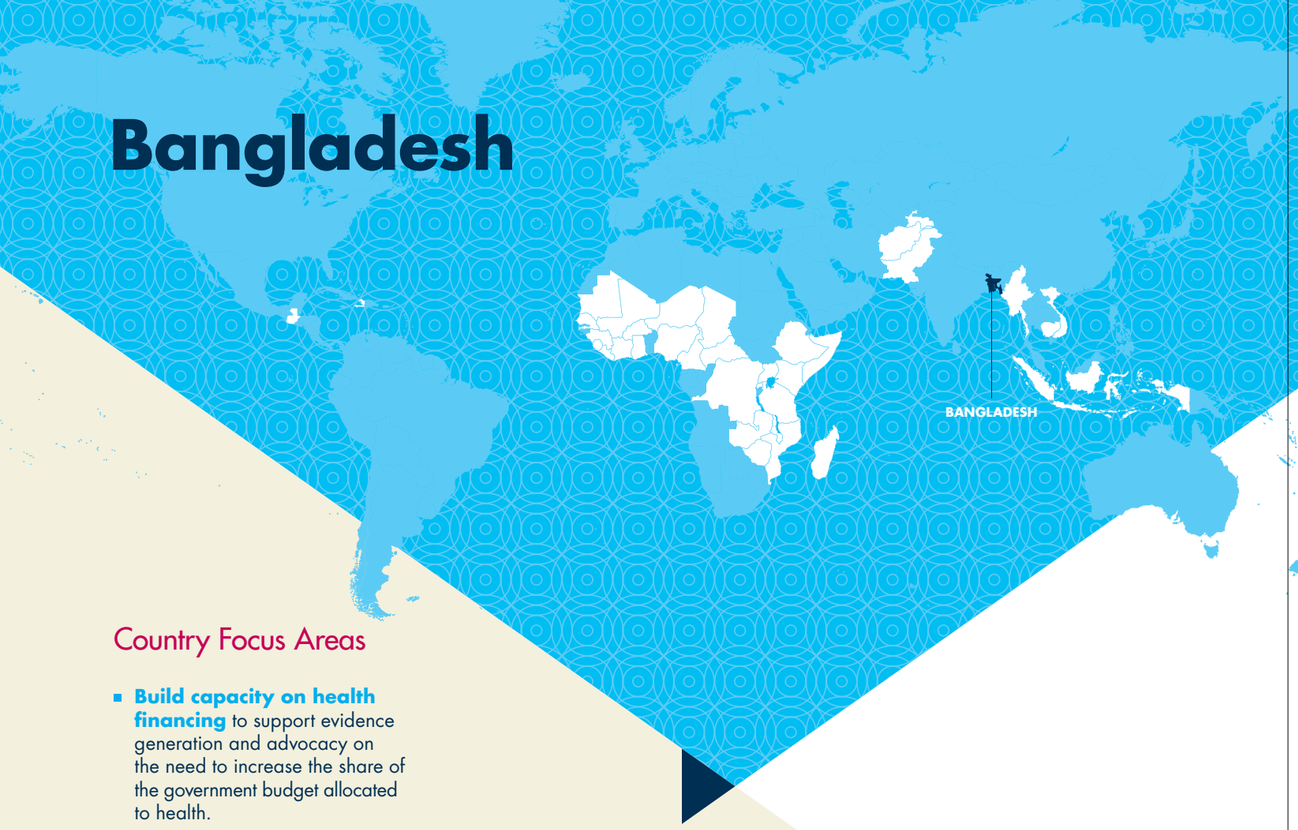
* Both included in the IC document or a separate document

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

*** 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.

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 ratio:
29 per 1,000 live births

Adolescent 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%**

Health Financing Core Indicators

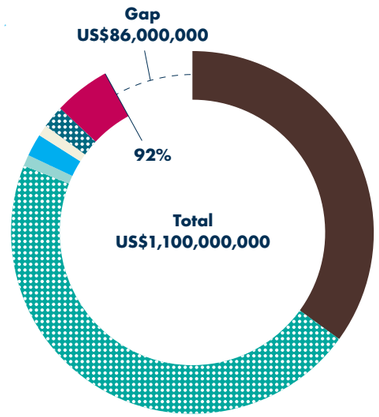
Health expenditure per capita financed from domestic sources: **US$6.14**

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

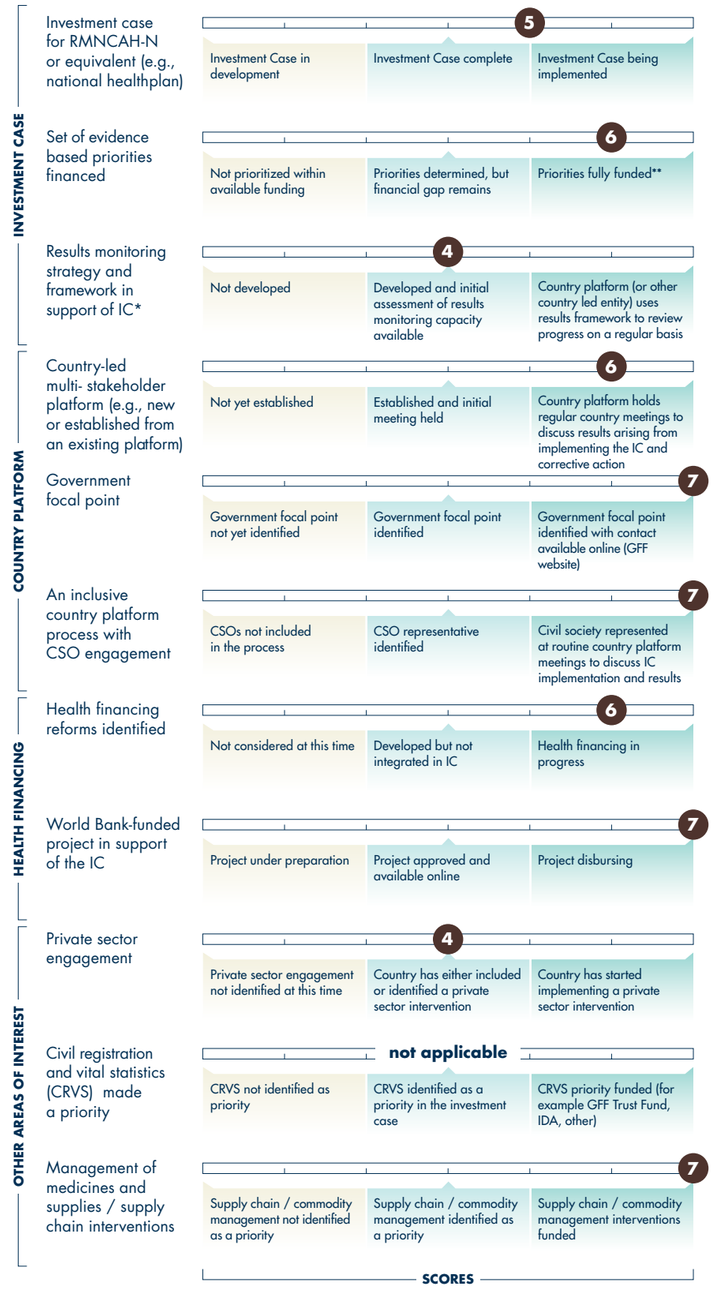
Resource Mapping



GOVERNMENT
WORLD BANK
GFF TRUST FUND
SIDA
NETHERLANDS
CANADA
DFID
GAP

The resource mapping for Bangladesh covers FY2018 to 2023. This chart includes one of the two World Bank projects, and is focused specifically on health and nutrition. The second project, which is co-financed by the GFF, is an education project focused on keeping girls in school in an effort to improve adolescent health. However, it is not included in the resource mapping since it is not part of the health sector. Presently there is only an 8% gap in financing for the IC.

Monitoring the Country-Led Process



* 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.

Burkina Faso

Country Focus Areas

- **Improve equitable access to and utilization of an integrated package of high-impact RMNCAH-N interventions.**
- **Strengthen the health systems pillars of human resource availability** and infrastructure, equipment, and commodities.
- **Improve governance of the health system**, including financing, civil registration, information systems, and multisectoral coordination.

RMNCAH-N Core Indicators

Maternal mortality ratio:
330 per 100,000 live births

Neonatal mortality ratio:
23 per 1,000 live births

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

Adolescent birth rate:
132 per 1,000 women

Percent of births <24 months after the preceding birth: **17.4%**

Stunting among children under 5 years of age: **25%**

Moderate to severe wasting among children under 5 years of age: **8.4%**

Health Financing Core Indicators

Health expenditure per capita financed from domestic sources: **US$16.42**

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

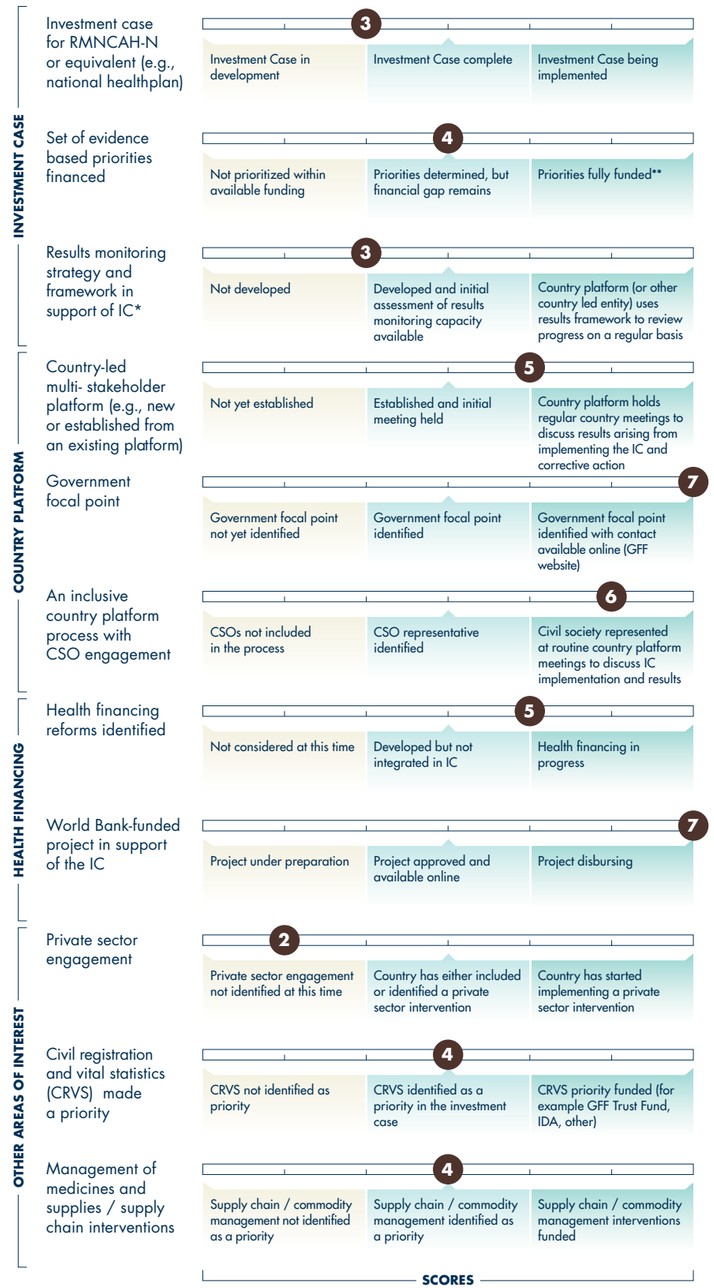
Percent of current health expenditures on primary/outpatient health care:
78.34%

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

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.

Monitoring the Country-Led Process



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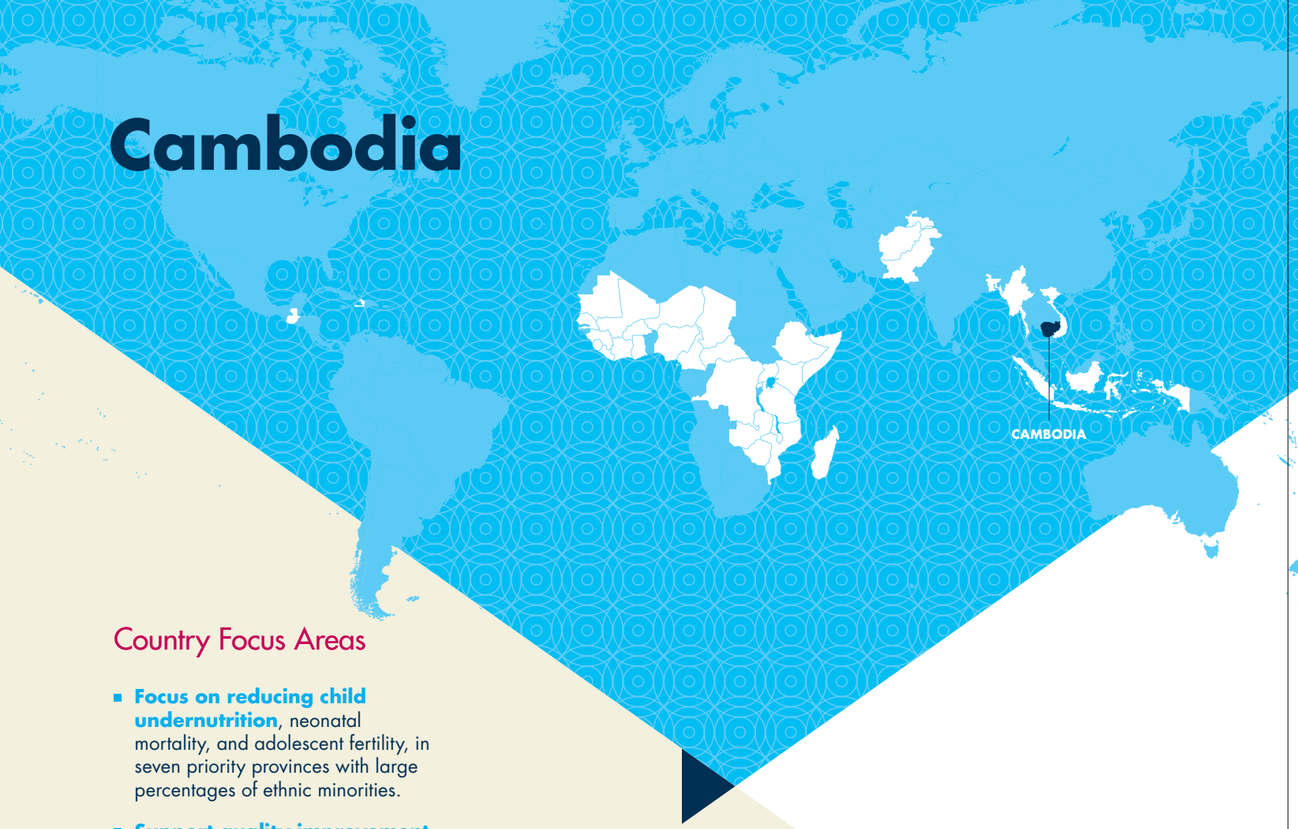
ART = antiretroviral therapy; ARV = antiretroviral; DTP3 = vaccination for Diphtheria, Tetanus, and Pertussis; ORS = oral rehydration solution; PMTCT = prevention of mother-to-child transmission; PNC = postnatal care.

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%**

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/outpatient health care: **67.37%**

Incidence of catastrophic and impoverishing health expenditures:
19.97% catastrophic
2.99% impoverishing

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$53 million project, Cambodia Nutrition project (2019-2024) financed by the Royal Government of Cambodia (US$12m), IDA (US$ 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.

