

FOURTH INVESTORS GROUP MEETING 3-4 November, 2016

INVESTORS GROUP MEETING REPORT

MAIN CONCLUSIONS AND ACTION POINTS

- 1. The Minister of Health from **Tanzania** provided a detailed account of the country's GFF experience (GFF-IG4-3 PPT). The Chair noted the following follow-up for the GFF:
 - The Secretariat needs to continue to provide platforms for countries to exchange experiences and lessons learned;
 - Donors and partners should continue to engage with the country platform to improve alignment around the financing of the Investment Case.
- 2. The **GFF Portfolio Update** demonstrated that significant progress is being made and many countries are moving to implementation (GFF-IG4-2). The Investors Group requested the following:
 - The Secretariat will continue to support the governments to identify country coordinators based at the Ministry of Health to support communications and timely engagement of all actors on the country platform;
 - The GFF Secretariat will circulate the list of country focal points within the Secretariat;
 - There is an opportunity to further strengthen the collaboration between Gavi, The Global Fund and GFF
 on joint financing of Investment Case priorities as well as the domestic resource mobilization and the GFF
 will continue to convene financiers on a regular basis to further this agenda.
- 3. Country representatives from Ethiopia, Kenya, Liberia and Nigeria participated in a Lessons Learned Country Panel (GFF-IG4-Lessons Learned PPT). The IG noted the following points for follow up:
 - The Secretariat will continue to create learning opportunities and exchange between countries on key elements of the GFF technical agenda;
 - There is a need to examine more closely the challenges in country with resource mapping of donor funding for a further discussion at the next IG.
- 4. A thematic joint session on **sexual and reproductive health and rights (SRHR) with a focus on family planning**, discussed the SRHR agenda as part of the GFF (GFF-IG4-11 PPTs). The Chair concluded the session as follows:
 - Engaging adolescents and youth voices in the IG is important and this will be addressed through the governance revision;
 - SRHR is a key part of the GFF agenda and inclusion of the comprehensive set of interventions in Investment Cases will be essential for the delivery of the GFF's goals;
 - The availability of high quality data through, for example, the work of FP2020 and the World Bank and other key partners on the demographic dividend will facilitate the inclusion of the SRHR in Investment Cases.
- 5. The Investors Group considered the work of the **Commodities** Task Team and agreed to the following actions based on the task team's recommendations (GFF-IG4-6):

- The IG agreed that the Chair ask the ISG to coordinate across agencies on efforts to improve access to RMNCAH commodities within the unified supply chain, specifically to improve in-country technical capacity in this area. The IG noted with appreciation that the WHO has agreed to host the ISG.
- The IG requested the GFF Secretariat strengthen the current Investment Case guidelines to ensure stronger focus on commodity access. In addition, the IG instructed the Secretariat to strengthen its coordination capacity on access to commodities so that it can serve as an efficient interlocutor between the country commodity access needs and the key partners and resources in the commodities and supply chain space.
- 6. The session on **Financing for RMNCAH** offered an examination of domestic resource mobilization in the GFF countries (GFF-IG4-4). The Chair noted these follow-up items:
 - The specific approach will differ from country to country and the GFF Secretariat will make country profiles available to country clients to facilitate planning;
 - Efficiency gains and how they are measured and tracked, is a key theme across the countries and this will be further discussed at the next IG meeting;
 - The health financing work needs to be underpinned by a focus on the poor and least-served;
 - There is a need to further clarify how the operationalization of the domestic resource mobilization agenda of the GFF will take place, including how it is tracked and measured. This will be discussed at the next IG.
- 7. An update on **CRVS** showed the GFF's progress in this area (GFF-IG4-10). The IG agreed on the following action items:
 - The Centre of Excellence will undertake the mapping of what partners are doing in CRVS and identify gaps;
 - The Centre of Excellence will develop guidelines for countries on how to access services and expertise of the Centre.
- 8. The task team on **Fragile Settings** presented its recommendations (GFF-IG4-5). The IG agreed on the following action items:
 - Acknowledging that the GFF is already working in fragile settings, the GFF should maintain its current approaches, given that the experience to date indicates that a number of aspects of the GFF model are well-suited to fragile settings; to complement this, more efforts should be placed on documenting and disseminating experiences;
 - The GFF should employ a country-tailored fragility approach with no or low additional costs; be intentional about role of fragility in development of Investments Cases;
 - Focus GFF's engagement to areas of comparative advantages and the value-add of the GFF and communicate clearly what the GFF will not do: rapid response, humanitarian coordination and activities which are beyond the RMNCAH focus;
 - In the future, as additional funding becomes available and further learning occurs in the current fragile settings, new approaches that require additional resources can be considered.
- 9. An update on the **Private Sector** revealed significant progress has been made across the diverse agenda. (GFF-IG4-8). The IG urged the Secretariat to continue the work on implementing the strategy.
- 10. The session on **Resource Mobilization** (GFF-IG4-9) outlined the GFF's major priorities for 2017-18 in this area. The IG agreed the following action points:

- The IG agreed to adopt the proposed approach for resource mobilization;
- The Secretariat needs to develop a resource mobilization strategy for a successful replenishment of the GFF Trust Fund to be discussed at the next IG;
- A 2018 replenishment is good timing for this replenishment and the plan should be aimed at that timeframe;
- PMNCH and the Bill and Melinda Gates Foundation offered to support the advocacy around the GFF resource mobilization.
- 11. A **Civil Society** representative provided an update on the Civil Society consultation. The CSO constituency will present a proposed CSO engagement strategy to the next IG.
- 12. A proposal for updating the Governance Document was agreed (GFF-IG4-7).

APPROVAL OF AGENDA

The GFF Investors Group (IG) held its fourth meeting 3 - 4 November 2016 in Dar es Salaam, Tanzania. The meeting Agenda (Annex 2) and a follow-up table (Annex 1) are attached. The documents including a Participant List are available at <u>www.globalfinancingfacility.org</u>. The Chair welcomed all participants, including new members, and expressed particular gratitude to the several Ministers of Health and country representatives in attendance. He warmly welcomed the newly appointed Director of the GFF, Dr. Mariam Claeson, who officially began her assignment with the GFF on 1 October 2016. He thanked the GFF task teams and others who helped to frame the content of the meeting. He explained that the meeting was preceded by a convening with the FP2020 Reference Group, which offered a special opportunity for to focus on the GFF's work in sexual and reproductive health and rights with a focus on family planning. The Agenda (GFF-IG4-1) was approved.

FOCUS COUNTRY: TANZANIA

The Honorable Ms. Ummy Mwalimu, Minister of Health, Community Development, Gender, Elderly and Children for Tanzania, and Ms. Mariam Ally, Acting Director, Policy and Planning Division, Ministry of Health, Community Development, Gender, Elderly and Children provided a detailed account of the country's GFF experience (GFF-IG4-3 PPT). The Minister restated her announcement the previous evening that the Tanzanian government planned to upgrade 100 health facilities to meet BEmONC (Basic Emergency Obstetric and Newborn Care) and CEmONC (Comprehensive Emergency Obstetric and Newborn Care) standards as part of their commitment to RMNCAH. She explained that the Tanzanian Health Policy from 2007 had already prioritized RMNCH services and this has continued under One Plan II which was launched in 2016, along with the RMNCAH Score Card. It includes strategies to strengthen reproductive, maternal, newborn, child, and adolescent health, scale-up the child health program and strengthen response to cross-cutting issues, e.g., commodities, community involvement, demand, HMIS. Implementation of the Investment Case has started, including with financing from IDA/GFF TF, USAID, JICA and domestic resources.

She noted that many of the challenges for Tanzania related to service delivery. She explained the efforts that had been put into coordinating the various partners and aligning funding to the One Plan II. She also explained the approach to focus on results in Tanzania and pointed to some progress through star rating assessments to improve quality, scorecards to monitor progress and results-based financing to address key indicators that are lagging in the country. The health financing strategy is under development. The Minister noted that even though the proportion of health within the government budget had decreased slightly, the absolute amount being spent on health has been increasing in recent years.