Monitoring the Country-Led Process

INVESTMENT CASE	Investment case for RMNCAH-N or equivalent (e.g., national healthplan)	3	Investment Case in development	Investment Case complete / Investment Case being implemented
	Set of evidence based priorities financed	4	Not prioritized within available funding	Priorities determined, but financial gap remains / Priorities fully funded**
	Results monitoring strategy and framework in support of IC*	3	Not developed	Developed and initial assessment of results monitoring capacity available / Country platform (or other country led entity) uses results framework to review progress on a regular basis
COUNTRY PLATFORM	Country-led multi- stakeholder platform (e.g., new or established from an existing platform)	5	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	7	Government focal point not yet identified	Government focal point identified / Government focal point identified with contact available online (GFF website)
	An inclusive country platform process with CSO engagement	6	CSOs not included in the process	CSO representative identified / Civil society represented at routine country platform meetings to discuss IC implementation and results
HEALTH FINANCING	Health financing reforms identified	6	Not considered at this time	Developed but not integrated in IC / Health financing in progress
	World Bank-funded project in support of the IC	4	Project under preparation	Project approved and available online / Project disbursing
OTHER AREAS OF INTEREST	Private sector engagement	4	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	3	CRVS not identified as 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	1	Supply chain / commodity management not identified as a priority	Supply chain / commodity management identified as a priority / Supply chain / commodity management interventions funded
		SCORES		

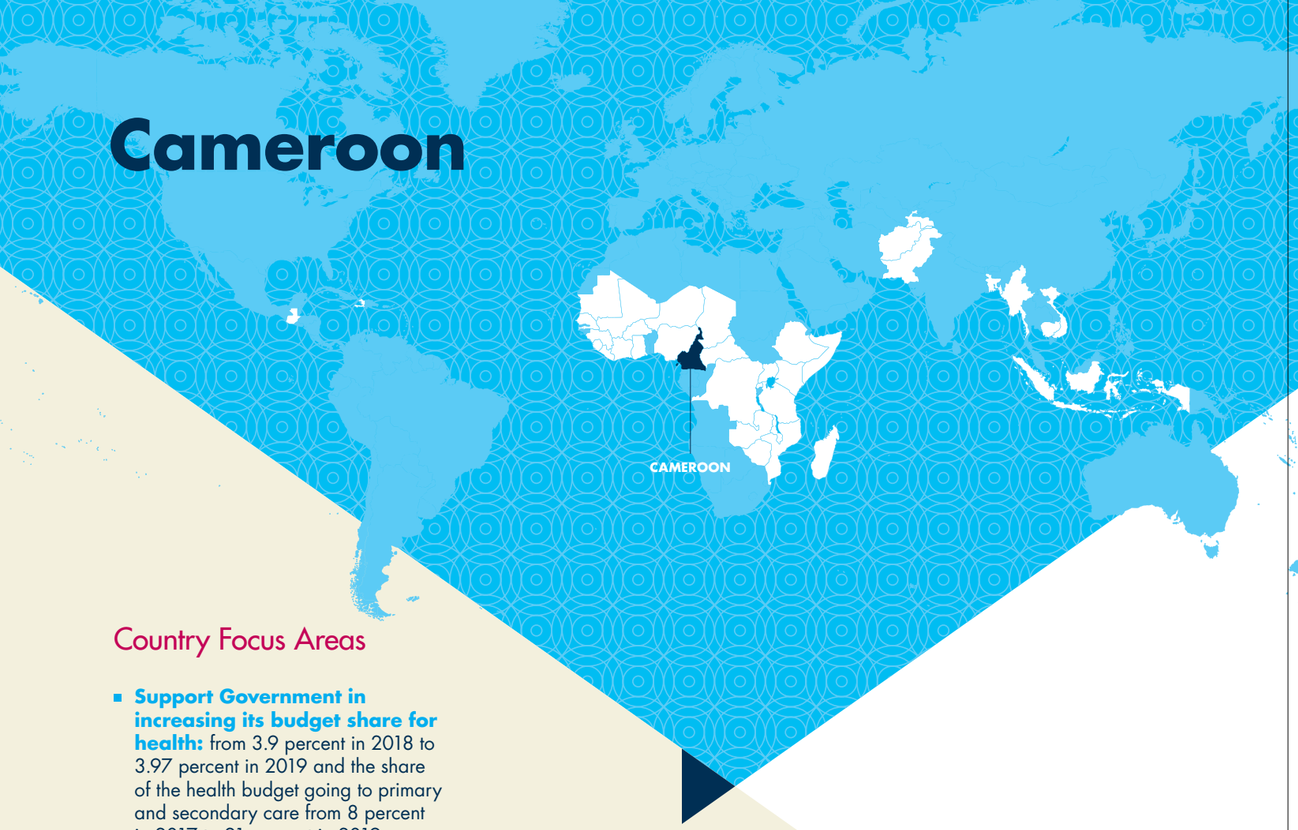
* Both included in the IC document or a separate document

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

*** 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.

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.

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:
122 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

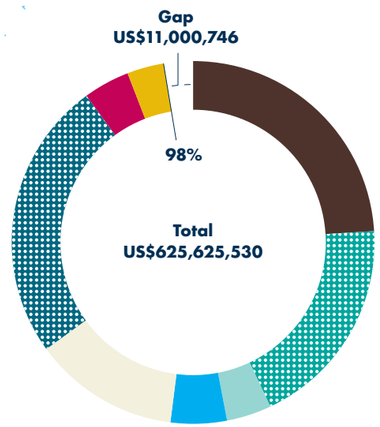
Health expenditure per capita financed from domestic sources: **US$8.60**

Ratio of government health expenditure to total government expenditures: **2.95%**

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

Resource Mapping



- GOVERNMENT
- WORLD BANK
- GFF TRUST FUND
- AFD & BMZ
- GFATM
- GAVI
- ISLAMIC DEVELOPMENT BANK
- OTHER
- GAP

This resource mapping was conducted in 2018 and updated in 2019 and provides estimates for implementing the investment case for FY2017 to 2020. At the time of the resource mapping, there was a 2% gap in financing of the IC.

Monitoring the Country-Led Process

INVESTMENT CASE	Investment case for RMNCAH-N or equivalent (e.g., national healthplan)	Investment Case in development	Investment Case complete	Investment Case being implemented (7)
	Set of evidence based priorities financed	Not prioritized within available funding	Priorities determined, but financial gap remains (4)	Priorities fully funded**
	Results monitoring strategy and framework in support of IC*	Not developed	Developed and initial assessment of results monitoring capacity available (5)	Country platform (or other country led entity) uses results framework to review progress on a regular basis
COUNTRY PLATFORM	Country-led multi- stakeholder platform (e.g., new or established from an existing platform)	Not yet established	Established and initial meeting held (5)	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 (GFF website) (7)
	An inclusive country platform process with CSO engagement	CSOs not included in the process	CSO representative identified (5)	Civil society represented at routine country platform meetings to discuss IC implementation and results
HEALTH FINANCING	Health financing reforms identified	Not considered at this time	Developed but not integrated in IC (5)	Health financing in progress
	World Bank-funded project in support of the IC	Project under preparation	Project approved and available online	Project disbursing (7)
OTHER AREAS OF INTEREST	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 (7)
	Civil registration and vital statistics (CRVS) made a priority	CRVS not identified as priority	CRVS identified as a priority in the investment case	CRVS priority funded (for example GFF Trust Fund, IDA, other) (7)
	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 (4)	Supply chain / commodity management interventions funded
			SCORES	

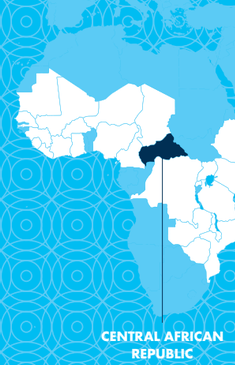
* Both included in the IC document or a separate document

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

*** 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.

Central African Republic



Country Focus Areas

- **Focus on increasing access and improving the quality of a high-impact package of RMNCAH-N services** through performance-based financing and free services for pregnant and breastfeeding women, children under five, and victims of gender-based violence.
- **Reduce fragmentation** by integrating humanitarian and development financing.
- **Strengthen health information systems** by aligning the investment case results framework with ongoing health information system reforms.

RMNCAH-N 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:
121.5 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

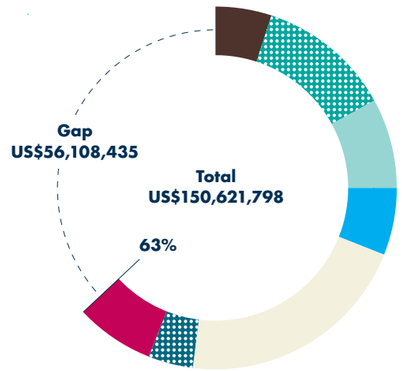
Health expenditure per capita financed from domestic sources: **US$2.43**

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

Resource Mapping



The resource mapping presented here covers FY 2020-22. There are currently over 5 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 and to ensure that external partners are aligned.

Monitoring the Country-Led Process

INVESTMENT CASE	Investment case for RMNCAH-N or equivalent (e.g., national healthplan)	5	Investment Case in development	Investment Case complete / Investment Case being implemented
	Set of evidence based priorities financed	5	Not prioritized within available funding	Priorities determined, but financial gap remains / Priorities fully funded**
	Results monitoring strategy and framework in support of IC*	3	Not developed	Developed and initial assessment of results monitoring capacity available / Country platform (or other country led entity) uses results framework to review progress on a regular basis
COUNTRY PLATFORM	Country-led multi- stakeholder platform (e.g., new or established from an existing platform)	6	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
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OTHER AREAS OF INTEREST	Private sector engagement	1	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	not applicable	CRVS not identified as 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	2	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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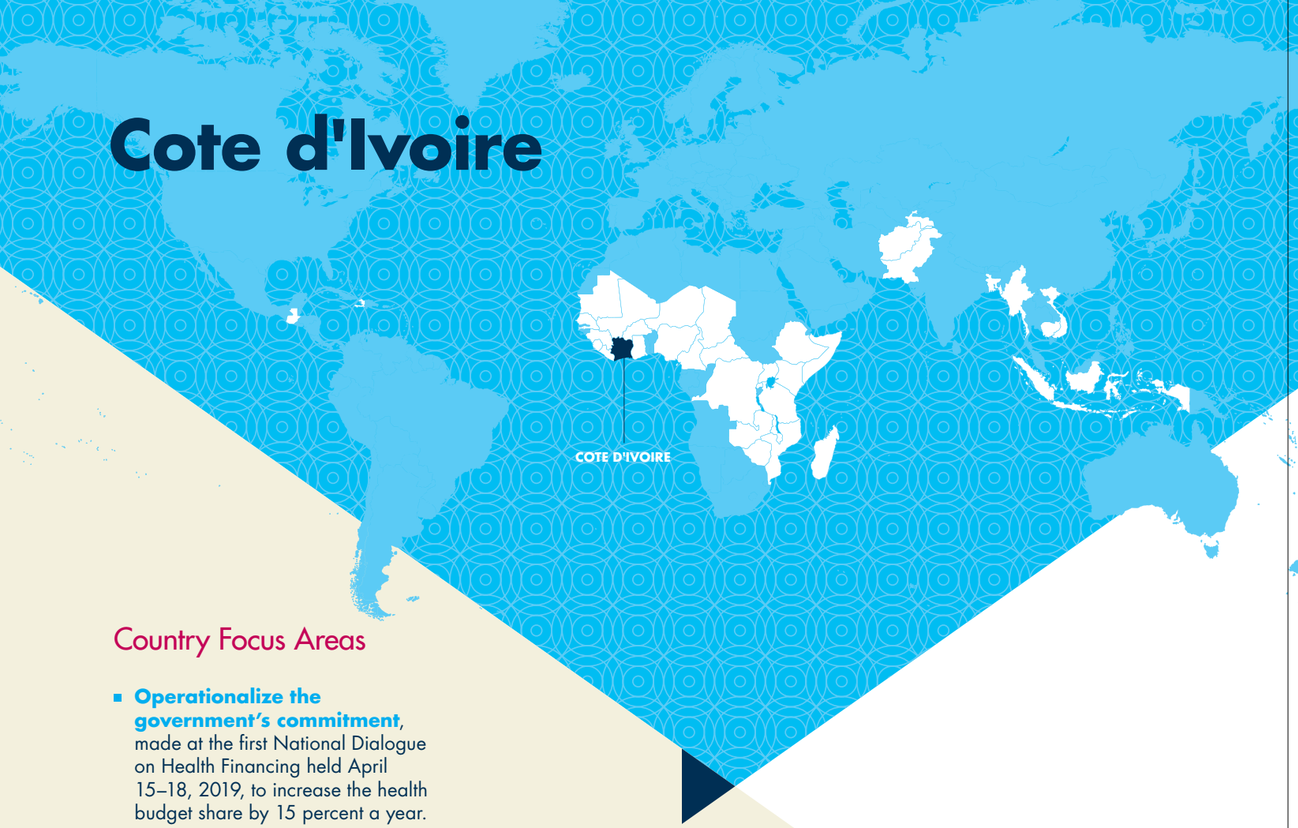
Cote d'Ivoire



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: **14.9%**

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:
8.82% catastrophic
1.73% impoverishing

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 commitments) 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.

Monitoring the Country-Led Process

INVESTMENT CASE	Investment case for RMNCAH-N or equivalent (e.g., national healthplan)	Investment Case in development	**4** Investment Case complete	Investment Case being implemented
	Set of evidence based priorities financed	Not prioritized within available funding	Priorities determined, but financial gap remains	**6** Priorities fully funded**
	Results monitoring strategy and framework in support of IC*	Not developed	**4** Developed and initial assessment of results monitoring capacity available	Country platform (or other country led entity) uses results framework to review progress on a regular basis
COUNTRY PLATFORM	Country-led multi- stakeholder platform (e.g., new or established from an existing platform)	Not yet established	**3** 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	**7** Government focal point identified with contact available online (GFF website)
	An inclusive country platform process with CSO engagement	CSOs not included in the process	**4** CSO representative identified	Civil society represented at routine country platform meetings to discuss IC implementation and results
HEALTH FINANCING	Health financing reforms identified	Not considered at this time	Developed but not integrated in IC	**5** Health financing in progress
	World Bank-funded project in support of the IC	Project under preparation	**4** Project approved and available online	Project disbursing
OTHER AREAS OF INTEREST	Private sector engagement	Private sector engagement not identified at this time	**4** 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	**1** CRVS not identified as 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	**3** Supply chain / commodity management identified as a priority	Supply chain / commodity management interventions funded
			SCORES	

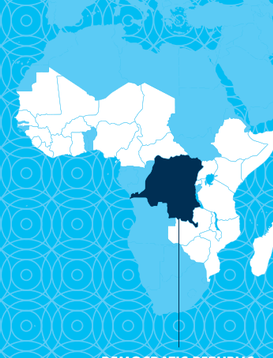
* Both included in the IC document or a separate document

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

*** 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.

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:
104 per 1,000 live births

Adolescent birth rate:
138.1 per 1,000 women

Percent of births <24 months after the preceding birth: **27.1%**

Stunting among children under 5 years of age: **43%**

Moderate to severe wasting among children under 5 years of age: **8%**

Health Financing Core Indicators

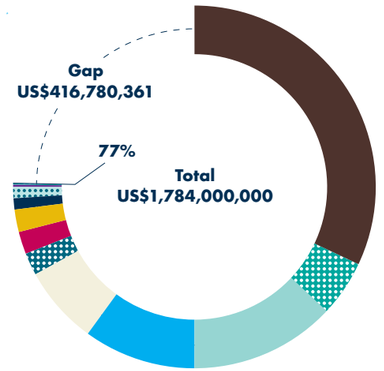
Health expenditure per capita financed from domestic sources: **US$2.51**

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

Resource Mapping



- GOVERNMENT
- WORLD BANK/ GFF TRUST FUND
- GFATM/BMGF
- USAID
- UNICEF/BMGF
- EUROPEAN COMMISSION
- WHO
- DFID
- CANADA
- GAVI
- SWISS/SIDA
- BELGIUM
- JICA
- GAP

The resource mapping shown here is for FY 2019. Presently there are more than 10 external partners aligned with and committed to financing the IC. The government only accounts for 32% of total needs for the IC. There is a funding gap of 23% for FY 2019. The resource mapping has been completed for the Plan National de Developpement de la Sante (PNDS), which serves as DRC's prioritized national health strategy and its IC. Data for this assessment was provided by the health donors coordination group, also known as Groupe Inter-Bailleurs de la Santé (GIBS). These estimates are still in the process of being updated by the GIBS.

Monitoring the Country-Led Process

INVESTMENT CASE	Investment case for RMNCAH-N or equivalent (e.g., national healthplan)	6	Investment Case in development	Investment Case complete / Investment Case being implemented
	Set of evidence based priorities financed	4	Not prioritized within available funding	Priorities determined, but financial gap remains / Priorities fully funded**
	Results monitoring strategy and framework in support of IC*	3	Not developed	Developed and initial assessment of results monitoring capacity available / Country platform (or other country led entity) uses results framework to review progress on a regular basis
COUNTRY PLATFORM	Country-led multi- stakeholder platform (e.g., new or established from an existing platform)	5	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	7	Government focal point not yet identified	Government focal point identified / Government focal point identified with contact available online (GFF website)
	An inclusive country platform process with CSO engagement	5	CSOs not included in the process	CSO representative identified / Civil society represented at routine country platform meetings to discuss IC implementation and results
HEALTH FINANCING	Health financing reforms identified	7	Not considered at this time	Developed but not integrated in IC / Health financing in progress
	World Bank-funded project in support of the IC	7	Project under preparation	Project approved and available online / Project disbursing
OTHER AREAS OF INTEREST	Private sector engagement	4	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	7	CRVS not identified as 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	6	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

*** 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.

Ethiopia

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

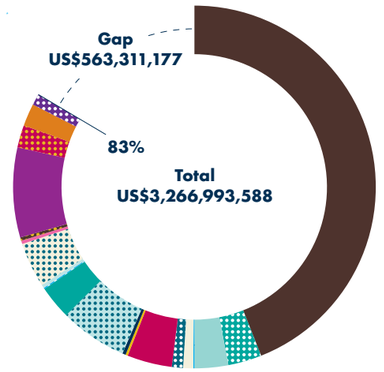
Health expenditure per capita financed from domestic sources: **US$10.60**

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
0.95% impoverishing

Resource Mapping



- GOVERNMENT
- WORLD BANK
- DFID
- AECID
- CIFF
- EUROPEAN COMMISSION
- GAVI
- IRISH AID
- AICS
- PFIZER FOUNDATION
- SWISS DEVELOPMENT COOPERATION
- GFATM
- UNAIDS
- UNFPA
- USAID
- WHO
- NETHERLANDS
- CHANNEL 3 NGOS
- CHANNEL 2 FUNDS
- COMMUNITY
- HEALTH INSURANCE/ CBHI
- GAP

Community represents the free labor contribution of the community converted in monetary value.

The resource mapping presented here is for FY 2018 to 2019. There are currently over 15 external partners, in addition to the Ministry of Health, who are aligned with and invested in financing the IC. Ethiopia has conducted a thorough resource mapping, including community contributions that have been converted into monetary value. Additionally, they have estimated the contributions of Community Based Health Insurance (CBHI) scheme, which subsidizes the primary health care package. Ethiopia also has two additional funding flows that are not typically documented in other countries; Channel 2 funds refer to financing that is on-plan, but not on-budget, while Channel 3 funds refer to financing from NGOs to the health sector that do not flow through the government system.

Monitoring the Country-Led Process

INVESTMENT CASE	Investment case for RMNCAH-N or equivalent (e.g., national healthplan)	Investment Case in development	Investment Case complete	Investment Case being implemented **7**
	Set of evidence based priorities financed	Not prioritized within available funding	Priorities determined, but financial gap remains **4**	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 (or other country led entity) uses results framework to review progress on a regular basis **7**
COUNTRY PLATFORM	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 **7**
	Government focal point	Government focal point not yet identified	Government focal point identified	Government focal point identified with contact available online (GFF website) **7**
	An inclusive country platform process with CSO engagement	CSOs not included in the process	CSO representative identified	Civil society represented at routine country platform meetings to discuss IC implementation and results **7**
HEALTH FINANCING	Health financing reforms identified	Not considered at this time	Developed but not integrated in IC	Health financing in progress **7**
	World Bank-funded project in support of the IC	Project under preparation	Project approved and available online	Project disbursing **7**
OTHER AREAS OF INTEREST	Private sector engagement	Private sector engagement not identified at this time	Country has either included or identified a private sector intervention **3**	Country has started implementing a private sector intervention
	Civil registration and vital statistics (CRVS) made a priority	CRVS not identified as priority	CRVS identified as a priority in the investment case	CRVS priority funded (for example GFF Trust Fund, IDA, other) **7**
	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 **6**	Supply chain / commodity management interventions funded
			SCORES	

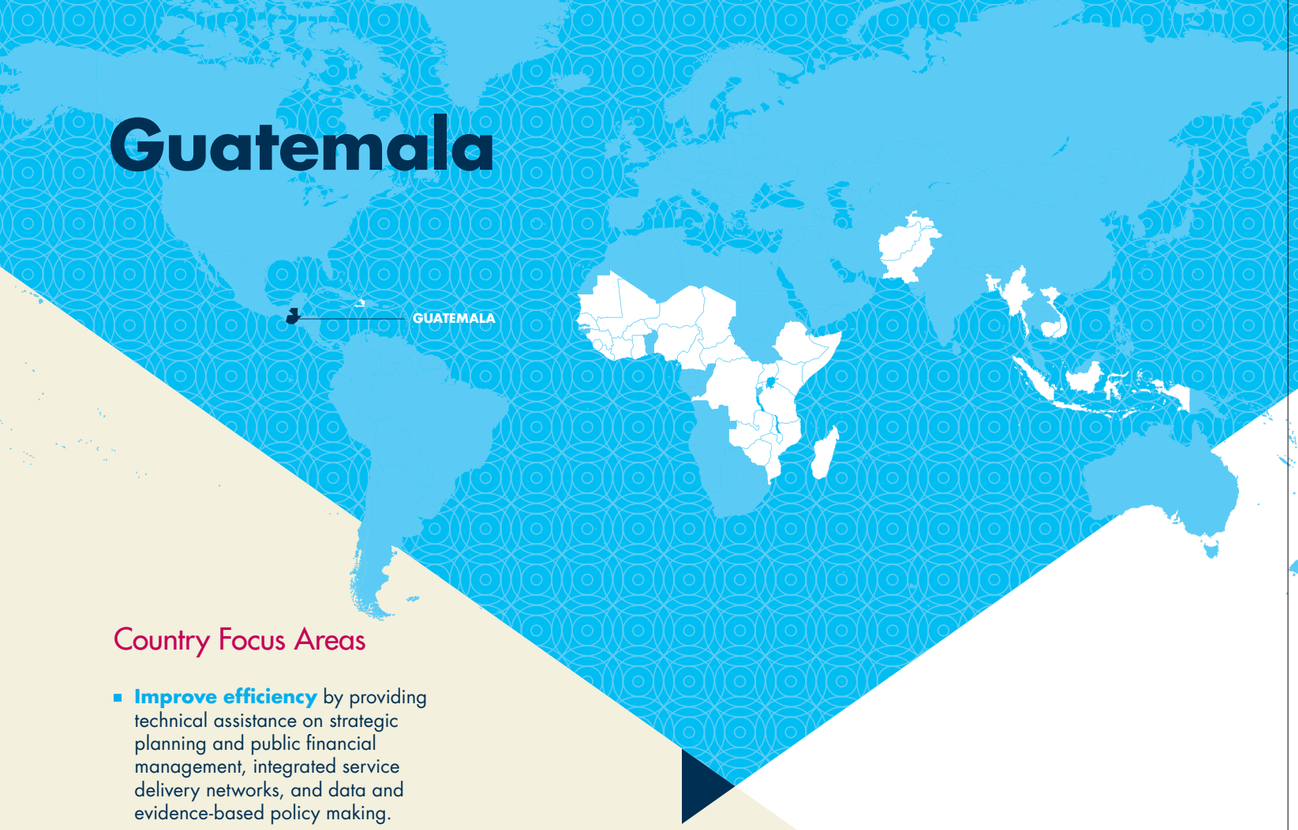
* Both included in the IC document or a separate document

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

*** 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.

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$18 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

Maternal mortality ratio:
140 per 100,000 live births

Neonatal mortality ratio:
17 per 1,000 live births

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

Adolescent birth rate:
92 per 1,000 women

Percent of births <24 months after the preceding birth: **18.8%**

Stunting among children under 5 years of age: **47%**

Moderate to severe wasting among children under 5 years of age: **1%**

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/outpatient 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.

Monitoring the Country-Led Process

INVESTMENT CASE	Investment case for RMNCAH-N or equivalent (e.g., national healthplan)	7	Investment Case in development	Investment Case complete / Investment Case being implemented
	Set of evidence based priorities financed	4	Not prioritized within available funding	Priorities determined, but financial gap remains / Priorities fully funded**
	Results monitoring strategy and framework in support of IC*	4	Not developed	Developed and initial assessment of results monitoring capacity available / Country platform (or other country led entity) uses results framework to review progress on a regular basis
COUNTRY PLATFORM	Country-led multi- stakeholder platform (e.g., new or established from an existing platform)	6	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	7	Government focal point not yet identified	Government focal point identified / Government focal point identified with contact available online (GFF website)
	An inclusive country platform process with CSO engagement	6	CSOs not included in the process	CSO representative identified / Civil society represented at routine country platform meetings to discuss IC implementation and results
HEALTH FINANCING	Health financing reforms identified	1	Not considered at this time	Developed but not integrated in IC / Health financing in progress
	World Bank-funded project in support of the IC	4	Project under preparation	Project approved and available online / Project disbursing
OTHER AREAS OF INTEREST	Private sector engagement	1	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	4	CRVS not identified as 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	3	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

*** 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.

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:
111 per 1,000 live births

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

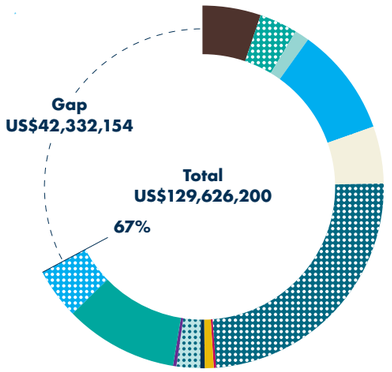
Health expenditure per capita financed from domestic sources: **US$4.61**

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

Resource Mapping



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 30%, Guinea has made a strong commitment to reducing maternal mortality by 15% and neonatal and infant mortality by 30% over the next 3 years. While these are ambitious goals, it expects to reach these targets through increased financing for the IC and improvements in allocative efficiencies.

Monitoring the Country-Led Process

INVESTMENT CASE	Investment case for RMNCAH-N or equivalent (e.g., national healthplan)	4	Investment Case in development	Investment Case complete / Investment Case being implemented
	Set of evidence based priorities financed	4	Not prioritized within available funding	Priorities determined, but financial gap remains / Priorities fully funded**
	Results monitoring strategy and framework in support of IC*	3	Not developed	Developed and initial assessment of results monitoring capacity available / Country platform (or other country led entity) uses results framework to review progress on a regular basis
COUNTRY PLATFORM	Country-led multi- stakeholder platform (e.g., new or established from an existing platform)	5	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	7	Government focal point not yet identified	Government focal point identified / Government focal point identified with contact available online (GFF website)
	An inclusive country platform process with CSO engagement	3	CSOs not included in the process	CSO representative identified / Civil society represented at routine country platform meetings to discuss IC implementation and results
HEALTH FINANCING	Health financing reforms identified	4	Not considered at this time	Developed but not integrated in IC / Health financing in progress
	World Bank-funded project in support of the IC	7	Project under preparation	Project approved and available online / Project disbursing
OTHER AREAS OF INTEREST	Private sector engagement	1	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	7	CRVS not identified as 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	2	Supply chain / commodity management not identified as a priority	Supply chain / commodity management identified as a priority / Supply chain / commodity management interventions funded
	SCORES			

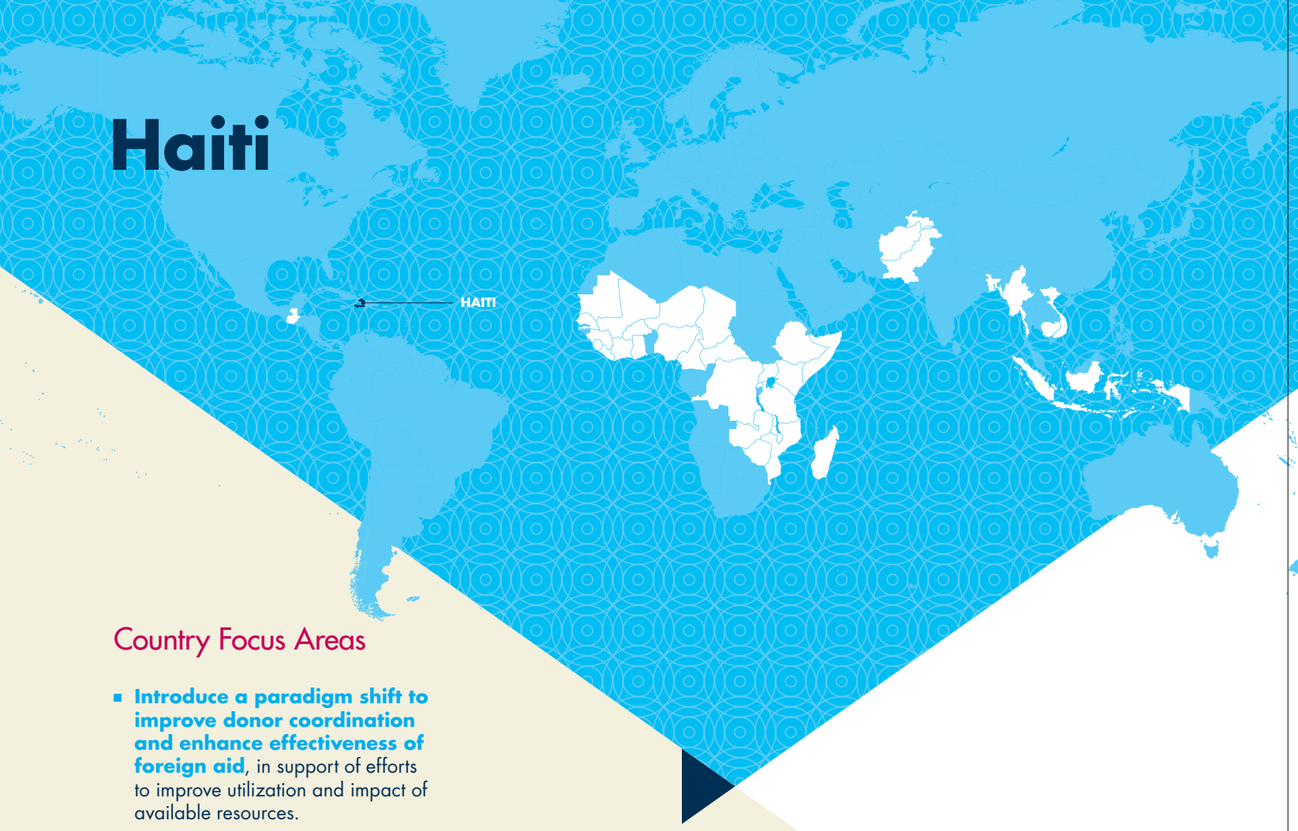
* Both included in the IC document or a separate document

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

*** 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.

Haiti



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 plan** 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** (SNADI) 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:
55 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%**

Health Financing Core Indicators

Health expenditure per capita financed from domestic sources: **US$5.79**

Ratio of government health expenditure to total government expenditures: **4.42%**

Percent of current health expenditures on primary/outpatient health care: **74.24%**

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

INVESTMENT CASE	Investment case for RMNCAH-N or equivalent (e.g., national healthplan)	1	Investment Case in development	Investment Case complete / Investment Case being implemented
	Set of evidence based priorities financed	3	Not prioritized within available funding	Priorities determined, but financial gap remains / Priorities fully funded**
	Results monitoring strategy and framework in support of IC*	1	Not developed	Developed and initial assessment of results monitoring capacity available / Country platform (or other country led entity) uses results framework to review progress on a regular basis
COUNTRY PLATFORM	Country-led multi- stakeholder platform (e.g., new or established from an existing platform)	3	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	7	Government focal point not yet identified	Government focal point identified / Government focal point identified with contact available online (GFF website)
	An inclusive country platform process with CSO engagement	3	CSOs not included in the process	CSO representative identified / Civil society represented at routine country platform meetings to discuss IC implementation and results
HEALTH FINANCING	Health financing reforms identified	5	Not considered at this time	Developed but not integrated in IC / Health financing in progress
	World Bank-funded project in support of the IC	4	Project under preparation	Project approved and available online / Project disbursing
OTHER AREAS OF INTEREST	Private sector engagement	3	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	1	CRVS not identified as 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	4	Supply chain / commodity management not identified as a priority	Supply chain / commodity management identified as a priority / Supply chain / commodity management interventions funded
		SCORES		

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** 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.

Indonesia

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 registration 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:
15 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.

Monitoring the Country-Led Process

INVESTMENT CASE	Investment case for RMNCAH-N or equivalent (e.g., national healthplan)	5	Investment Case in development	Investment Case complete / Investment Case being implemented
	Set of evidence based priorities financed	5	Not prioritized within available funding	Priorities determined, but financial gap remains / Priorities fully funded**
	Results monitoring strategy and framework in support of IC*	4	Not developed	Developed and initial assessment of results monitoring capacity available / Country platform (or other country led entity) uses results framework to review progress on a regular basis
COUNTRY PLATFORM	Country-led multi- stakeholder platform (e.g., new or established from an existing platform)	4	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	7	Government focal point not yet identified	Government focal point identified / Government focal point identified with contact available online (GFF website)
	An inclusive country platform process with CSO engagement	5	CSOs not included in the process	CSO representative identified / Civil society represented at routine country platform meetings to discuss IC implementation and results
HEALTH FINANCING	Health financing reforms identified	5	Not considered at this time	Developed but not integrated in IC / Health financing in progress
	World Bank-funded project in support of the IC	6	Project under preparation	Project approved and available online / Project disbursing
OTHER AREAS OF INTEREST	Private sector engagement	4	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	4	CRVS not identified as 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	3	Supply chain / commodity management not identified as a priority	Supply chain / commodity management identified as a priority / Supply chain / commodity management interventions funded
		SCORES		