The IG thanked the Minister and Dr. Ally for the very interesting presentation; the subsequent discussion focused on the following areas:

- How to define the financing gap more precisely and attract additional co-financing to the Investment Case, in addition to IDA, GFF TF, Power of Nutrition, JICA and USAID financing;
- The issue of partners using different analytical tools and how establish a consistent data set;
- Countries noted the value of hearing the experiences of the Tanzanian team and requested more opportunities to learn from each other;

- The importance of community engagement and CSO oversight at the delivery level was noted for accountability and monitoring of quality;
- The challenge of reaching adolescents was discussed and the need for a multi-sectoral approach to address their needs;
- The need for much more work to be done on CRVS was noted;
- Results-based financing was credited with having strengthened health systems more broadly and is seen as part of the solution going forward.

The Chair thanked the Minister for her insightful presentation and update. He noted the need for the GFF to continue to provide platforms for countries to exchange experiences and lessons learned. He also suggested that donors and partners should continue to engage with the country platform to improve alignment around the financing of the Investment Case.

PORTFOLIO UPDATE

Dr. Monique Vledder, Practice Manager, GFF Secretariat, presented the **Portfolio Update** (GFF-IG4-2). She highlighted that eight Investment Cases have been finalized and four health financing strategies are awaiting parliamentary approval and seven countries have well developed drafts or are already focusing on implementation of key reforms. There are six IDA/ TF projects approved, financing part of the Investment Case in Cameroon, DRC, Nigeria, Tanzania, Uganda and Kenya. There are significant contributions from other financiers providing complimentary financing to the Investment Cases across various countries. The quality of the Investment Cases is improving over time and the focus in many countries is shifting to supporting implementation.

The IG country representatives were then invited to provide brief updates on progress in country, Dr. Awa Coll-Seck and Dr. Bocar Mamadou Daff (Senegal), Ms. Yah Zolia (Liberia), Dr. O.A. Omar (Kenya) and Ms. Abebayehu Haile (Ethiopia).

- In Senegal they are in the consultation phase to develop a consolidated, integrated plan on RMNCAH with the support of many partners, their focus is on getting the tools in place for data analysis and developing an evidence base to guide the IC and the health financing strategy with plans for a national and regional consultation on the plan;
- In Liberia the Investment Case is finalized, they are focusing on the health financing strategy and looking at improving the efficiency through better donor alignment and coordination;
- In Kenya, the framework has been disseminated to stakeholders and is available online with partners increasingly using it to program RMNCAH interventions. The health financing strategy has been finalized and will require parliamentary approval.
- In Ethiopia, the health sector transformation plan is being implemented with an accompanying health financing plan which includes domestic resources. The IDA/ TF project is under development.

The Investors Group provided the following feedback and commentary:

- Members expressed interest in ensuring more synergy and alignment of donor funding at the country level and were looking for ways to make this work better, including more information on where the funding gaps were, and how the GFF funds and complimentary financing was being allocated;
- They requested more information on the draft project documents and contact information for country coordinators in the government and country focal points in the Secretariat;

The Investors Group requested the following:

- The Secretariat will continue to support the governments to identify country coordinators based at the Ministry of Health to support communications and timely engagement of all actors on the country platform;
- The GFF Secretariat will circulate the list of country focal points within Secretariat;
- There is an opportunity to further strengthen the collaboration between Gavi, The Global Fund and GFF on joint financing of Investment Case priorities as well as the domestic resource mobilization and the GFF will continue to convene financiers on a regular basis to further this agenda.

LESSONS LEARNED COUNTRY PANEL

Ms. Petra Vergeer, GFF Secretariat moderated a discussion on lessons learned in four GFF countries. Panelists included country representatives from Liberia, Kenya, Nigeria and Ethiopia:

- Ms. Yah Zolia, Deputy Minister of Health and Social Welfare in Liberia
- Dr. O.A. Omar, Division of Health Financing for the Ministry of Health in Kenya
- Dr. Abdullahi Dauda Belel, Executive, Chairman from Adamawa State Primary Health Care Development Agency, State Primary Health Care Board of Nigeria; and
- Mr. Tseganeh Amsalu, Technical Assistant from the Federal Ministry of Health in Ethiopia.