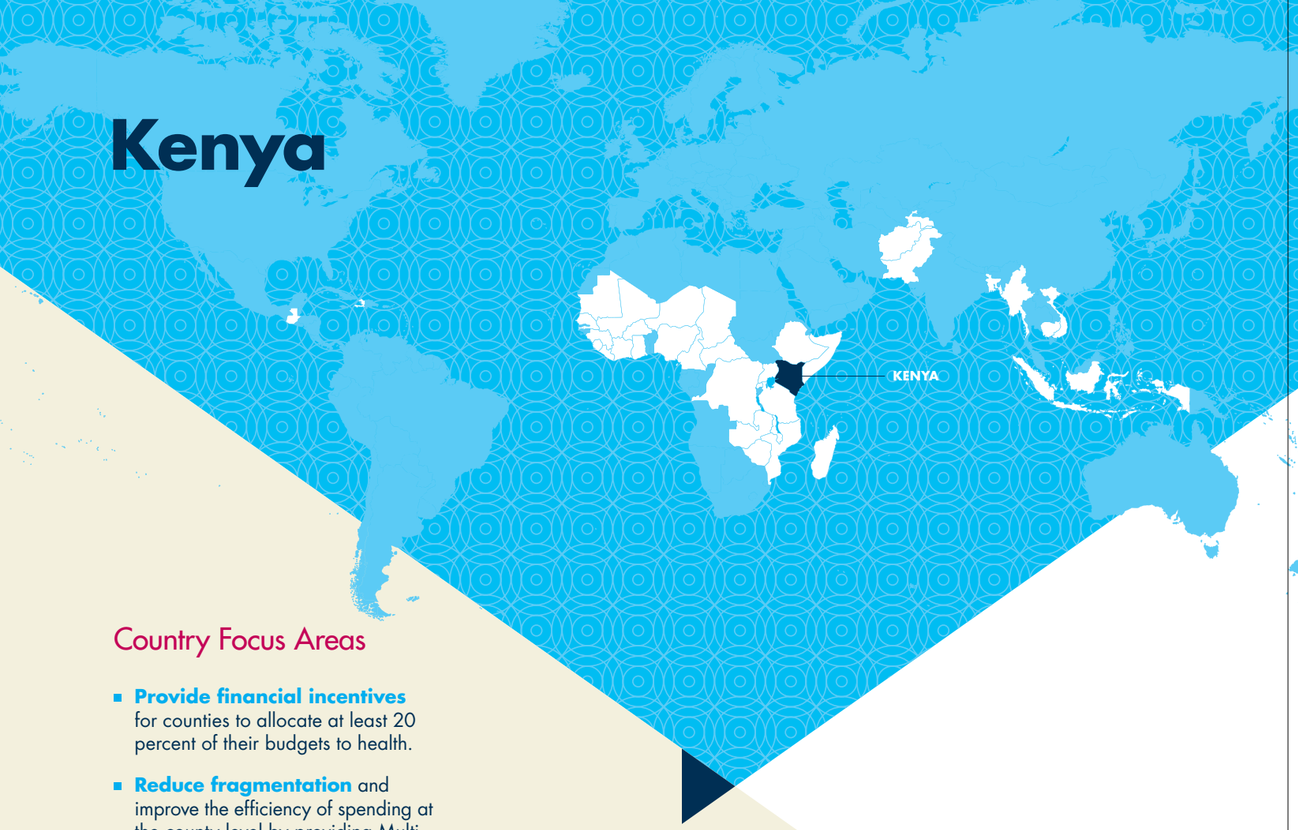
* Both included in the IC document or a separate document

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

*** 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.

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:
4% 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: **63.98%**

Incidence of catastrophic and impoverishing health expenditures:
5.83% catastrophic
1.5% impoverishing

Resource Mapping

Resource mapping informs and supports the implementation the RMNCAH investment case. The financial requirement for RMNCAH investments for the 20 priority counties was estimated at US$989 million from 2017-18 to 2019-20 (source: RMNCAH investment framework). Although detailed information is not currently available, Kenya's Ministry of Health estimates that the government contributes 40 percent of all health expenditures, households (through out of pocket payments) 31 percent, donors 23 percent, and other private sources 6 percent (source: NHA); representing a 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.

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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, strengthen death registration and recording and the coding of causes of death, and develop an integrated civil registration management information system.

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

Percent of births <24 months after the preceding birth: **15.5%**

Stunting among children under 5 years of age: **32%**

Moderate to severe wasting among children under 5 years of age: **6%**

Health Financing Core Indicators

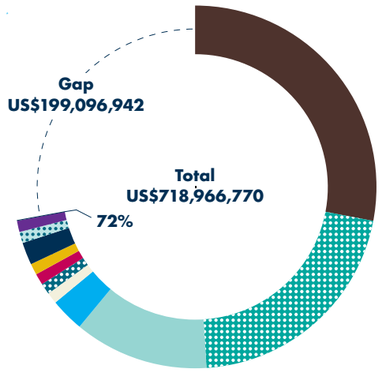
Health expenditure per capita financed from domestic sources: **US$9.73**

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

Resource Mapping



Resource map completed in 2017

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. As such, there is an ongoing expenditure analysis focusing on how to improve efficiency of spending and strategic purchasing.

Monitoring the Country-Led Process

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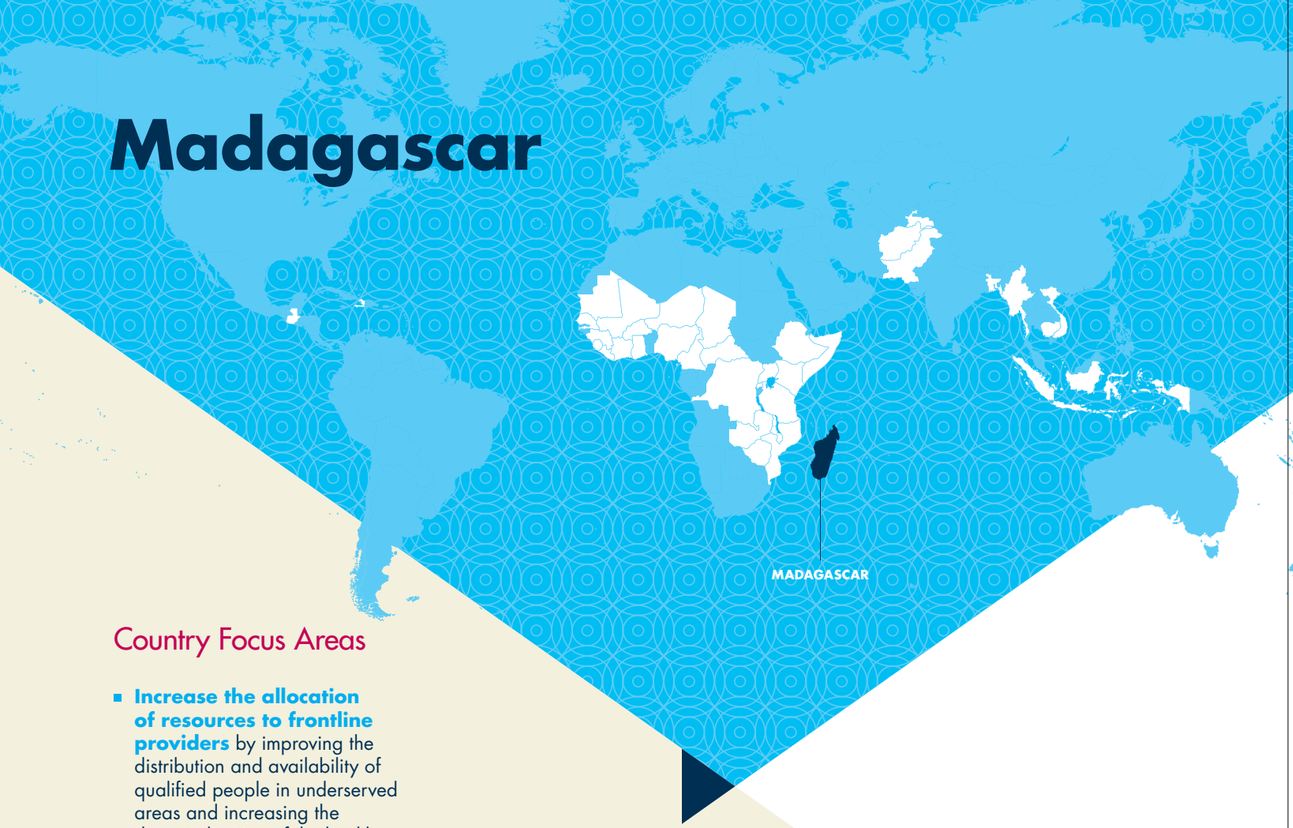
ART = antiretroviral therapy; ARV = antiretroviral; DTP3 = vaccination for Diphtheria, Tetanus, and Pertussis; ORS = oral rehydration solution; PMTCT = prevention of mother-to-child transmission; PNC = postnatal care.

Madagascar



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 health 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 ratio:
24 per 1,000 live births

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

Adolescent birth rate:
152 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 expenditures:
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 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.

Monitoring the Country-Led Process

INVESTMENT CASE	Investment case for RMNCAH-N or equivalent (e.g., national healthplan)		3	
		Investment Case in development	Investment Case complete	Investment Case being implemented
	Set of evidence based priorities financed		5	
		Not prioritized within available funding	Priorities determined, but financial gap remains	Priorities fully funded**
	Results monitoring strategy and framework in support of IC*		5	
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COUNTRY PLATFORM	Country-led multi- stakeholder platform (e.g., new or established from an existing platform)		6	
		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			7
		Government focal point not yet identified	Government focal point identified	Government focal point identified with contact available online (GFF website)
	An inclusive country platform process with CSO engagement			7
		CSOs not included in the process	CSO representative identified	Civil society represented at routine country platform meetings to discuss IC implementation and results
HEALTH FINANCING	Health financing reforms identified		3	
		Not considered at this time	Developed but not integrated in IC	Health financing in progress
	World Bank-funded project in support of the IC	1		
		Project under preparation	Project approved and available online	Project disbursing
OTHER AREAS OF INTEREST	Private sector engagement		not applicable	
		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		5	
		CRVS not identified as 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		not applicable	
		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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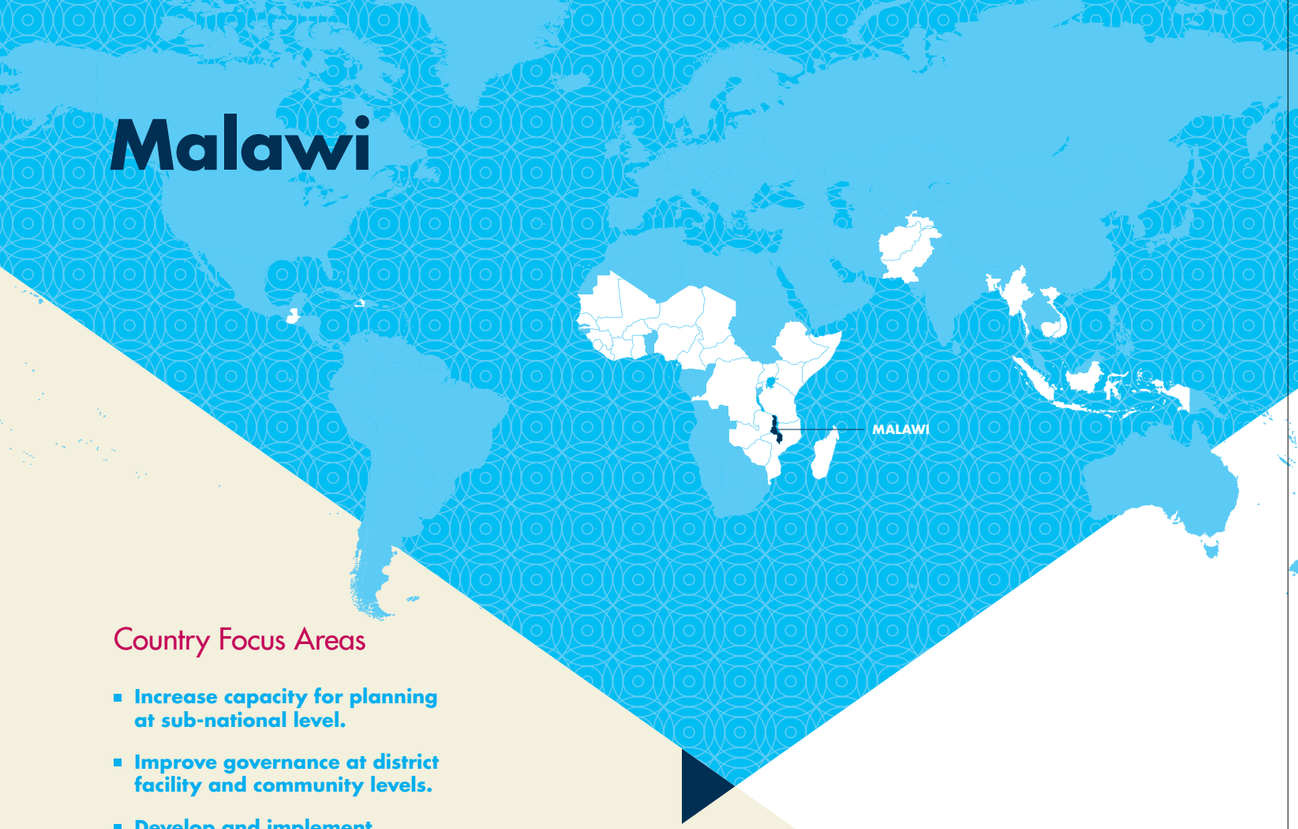
ART = antiretroviral therapy; ARV = antiretroviral; DTP3 = vaccination for Diphtheria, Tetanus, and Pertussis; ORS = oral rehydration solution; PMTCT = prevention of mother-to-child transmission; PNC = postnatal care.

Malawi



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 ratio:
63 per 1,000 live births

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%**

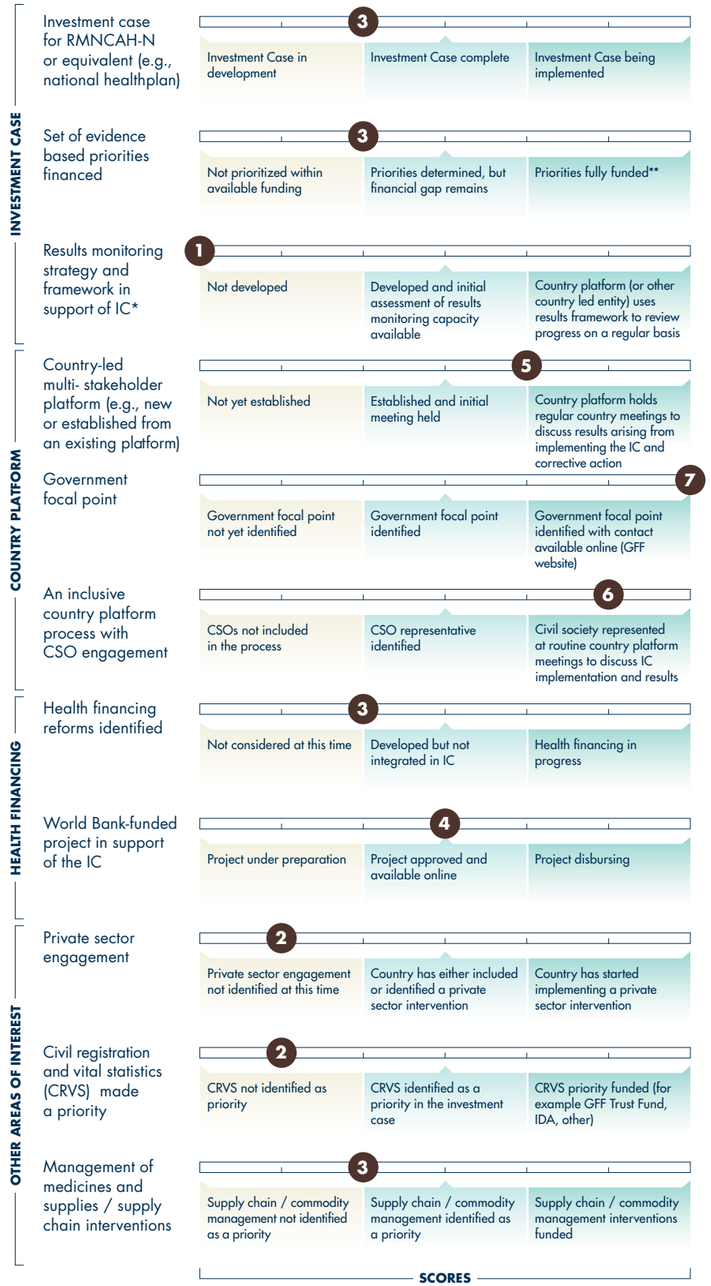
Percent of current health expenditures on primary/outpatient health care:
Not available

Incidence of catastrophic and impoverishing health expenditures:
1.3% catastrophic
0.52% 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



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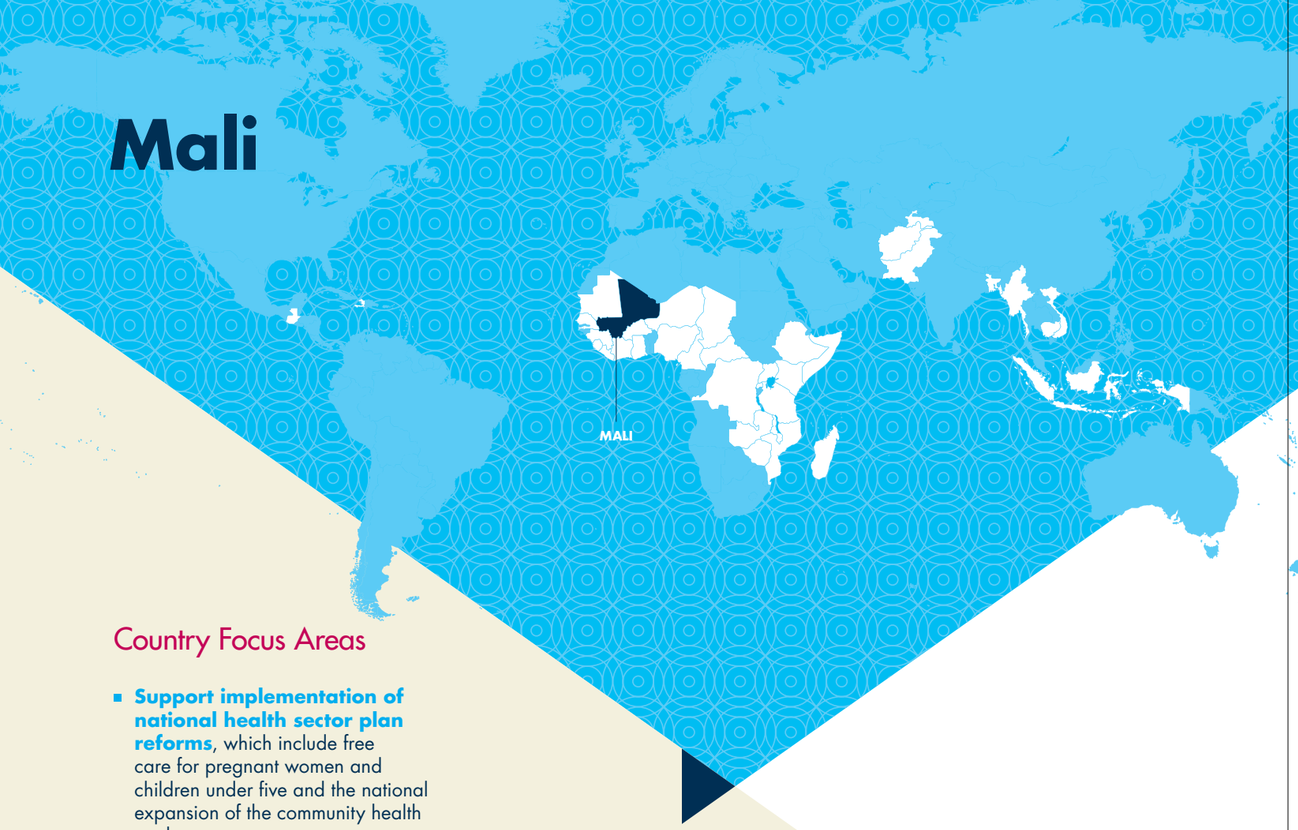
Mali



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%**

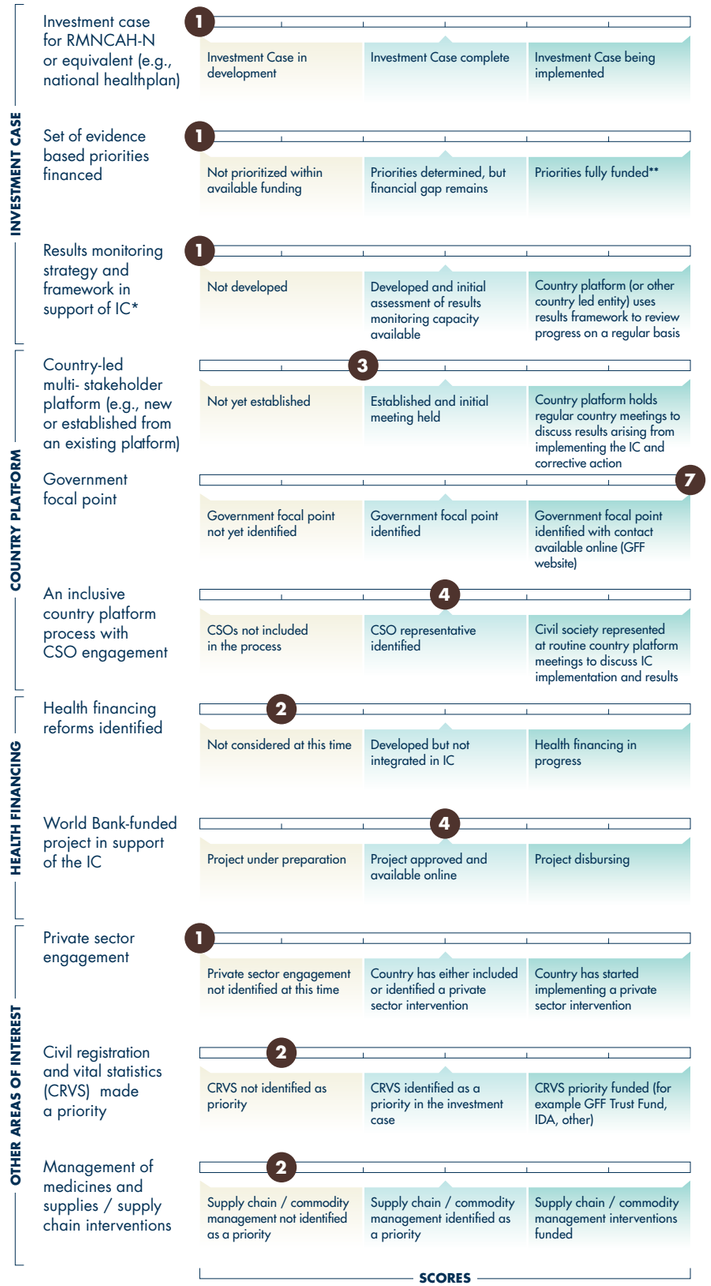
Percent of current health expenditures on primary/outpatient health care: **81.60%**

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



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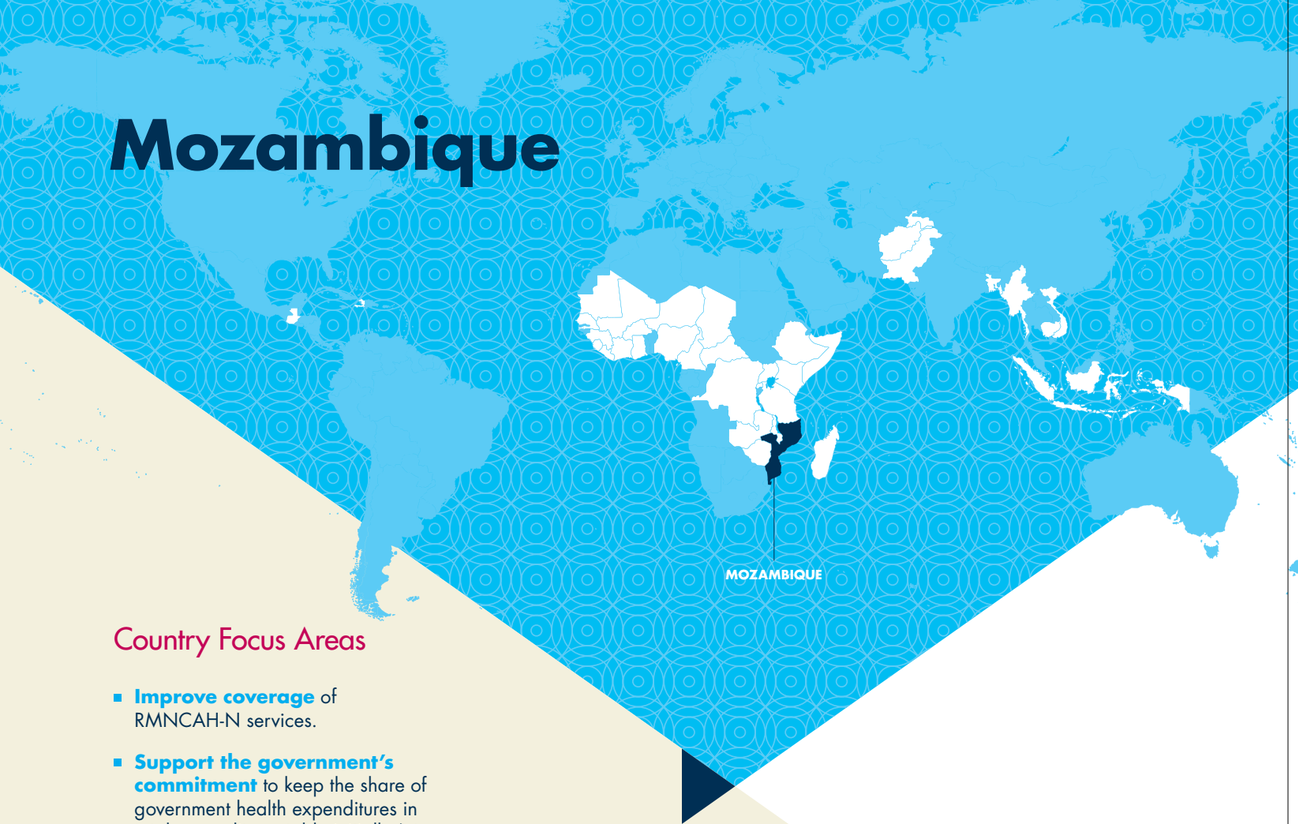
Mozambique



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 7.9 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 and the release of statistical reports.
- **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: **5.9%**

Health Financing Core Indicators

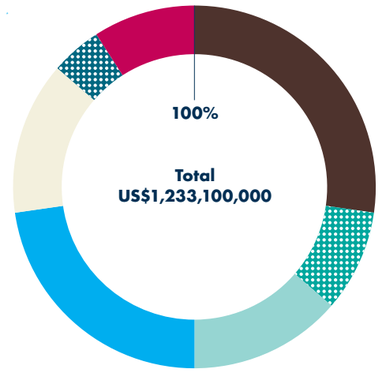
Health expenditure per capita financed from domestic sources: **US$10.25**

Ratio of government health expenditure to total government expenditures: **8.35%**

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

Incidence of catastrophic and impoverishing health expenditures:
1.61% catastrophic
0.55% impoverishing

Resource Mapping



Resource mapping was conducted as part of the development of the Investment Case. Mozambique has committed to developing a fully funded investment case with prioritized investments to ensure no financing gap. These budgets are indicative commitments for 2019 and beyond. All contributions in the chart are channeled through government systems. In addition, there are development partners that are financing the IC through parallel financing (e.g. DFID's first contribution to the Investment Case was channeled through UN agencies). There are two multi-donor trust funds. One with financing from DFID, Netherlands, Canada, USAID (through a single-donor trust fund managed by the World Bank), the World Bank, and GFF. The second one, PROSAUDE, is the health sector common fund that provides budget support to the Ministry of Health. Several partners, including the Global Fund, Gavi and the Government of Sweden, contribute to the IC but channel their funding through other mechanisms.

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Myanmar

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:
25 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: **6.9%**

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%

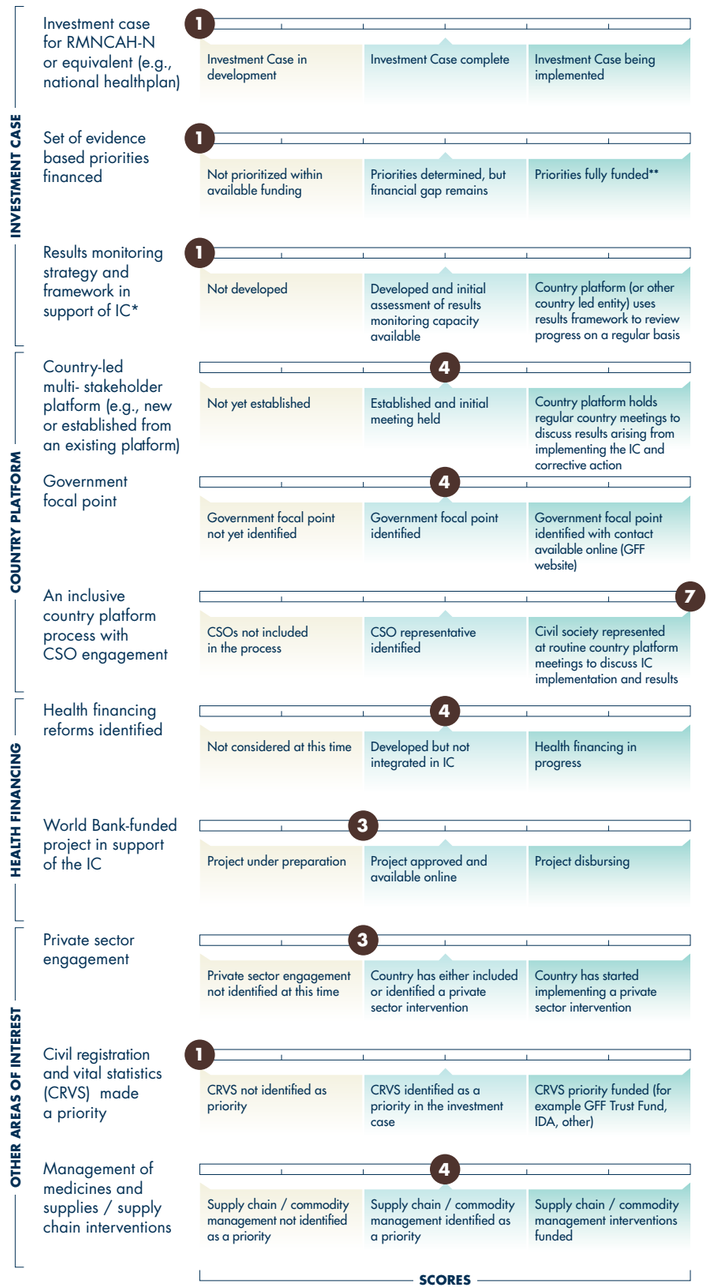
Percent of current health expenditures on primary/outpatient health care:
Not available

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.

Monitoring the Country-Led Process



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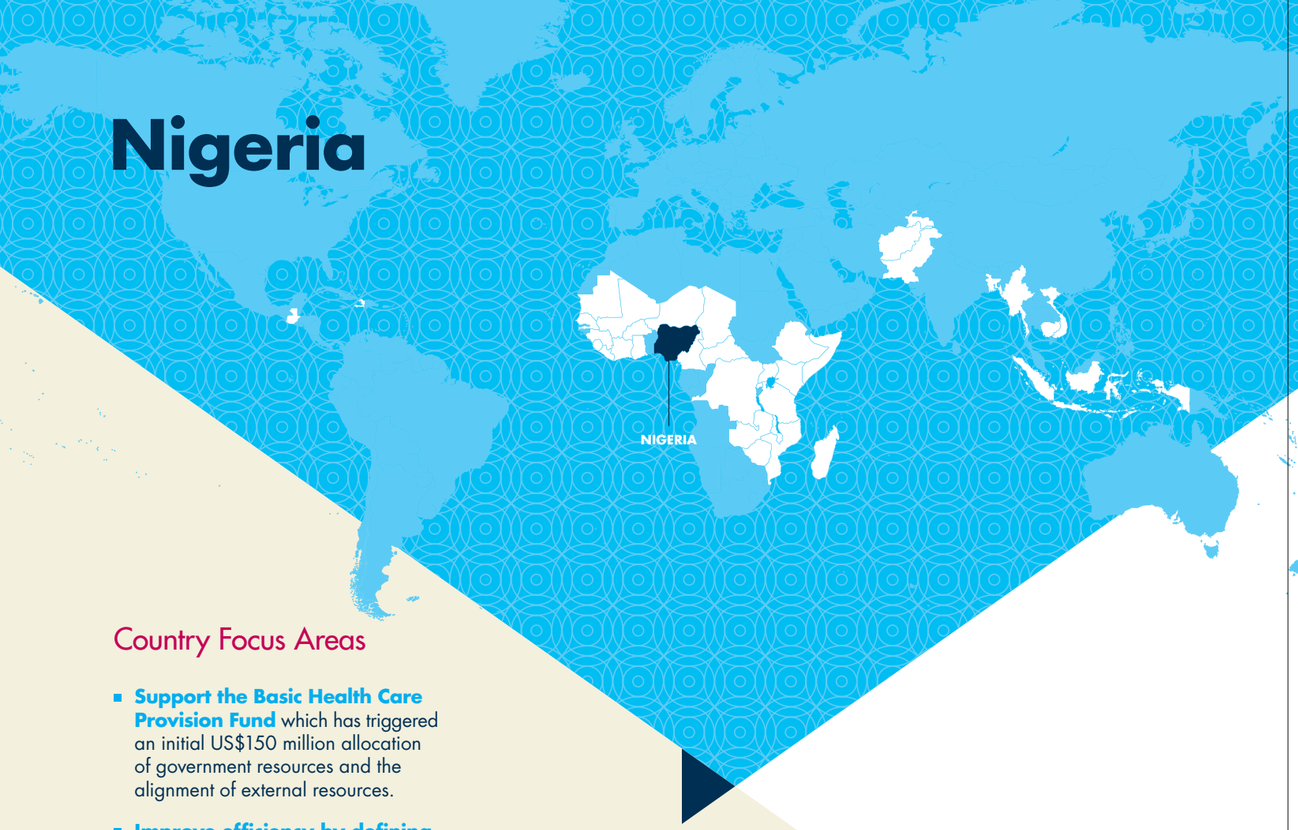
Nigeria



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

Percent of births <24 months after the preceding birth: **32.7%**

Stunting among children under 5 years of age: **44%**

Moderate to severe wasting among children under 5 years of age: **11%**

Health Financing Core Indicators

Health expenditure per capita financed from domestic sources: **US$10.33**

Ratio of government health expenditure to total government expenditures: **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.

Monitoring the Country-Led Process

INVESTMENT CASE	Investment case for RMNCAH-N or equivalent (e.g., national healthplan)	7	Investment Case in development	Investment Case complete	Investment Case being implemented
	Set of evidence based priorities financed	5	Not prioritized within available funding	Priorities determined, but financial gap remains	Priorities fully funded**
	Results monitoring strategy and framework in support of IC*	4	Not developed	Developed and initial assessment of results monitoring capacity available	Country platform (or other country led entity) uses results framework to review progress on a regular basis
COUNTRY PLATFORM	Country-led multi- stakeholder platform (e.g., new or established from an existing platform)	5	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	7	Government focal point not yet identified	Government focal point identified	Government focal point identified with contact available online (GFF website)
	An inclusive country platform process with CSO engagement	7	CSOs not included in the process	CSO representative identified	Civil society represented at routine country platform meetings to discuss IC implementation and results
HEALTH FINANCING	Health financing reforms identified	7	Not considered at this time	Developed but not integrated in IC	Health financing in progress
	World Bank-funded project in support of the IC	7	Project under preparation	Project approved and available online	Project disbursing
OTHER AREAS OF INTEREST	Private sector engagement	7	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	4	CRVS not identified as 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	1	Supply chain / commodity management not identified as a priority	Supply chain / commodity management identified as a priority	Supply chain / commodity management interventions funded
		SCORES			

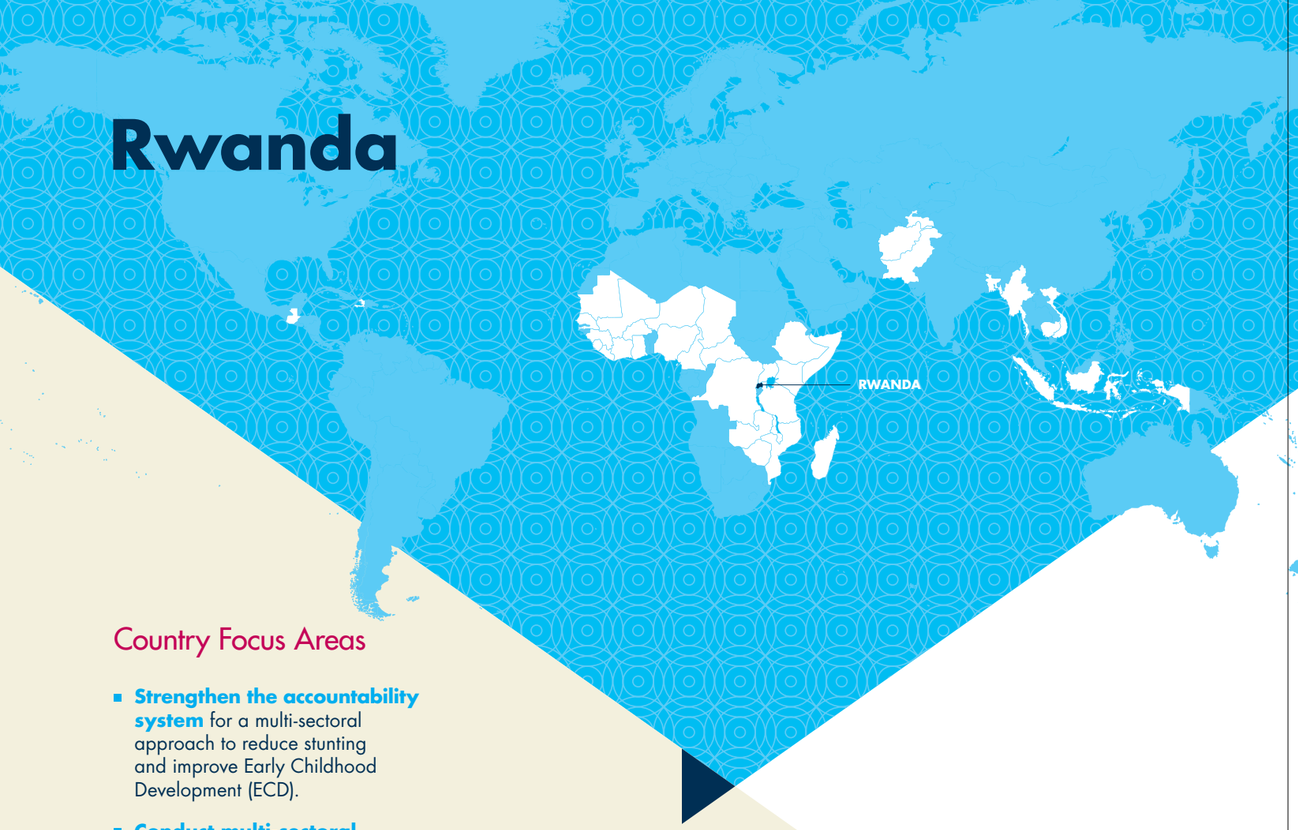
* Both included in the IC document or a separate document

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

*** 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.

Rwanda



Country Focus Areas

- **Strengthen the accountability system** for a multi-sectoral approach to reduce stunting and improve Early Childhood Development (ECD).
- **Conduct multi-sectoral nutrition expenditure analysis** to inform allocative efficiency and enhance tracking.
- **Strengthen the functionality of the civil registration system** for birth registration, certification, and train and sensitize government officials on civil registration and vital statistics.
- **Improving awareness and understanding of stunting** through BCC campaigns, use of child-length mat, and intensive work by CHWs.
- **Demand side incentives for the poorer households** to enhance intake of health and nutrition services during the first 1000 days through Nutrition Sensitive Direct Support—a Co-Responsibility Cash Transfer Program.

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:
45 per 1,000 women

Percent 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

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.

Monitoring the Country-Led Process

INVESTMENT CASE	Investment case for RMNCAH-N or equivalent (e.g., national healthplan)	5	Investment Case in development	Investment Case complete / Investment Case being implemented
	Set of evidence based priorities financed	4	Not prioritized within available funding	Priorities determined, but financial gap remains / Priorities fully funded**
	Results monitoring strategy and framework in support of IC*	4	Not developed	Developed and initial assessment of results monitoring capacity available / Country platform (or other country led entity) uses results framework to review progress on a regular basis
COUNTRY PLATFORM	Country-led multi- stakeholder platform (e.g., new or established from an existing platform)	5	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	7	Government focal point not yet identified	Government focal point identified / Government focal point identified with contact available online (GFF website)
	An inclusive country platform process with CSO engagement	5	CSOs not included in the process	CSO representative identified / Civil society represented at routine country platform meetings to discuss IC implementation and results
HEALTH FINANCING	Health financing reforms identified	5	Not considered at this time	Developed but not integrated in IC / Health financing in progress
	World Bank-funded project in support of the IC	7	Project under preparation	Project approved and available online / Project disbursing
OTHER AREAS OF INTEREST	Private sector engagement	5	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	7	CRVS not identified as 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	5	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

*** 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.

Senegal

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: **8.9%**

Health Financing Core Indicators

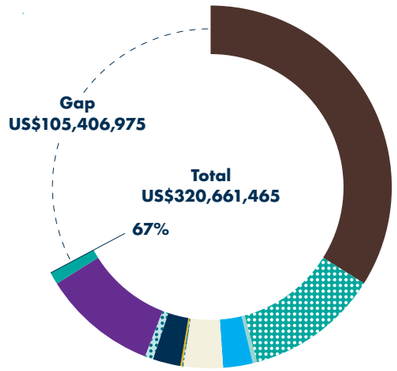
Health expenditure per capita financed from domestic sources: **US$17.86**

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

Resource Mapping



Source: Sénégal, cartographie des ressources des partenaires 2018

In early 2018, Senegal's investment case had a nearly 70% financing gap. After further prioritization and better alignment of partners around the IC, Senegal was able to reduce its financing gap to 32% by the end of 2018.

Monitoring the Country-Led Process

INVESTMENT CASE	Investment case for RMNCAH-N or equivalent (e.g., national healthplan)	6	Investment Case in development	Investment Case complete / Investment Case being implemented
	Set of evidence based priorities financed	4	Not prioritized within available funding	Priorities determined, but financial gap remains / Priorities fully funded**
	Results monitoring strategy and framework in support of IC*	4	Not developed	Developed and initial assessment of results monitoring capacity available / Country platform (or other country led entity) uses results framework to review progress on a regular basis
COUNTRY PLATFORM	Country-led multi- stakeholder platform (e.g., new or established from an existing platform)	7	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	7	Government focal point not yet identified	Government focal point identified / Government focal point identified with contact available online (GFF website)
	An inclusive country platform process with CSO engagement	7	CSOs not included in the process	CSO representative identified / Civil society represented at routine country platform meetings to discuss IC implementation and results
HEALTH FINANCING	Health financing reforms identified	7	Not considered at this time	Developed but not integrated in IC / Health financing in progress
	World Bank-funded project in support of the IC	2	Project under preparation	Project approved and available online / Project disbursing
OTHER AREAS OF INTEREST	Private sector engagement	7	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	7	CRVS not identified as 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	6	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

*** 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.

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%**

Health Financing Core Indicators

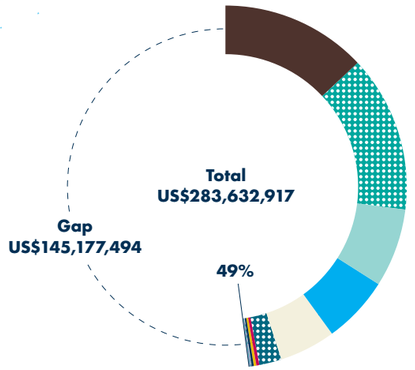
Health expenditure per capita financed from domestic sources: **US$9.64**

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

Resource Mapping



- GOVERNMENT
- WORLD BANK
- GAVI
- DFID
- GFATM
- UNFPA
- UNICEF
- USAID/PEPFAR
- PRIVATE DONOR
- MPTF
- IRISH AID
- ERMTF
- BMGF
- WHO AFRO
- WAHO
- ADB
- GOVERNMENT OF ITALY
- GAP

The resource mapping for Sierra Leone is presented for FY2019 to 2021. There are more than 15 partners aligned to and invested in financing the IC. The Government of Sierra Leone has committed to achieving UHC as a key member of the UHC2030 agenda. Despite a significant gap in financing for the IC (51%), financing for health is expected to increase in coming years. So far, there is no GFF Trust Fund financing to Sierra Leone, as there has not been a recent opportunity for co-financing an IDA loan. There will be a new project financed in FY 2020 and GFF Trust Fund plans to co-finance at this time.

Monitoring the Country-Led Process

INVESTMENT CASE	Investment case for RMNCAH-N or equivalent (e.g., national healthplan)	4	Investment Case in development	Investment Case complete / Investment Case being implemented
	Set of evidence based priorities financed	3	Not prioritized within available funding	Priorities determined, but financial gap remains / Priorities fully funded**
	Results monitoring strategy and framework in support of IC*	2	Not developed	Developed and initial assessment of results monitoring capacity available / Country platform (or other country led entity) uses results framework to review progress on a regular basis
COUNTRY PLATFORM	Country-led multi- stakeholder platform (e.g., new or established from an existing platform)	3	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	7	Government focal point not yet identified	Government focal point identified / Government focal point identified with contact available online (GFF website)
	An inclusive country platform process with CSO engagement	4	CSOs not included in the process	CSO representative identified / Civil society represented at routine country platform meetings to discuss IC implementation and results
HEALTH FINANCING	Health financing reforms identified	3	Not considered at this time	Developed but not integrated in IC / Health financing in progress
	World Bank-funded project in support of the IC	1	Project under preparation	Project approved and available online / Project disbursing
OTHER AREAS OF INTEREST	Private sector engagement	2	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	4	CRVS not identified as 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	3	Supply chain / commodity management not identified as a priority	Supply chain / commodity management identified as a priority / Supply chain / commodity management interventions funded
		SCORES		

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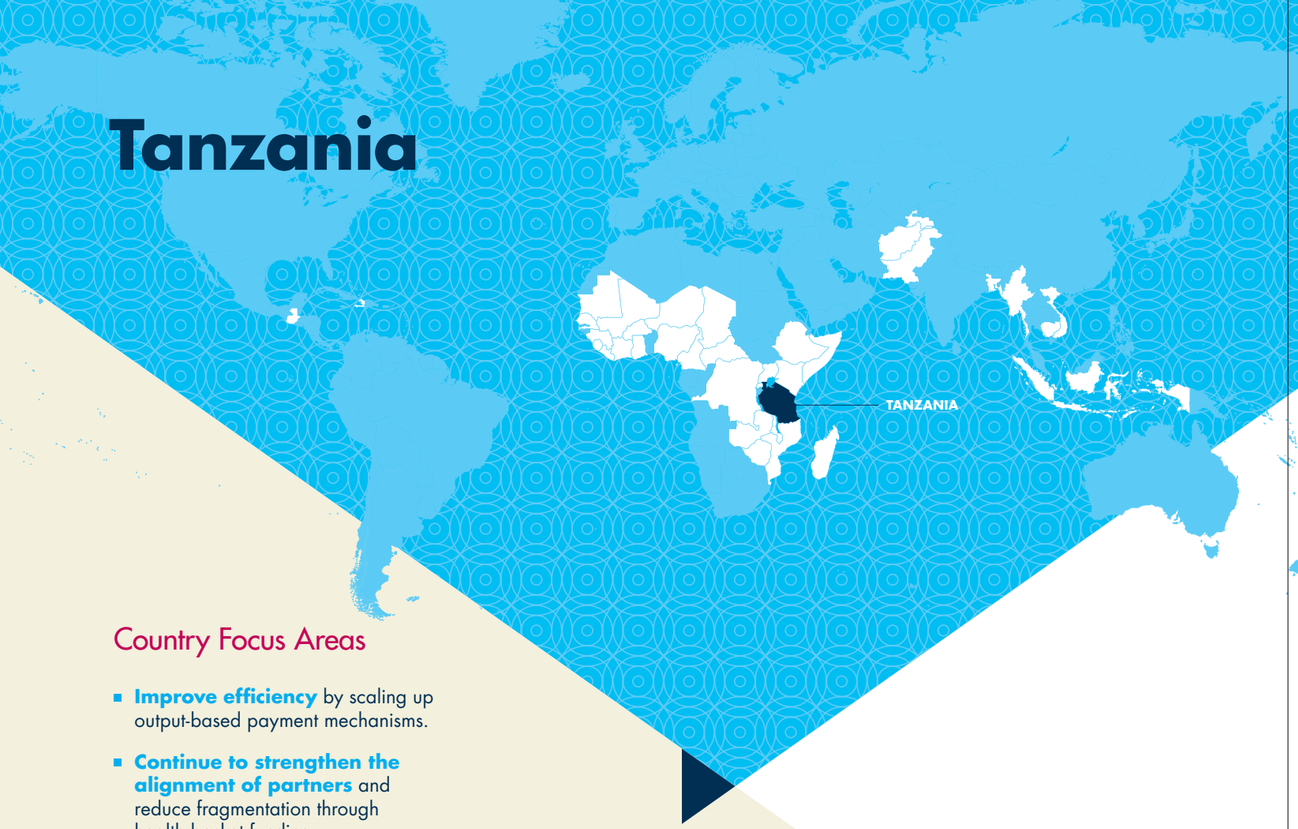
** Meaning that funding was allocated, disbursed and released – payment done
*** ANC4 = four antenatal care visits
ART = antiretroviral therapy; ARV = antiretroviral; DTP3 = vaccination for Diphtheria, Tetanus, and Pertussis; ORS = oral rehydration solution; PMTCT = prevention of mother-to-child transmission;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

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:
25 per 1,000 live births

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

Adolescent birth rate:
132 per 1,000 women

Percent of births <24 months after the preceding birth: **18.8%**

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

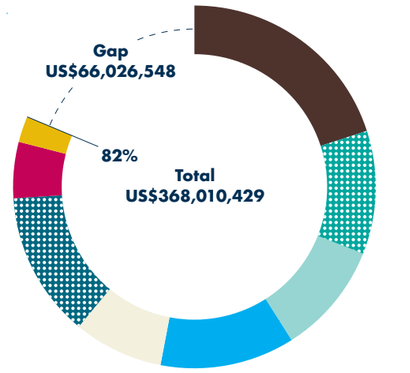
Health expenditure per capita financed from domestic sources: **US$14.42**

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

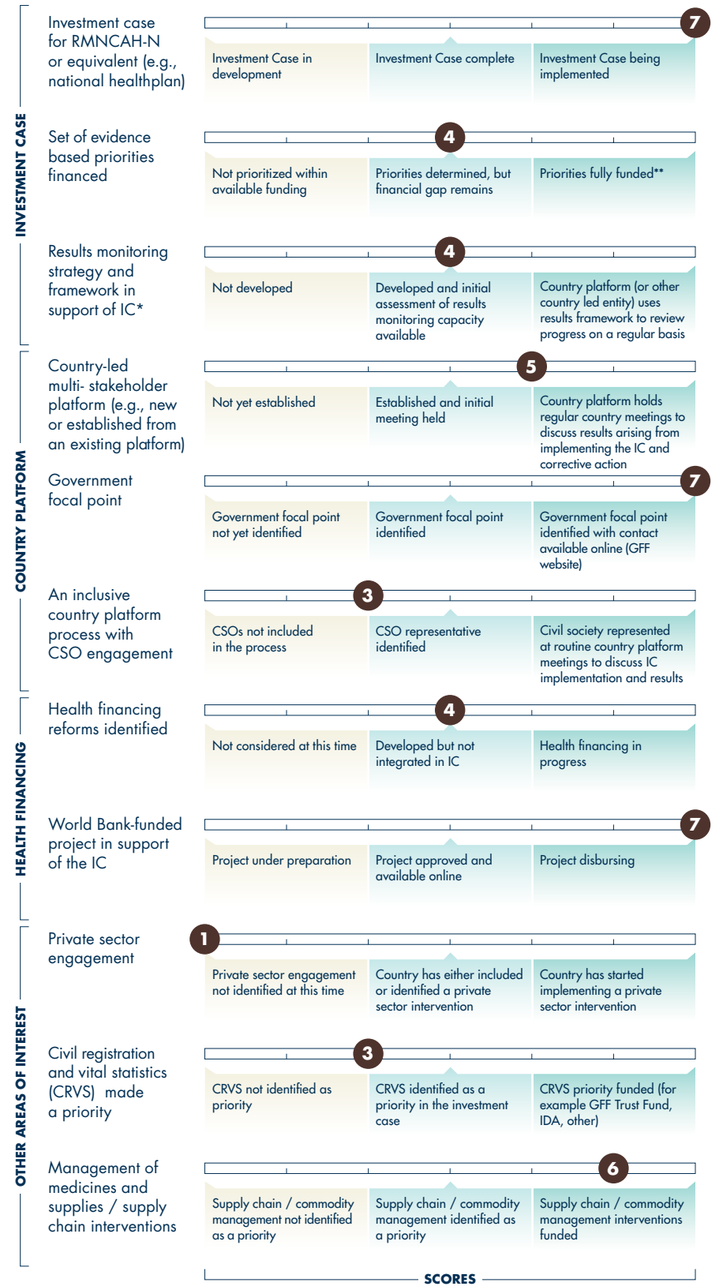
Resource Mapping



- GOVERNMENT
- WB/GFF/ USAID/PON
- BASKET FUND (EXCLUDING WB)
- USAID
- PEPFAR (INCLUDING USAID-PEPFAR)
- GAVI
- GFATM
- UNFPA
- GAP

Tanzania is embarking on its mid-term review of its One Plan II investment case. As part of this review, they are conducting an updated annual resource mapping. Based on initial estimates, compared to the previous year estimates, the gap has increased from 5% to 18%, with GFATM funds reduced. The governments of Canada, Denmark, Ireland, and Switzerland; KOICA; UNICEF; and the World Bank and the GFF flow funds through Tanzania's "Health Basket Fund," which links payment to results. Although World Bank funds flow through the Basket Fund, this data has been shown separately for the purpose of this resource mapping pie.

Monitoring the Country-Led Process



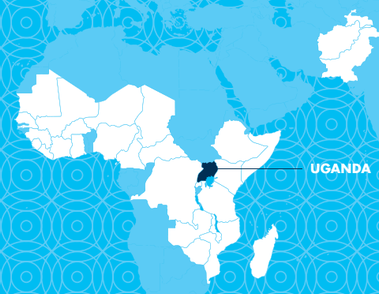
* Both included in the IC document or a separate document

** 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.

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 ratio:
27 per 1,000 live births

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

Adolescent birth rate:
132 per 1,000 women

Percent of births <24 months after the preceding birth: **24.3%**

Stunting among children under 5 years of age: **28.9%**

Moderate to severe wasting among children under 5 years of age: **3.4%**

Health Financing Core Indicators

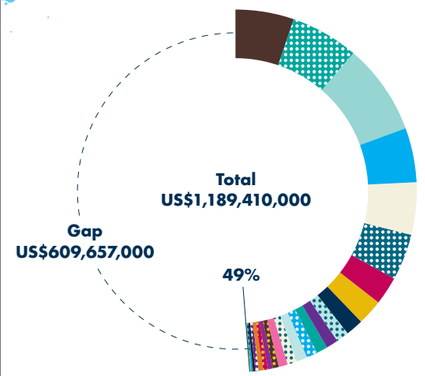
Health expenditure per capita financed from domestic sources: **US$6.23**

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:
15.27% catastrophic
3.18% impoverishing

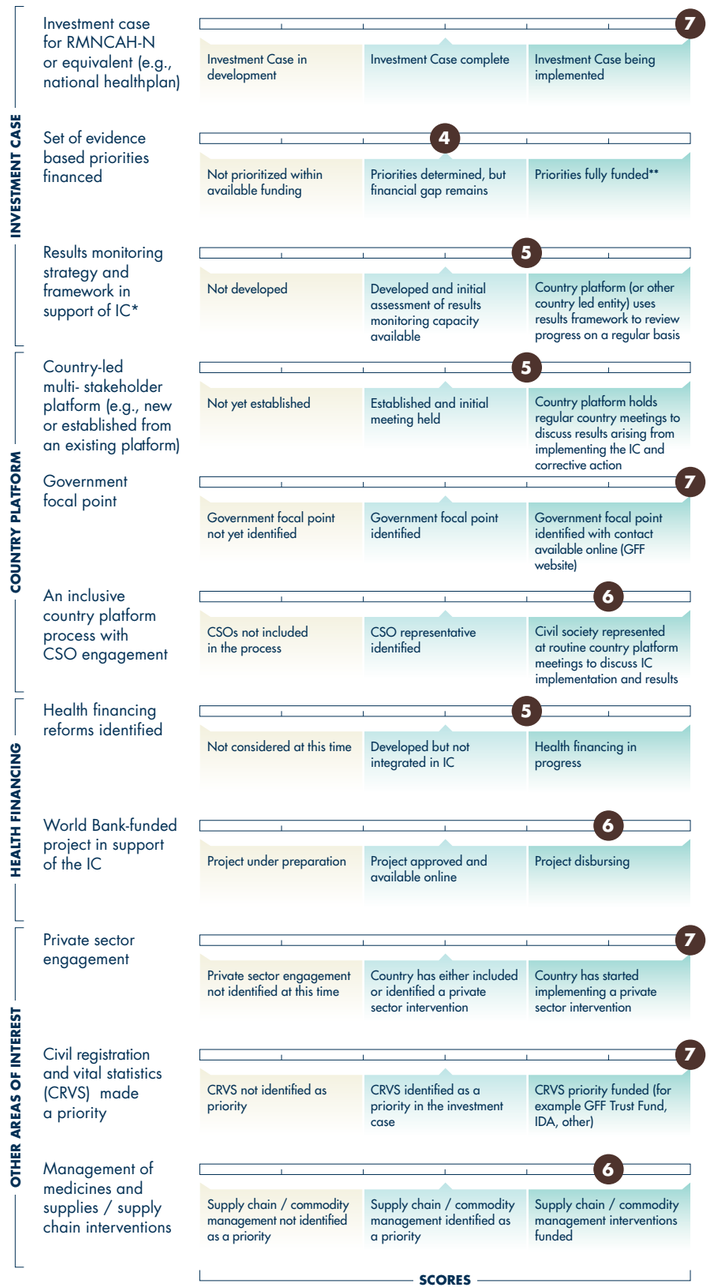
Resource Mapping



- GOVERNMENT
- WORLD BANK
- UNFPA
- UNICEF
- DFID
- USAID
- GAVI
- WORLD VISION UGANDA
- GFATM
- SIDA
- SAVE THE CHILDREN UGANDA
- AECID
- MARIE STOPES UGANDA
- MALARIA CONSORTIUM
- KOICA
- AMREF
- BTC/ENABLE
- LIVING GOODS
- ISLAMIC DEV BANK
- CHAI
- JICA
- PSI
- JHPEIGO
- UPMB
- WHO
- GAP

Uganda's resource map covers FY 2018 to 2021, including more than 26 aligned donors to the IC. However, a 51% gap in financing the 5-year IC remains. Uganda's government budget accounts for approximately 10% of the overall available financing for the IC.

Monitoring the Country-Led Process



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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.

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 Statics (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 ratio:
11.5 per 1,000 live births

Under-five mortality ratio:
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: **8.95%**

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

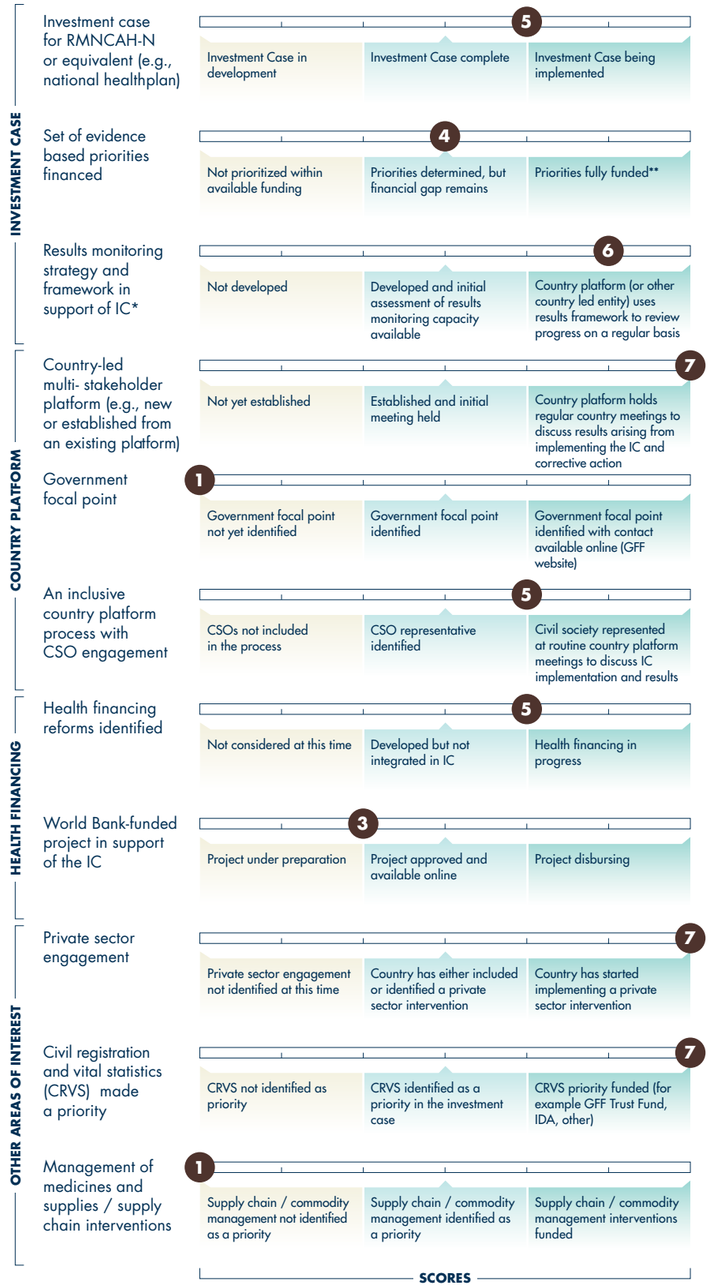
Incidence of catastrophic and impoverishing health expenditures:
9.81% catastrophic
0.2% impoverishing

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$5 million from the Integrating Donor-Financed Health Programs Multi-Donor Trust Fund funded with Australian support, a co-financing grant of US$3 million from the Tackling Non-Communicable Diseases Challenges in Low- and Middle-income Countries MDTF (Pharmaceutical Governance Fund), and US$21.25 million from the Government of Vietnam in addition to the U$17 million GFF financing for the IDA-TS credit buydown. A recent fiscal space assessment for Vietnam analyzed trends in health spending and identified possible sources for future resources for health for the country.[1]

1 http://documents.worldbank.org/curated/en/222831563548465796/pdf/The-Future-of-Health-Financing-in-Vietnam-Ensuring-Sufficiency-Efficiency-and-Sustainability.pdf

Monitoring the Country-Led Process



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

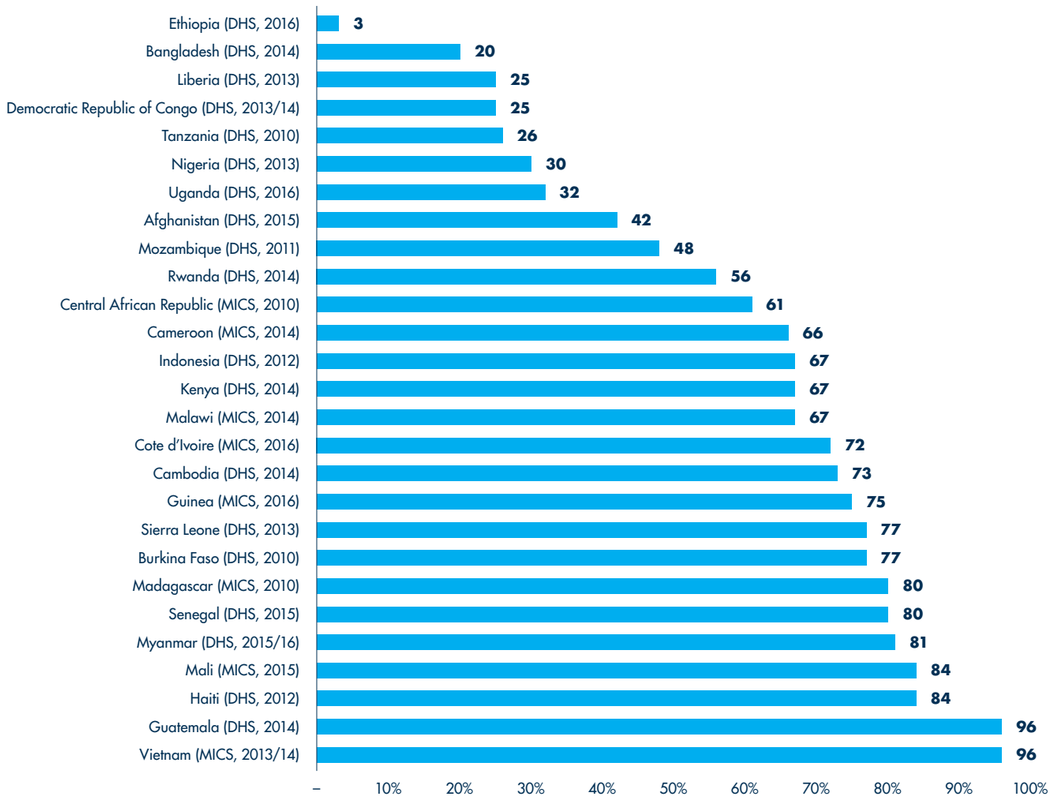
*** ANC4 = four antenatal care visits

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.

Strengthening Civil Registration and Vital Statistics to Protect Women, Children, and Adolescents

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



Source: Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS) conducted between 2000 and 2016.

Well-functioning CRVS systems register all births and deaths, record all CODs, issue birth and death certificates, and produce vital statistics. The GFF makes a strong case for establishing the strengthening of CRVS systems as a priority in investment cases. It provides financing from the GFF Trust Fund, which is matched by funds from the International Development Association (IDA), to selected countries. Fifteen GFF-supported countries currently include CRVS in their investment cases, and 12 countries have been allocated financing specifically for strengthening CRVS systems, mostly through World Bank projects/programs in health but also through projects/programs in social protection; discussions are underway to support CRVS through governance projects as well.

Some countries have made progress in the past year in strengthening their CRVS systems. **Uganda** received funding from the GFF Trust Fund and IDA in 2016 to strengthen its institutional capacity to deliver birth and death registration (BDR) services and to scale up BDR services in health facilities and communities. All district registration officers have been trained in BDR processes, outreach birth registrations have been undertaken, and a national CRVS task force composed of representatives from the government and development partners has been established and meets regularly. Business processes for BDR have been revised; changes have been made to the mobile vital registration system to enable registration of births that have been notified from hospitals and subcounties; and the National Identification and Registration Agency (NIRA), the Ministry of Health, and local governments are collaborating closely to register births and deaths. The Ministry of Health has instructed all health facilities to support BDR services through notification of births to the Civil Registry Office. About 75 trainers (including medical practitioners, data managers, and civil registration and statistics officials) were trained in COD certification; coding, using the start-up mortality list and the 11th revision of the International Classification of Diseases (ICD-11); and verbal autopsy. Two mobile registration trucks have been procured to pilot the provision of BDR services in hard-to-reach areas, and a consultancy to develop a CRVS communications strategy has been commissioned. Procurement processes are underway to develop an electronic integrated civil registration with an ID management system and a CRVS strategic plan. BDR services are now offered in 14 districts; and more than 600,000 children have been registered with the civil registration authority (NIRA) since February 2019. Other partners supporting CRVS system strengthening in Uganda include UNICEF, Plan International, the World Health Organization (WHO), and the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Liberia received funding from the GFF Trust Fund in 2017 to support the improvement of BDR services and the expansion of the BDR system coverage. To strengthen civil registration at the hospital level, it will include CRVS indicators in hospital performance-based financing, starting with birth registration completeness in July 2019 and death registration completeness in 2020. To expand BDR coverage, birth registration services have been expanded to 14 hospitals in five counties. All were provided with computers, laptops, printers, registration tools, and office supplies to facilitate registration and the issuance of certificates. Birth registration campaigns and services have been undertaken during immunization and community maternal and child health outreach services. Uniform birth registration forms and certificates and a single web-based birth registration platform have been adopted throughout the country. All forms associated with death registration, COD recording, and burial permits are being revised. Capacity-building activities in birth registration and immunization awareness have been conducted for medical practitioners in COD certification, registrars in BDR services, and community health workers and vaccinators. Between January and May 2019, 41,876 children were registered, 10 percent of them at the newly established registration centers within two months of operation. Strengthening the CRVS system in Liberia is being undertaken in collaboration with various partners, including UNICEF, the WHO, and Gavi.

Vietnam received a grant from the GFF Trust Fund in 2017 to support advisory services and analytics for improving death registration and recording the COD. Technical assistance was provided to the Ministry of Health to facilitate implementation of the National Action Program on CRVS for 2017–24. The implementation plan developed and approved by the Ministry of Health in 2018 (Decision 6378/QD-BYT) provides a clear roadmap, with specific activities for the Ministry of Health to achieve the actions it committed to and milestones to improve the CRVS system in Vietnam. Subsequently, in collaboration with the WHO and the Global Fund, capacity building was provided through expert training of certifiers and coders in death notification and COD certification, use of the verbal autopsy standard tool, and familiarization with ICD11. A multicountry workshop, including participants from Vietnam, Cambodia, Indonesia, the Lao People's Democratic Republic, Liberia, Mongolia, the Solomon Islands, and Sri Lanka, was held in Hanoi in 2018. Technical assistance also supported efforts by the Ministry of Health to carry out a review of the issuance and use of the death notification system in health facilities that yielded a national COD list for deaths occurring in communities, which the ministry plans to integrate into the health information system. A detailed guideline and training manual on how to apply the COD list and coding at the community level was also developed. Support was also provided for a study tour to Bangladesh for Vietnamese officials from the Ministry of Health, the Ministry of Justice, and the General Statistics Office to learn more about the Ministry of Health's responsibilities in CRVS. The study tour also focused on COD recording at health facilities and in communities and data quality management. The activities in Vietnam were undertaken in collaboration with the WHO, UNICEF, the United Nations Population Fund (UNFPA), Vital Strategies, and Melbourne University.

GFF Financials

As of June 30, 2019, contributions to the GFF Trust Fund total US$992.8 million equivalent, of which $629 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 GFF-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.

Figure 1

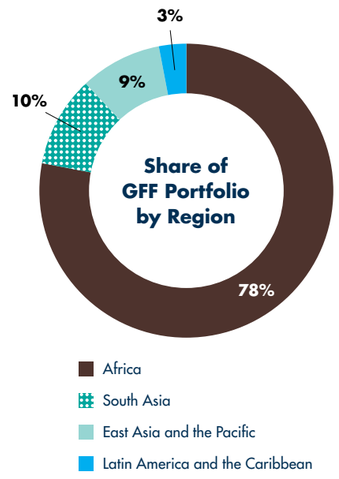


Table 1 **List of Board Approved Projects as of June 30, 2019**

Project	GFF amount	IDA amount	IBRD
Tanzania	$40	$200	
DRC (AF-CRVS)	$10	$30	
Cameroon	$27	$100	
Nigeria (AF)	$20	$125	
Kenya	$40	$150	
Uganda	$30	$110	
Liberia (AF)	$16	$50	
Guatemala	$9		$100
DRC (AF)	$40	$320	
Ethiopia	$60	$150	
Bangladesh	$15	$500	
Bangladesh (Education)	$10	$510	
Mozambique	$25	$80	
Rwanda (Health)	$10	$25	
Afghanistan	$35	$140	
Rwanda (AF-Social Protection)	$8	$80	
Guinea	$10	$45	
Indonesia	$20		$400
Nigeria (Nutrition)	$7	$225	
Burkina Faso	$20	$80	
Nigeria (Part 2)	$20	$0	
CAR	$10	$43	
Malawi	$10	$50	
Mali	$10	$50	
Cote d'Ivoire	$20	$200	
Cambodia	$10	$15	
Haiti	$15	$55	
DRC (Nutrition)	$10	$492	
Vietnam	$17	$80	

Investors Group Members

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

ABT Associates (representing the private sector constituency)

Bill & Melinda Gates Foundation

Education as a Vaccine (representing youth for the civil society constituency)

Gavi, the Vaccine Alliance

Global Fund to Fight AIDS, Tuberculosis, and Malaria

Government of Canada

Government of Ethiopia

Government of Denmark

Government of Japan

Japan International Cooperation Agency

Government of Kenya

Government of the Kingdom of the Netherlands

Government of Liberia

MSD for Mothers (representing the private sector constituency)

Government of Norway

PAI (representing the civil society constituency)

PATH (representing the civil society constituency)

Partnership for Maternal, Newborn, and Child Health

Philips (representing the private sector constituency)

Réseau Africain pour le Développement Durable (RA2D) (representing the civil society constituency)

The Susan Thompson Buffett Foundation

Government of Senegal

Government of United Kingdom

Government of United States

Office of the UN Secretary-General

UNFPA

UNICEF

World Bank Group

World Health Organization

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 Dévelopement (France)

BMZ Federal Ministry of Economic Cooperation and Development (Germany)

ANC antenatal care

ANC4 four antenatal care visits

BEmONC Basic Emergency Obstetric and Newborn Care

BHCPF Basic Health Care Provision Fund

CEmONC Comprehensive Emergency Obstetric and Newborn Care

CSO civil society organization

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

IBRD International Bank for Reconstruction and Development

KFW German Development Bank (government-owned)

IDA International Development Association

IPT2 intermittent preventative treatment (for malaria)

JICA Japan International Cooperation Agency

MICS Multiple Indicator Cluster Survey

PBF performance-based financing

PMNCH Partnership for Maternal, Newborn, and Child Health

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

SDG Sustainable Development Goal

SIDA Swedish International Development Cooperation Agency

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 Vledder, Program Manager. The GFF Secretariat would like to thank the contributors, who gave their time, expertise and energy, in particular, Anna Astvatsatryan, Julie Ruel Bergeron, Kimberly Boer, Maria Eugenia Bonilla-Chacin, Marion Cros, Karin Lane Gichuhi, Josine Karangwa, Toni Lee Kuguru, Luc Laviolette, Brendan Hayes, Vineetha Menon, Segen Teklu Moges, Christina Nelson, Augustina Nikolova, Carolyn Reynolds, Genesis Samonte, Robert Walter Scherpbier, Mirja Channa Sjoblom, Aissa Socorro, Meg Sommerfeld, Maletela Tuoane-Nkhasi, Ellen Van De Poel and Petra Vergeer.

APPENDIX A

Indicators Description

Category	INDICATOR	DESCRIPTION
RMNCAH-N CORE INDICATORS	Maternal Mortality Ratio	Number of female deaths from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, expressed per 100 000 live births, for a specified time period
	Under 5 Mortality Ratio	Probability of a child born in a specific year or period dying before reaching the age of 5 years, expressed per 1000 live births
	Neonatal Mortality Ratio	Probability of a child born in a specific year or period dying in the first month of life, expressed per 1000 live births
	Adolescent Birth Rate* (15-19)	Number of births to females aged 15–19 years per 1000 females in the three years preceding the survey
	Percent of births <24 months after the preceding birth*	Percentage of non-first births in the five years preceding the survey whose previous birth interval is 7-23 months. This excludes the first birth.
	Prevalence of stunting among children under 5 years of age	Percentage of children under five years of age who are below -2 SD of height for age according to the WHO standard
	Moderate to severe wasting among children 5 years of age (Total)	Percentage of children aged under five years of age with weight-for-height < -2 SD of the WHO Children Growth Standards median
HEALTH FINANCING CORE INDICATORS	Health expenditure per capita financed from domestic sources	Government health expenditures per inhabitant (numerator: Total government expenditures for health; denominator: Total population)
	Ratio of domestic government health expenditure to total government expenditures	Share of domestic government health spending to total government expenditures (numerator: Total domestic government expenditures for health; denominator: Total government expenditures from domestic sources)
	Percent of current health expenditures on primary/ outpatient health care	Percentage of current health expenditures spent on primary/outpatient health care (numerator: Total current health expenditures spent on primary/outpatient health care; denominator: Total current health expenditures)
	Incidence of catastrophic health expenditures	Proportion of households with out of pocket health expenditures that exceed 40% of total household expenditures (numerator: Number of households with out of pocket health expenditures ≥40% to total household's expenditures; denominator: Total number of households)
	Incidence of impoverishing health expenditures	Proportion of households with out of pocket health expenditure that caused the households to drop below the poverty line (numerator: Total number of households with impoverishing health expenditure; denominator: Total number of households)

*The definition for these indicators might vary slightly depending on the source of the data and/or the country

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APPENDIX B

Data Sources

INDICATOR / SOURCE (YEAR)	AFGHANISTAN	BANGLADESH	BURKINA FASO	CAMBODIA	CAMEROON	CENTRAL AFRICAN REPUBLIC	COTE D'IVOIRE	DRC	ETHIOPIA	GUATEMALA	GUINEA	HAITI	INDONESIA	KENYA	LIBERIA	MADAGASCAR
RMNCAH-N CORE INDICATORS																
Maternal Mortality Ratio	not available	Sample Vital Registration System (SVRS) 2018	EMDS 2015	DHS 2014	WDI 2015	WDI 2015	DHS 2011/12	DHS 2014	DHS 2016	ENSMI 2014/15	MICS 2016	DHS 2016/17	SUPAS 2015 (Intercensal Population Survey)	DHS 2014	DHS 2013	DHS 2008/09
Under 5 Mortality Ratio	UN/IGME 2018 report	Sample Vital Registration System (SVRS) 2018	EMDS 2015	DHS 2014	DHS 2018	WDI 2017	MICS 2016	DHS 2014	DHS 2019	ENSMI 2014/15	DHS 2018	DHS 2016/17	DHS 2017	DHS 2014	DHS 2013	DHS 2008/09
Neonatal Mortality Ratio	UN/IGME 2018 report	Sample Vital Registration System (SVRS) 2018	EMDS 2015	DHS 2014	DHS 2018	WDI 2017	MICS 2016	DHS 2014	DHS 2019	ENSMI 2014/15	DHS 2018	DHS 2016/17	DHS 2017	DHS 2014	DHS 2013	DHS 2008/09
Adolescent Birth Rate (15-19)	AHS 2018	Sample Vital Registration System (SVRS) 2018	MIS 2014	DHS 2014	DHS 2018	WDI 2016	MICS 2016	DHS 2014	DHS 2016	ENSMI 2014/15	DHS 2018	DHS 2016/17	DHS 2017	DHS 2014	DHS 2013	MIS 2016
Percent of births <24 months after the preceding birth	DHS 2015	DHS 2014	MIS 2014	DHS 2014	DHS 2011	not available	DHS 2011/12	DHS 2014	DHS 2016	ENSMI 2014/15	DHS 2018	DHS 2016/17	DHS 2017	DHS 2014	DHS 2013	MIS 2016
Stunting among children under 5 years of age	AHS 2018	DHS 2014	ENUT 2018	DHS 2014	DHS 2018	UNICEF Malnutrition 2012	MICS 2016	DHS 2014	DHS 2019	ENSMI 2014/15	DHS 2018	DHS 2016/17	RISKESDAS 2018 (Basic Health Survey)	DHS 2014	DHS 2013	UNICEF Malnutrition 2012-13
Moderate to severe wasting among children under 5 years of age	AHS 2018	DHS 2014	ENUT 2018	DHS 2014	DHS 2018	UNICEF Malnutrition 2012	MICS 2016	DHS 2014	DHS 2019	ENSMI 2014/15	DHS 2018	DHS 2016/17	RISKESDAS 2018 (Basic Health Survey)	DHS 2014	DHS 2013	UNICEF Malnutrition 2012-13
HEALTH FINANCING CORE INDICATORS																
Health expenditure per capita financed from domestic sources	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016	NHA VII (2016/17)	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016
Ratio of government health expenditure to total government expenditure	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016	NHA VII (2016/17)	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016
Percent of current health expenditures on primary/outpatient health care	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016
Incidence of Catastrophic and impoverishing health expenditures	The 2018 Health Equity and Financial Protection Indicators Database	The 2018 Health Equity and Financial Protection Indicators Database	The 2018 Health Equity and Financial Protection Indicators Database	The 2018 Health Equity and Financial Protection Indicators Database	The 2018 Health Equity and Financial Protection Indicators Database	The 2018 Health Equity and Financial Protection Indicators Database	The 2018 Health Equity and Financial Protection Indicators Database	The 2018 Health Equity and Financial Protection Indicators Database	The 2018 Health Equity and Financial Protection Indicators Database	The 2018 Health Equity and Financial Protection Indicators Database	The 2018 Health Equity and Financial Protection Indicators Database	The 2018 Health Equity and Financial Protection Indicators Database	The 2018 Health Equity and Financial Protection Indicators Database	The 2018 Health Equity and Financial Protection Indicators Database	The 2018 Health Equity and Financial Protection Indicators Database	The 2018 Health Equity and Financial Protection Indicators Database
OTHER																
Resource Mapping	n/a	Data on domestic financing from government budgets and expenditure reports. Data on external financing based on submissions by development partners	n/a	n/a	Data on domestic financing from government budgets and expenditure reports. Data on external financing based on submissions by development partners	Data on domestic financing from government budgets and expenditure reports. Data on external financing based on submissions by development partners	n/a	Data on domestic financing from government budgets and expenditure reports. Data on external financing based on submissions by development partners	Data on domestic financing from government budgets and expenditure reports. Data on external financing based on submissions by development partners	n/a	Data on domestic financing from government budgets and expenditure reports. Data on external financing based on submissions by development partners	n/a	n/a	n/a	Data on domestic financing from government budgets and expenditure reports. Data on external financing based on submissions by development partners	n/a

INDICATOR / SOURCE (YEAR)	MALAWI	MALI	MOZAMBIQUE	MYANMAR	NIGERIA	RWANDA	SENEGAL	SIERRA LEONE	TANZANIA	UGANDA	VIETNAM
RMNCAH-N CORE INDICATORS											
Maternal Mortality Ratio	DHS 2015/16	DHS 2018	DHS 2011	DHS 2015/16	DHS 2013	DHS 2014/15	DHS 2017	DHS 2013	TDHS-MIS 2015/16	DHS 2016	UN-MMEIG 2015
Under 5 Mortality Rate	DHS 2015/16	DHS 2018	DHS 2011	DHS 2015/16	MICS 2017	DHS 2014/15	DHS 2017	MICS 2017	TDHS-MIS 2015/16	DHS 2016	UNIGME 2016
Neonatal Mortality Rate	DHS 2015/16	DHS 2018	DHS 2011	DHS 2015/16	DHS 2013	DHS 2014/15	DHS 2017	MICS 2017	TDHS-MIS 2015/16	DHS 2016	UNIGME 2016
Adolescent Birth Rate (15-19)	DHS 2015/16	DHS 2018	AIS 2015	DHS 2015/16	MICS 2017	DHS 2014/15	DHS 2017	DHS 2013	TDHS-MIS 2015/16	DHS 2016	WDI 2016
Percent of births <24 months after the preceding birth	DHS 2015/16	MIS 2015	AIS 2015	DHS 2015/16	MIS 2015	DHS 2014/15	DHS 2017	MIS 2016	TDHS-MIS 2015/16	DHS 2016	MICS 2014
Stunting among children under 5 years of age	DHS 2015/16	DHS 2018	DHS 2011	DHS 2015/16	MICS 2017	DHS 2014/15	DHS 2017	National Nutrition Survey (UNICEF - MOH 2014)	TDHS-MIS 2015/16	DHS 2016	National Institute of Nutrition 2015
Moderate to severe wasting among children under 5 years of age	DHS 2015/16	DHS 2018	DHS 2011	DHS 2015/16	MICS 2017	DHS 2014/15	DHS 2017	National Nutrition Survey (UNICEF - MOH 2014)	DHS 2016	DHS 2016	National Institute of Nutrition 2015
HEALTH FINANCING CORE INDICATORS											
Health expenditure per capita financed from domestic sources	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016
Ratio of government health expenditure to total government expenditure	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016
Percent of current health expenditures on primary/outpatient health care	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016	WHO-GHED 2016
Incidence of Catastrophic and impoverishing health expenditures	The 2018 Health Equity and Financial Protection Indicators Database	The 2018 Health Equity and Financial Protection Indicators Database	The 2018 Health Equity and Financial Protection Indicators Database	The 2018 Health Equity and Financial Protection Indicators Database	The 2018 Health Equity and Financial Protection Indicators Database	The 2018 Health Equity and Financial Protection Indicators Database	The 2018 Health Equity and Financial Protection Indicators Database	The 2018 Health Equity and Financial Protection Indicators Database	The 2018 Health Equity and Financial Protection Indicators Database	The 2018 Health Equity and Financial Protection Indicators Database	The 2018 Health Equity and Financial Protection Indicators Database
OTHER											
Resource Mapping	n/a	n/a	Data on domestic financing from government budgets and expenditure reports. Data on external financing based on submissions by development partners	n/a	n/a	n/a	Data on domestic financing from government budgets and expenditure reports. Data on external financing based on submissions by development partners	Data on domestic financing from government budgets and expenditure reports. Data on external financing based on submissions by development partners	Data on domestic financing from government budgets and expenditure reports. Data on external financing based on submissions by development partners	Data on domestic financing from government budgets and expenditure reports. Data on external financing based on submissions by development partners	n/a

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