The panelists presented challenges and lessons learned from the GFF engagement in their countries (GFF-IG4-Lessons Learned Panel PPT) including:

- Liberia: the Investment Case is almost finalized. A major step in the GFF process has been the budget and resource mapping for the IC, which has been challenging and identifying real gaps in financing has been difficult. At the same time, it became clear there is limited interest of donors in financing capital investments which are highly needed in post-conflict Liberia. Budget classifications are to be much clearer and disaggregated information to be provided in much more detail by donors for such resource mapping. The IC has proven very useful in improving donor coordination and getting donors to align their funding more to the priorities identified. Such discussions/meetings need to be institutionalized to allow follow up while expenditure tracking can help ensure donors are held accountable. The GFF has helped to do business differently and created momentum to the IHP+ process it is felt that it contributes to realizing UHC so results can be achieved.
- Kenya: the RMNCAH investment framework was developed following an extensive consultative process and includes a range of strategies for counties to adopt. In view of devolution, the actual Investment Cases are being developed at county level. Through a Trust Fund support from DFID and USAID, technical assistance will be provided at county level to support the development and implementation of the county

plans as capacity building is critical at the devolved level. The Ministry has observed that there is clear convergence of partners to join the GFF process and support the RMNCAH investment framework. The Transforming Health Systems for Universal Care Project uses a performance based approach which ensures minimal funding is allocated to health while giving counties more flexibility to decide what strategies to implement but also more responsibility in their implementation. The challenges raised relate to duplicate planning processes, as promoted by different development partners, at national and decentralized level and the need to build a coherent country platform enabling ease of planning and resource mobilization and supporting the principle of aid effectiveness.

- Adamawa State in Northern Nigeria, is one of the beneficiaries of the Bank and GFF TF supported project, while the country at the same time is working on the national strategic health development plan which will serve as the IC. The design of the project in the North is based on the experience in Adamawa, where the government already implemented a performance based financing approach at the time of the insurgency and managed to expand the contracts with public health facilities to ensure the delivery of basic services to Internally Displaced People coming in from neighboring Borno State, which placed significant strains on the facilities. The project in Northern Nigeria will use private sector firms as Contract Management and Verification Agencies (CMVA) and Independent Verification Agencies will be contracted to ensure basic services will be provided to IDPs in host communities, poor people and hard to reach communities. Where needed, private sector health care providers will be contracted through performance contracts. A plea was made that, where possible and with support from development partners, government should be put in charge to deal with the effects of conflict and continue to provide services using Community Based Organizations, Faith Based Organizations and/or government, as appropriate, and that the results based financing approach is considered useful in this.
- Ethiopia: the Global Financing Facility Platform refreshed the in-country, regional and international discussions on sustainable domestic health financing putting Health Care Financing, specifically Domestic Health Care financing, as a priority and cross cutting piece of the RMNCAYH agenda. There is renewed interest and strong commitment from partners to support health care financing, with more partners joining the pool fund to implement the national health sector transformation plan, and support provided to implement the health care financing strategy. Such pooling and alignment reduces transaction costs and improves the efficiency, rather than budgets used outside of the government system. The cooperation of government and donor partners is essential for this to work. One of the main challenges is limited capacity in health care financing at the national, but also specifically at the sub-national level. As a result, there is a need for more technical support and capacity building to ensure the full implementation of effective health funding and aligned allocation at the national and decentralized level. In addition, there is a need for policy implementation research so as to ensure evidence generation and decision-making.

The subsequent rich discussion with the Investors Group touched on issues of equity, donor alignment and aid effectiveness, devolution and budgeting and financing at the local level, capacity building and technical assistance. This session will be captured in more detail in a separate document as part of the dissemination of lessons learned.

The Chair thanked the panel for the very helpful insights and noted the following points for follow up:

- The Secretariat will continue to create learning opportunities and exchange between countries on key elements of the GFF technical agenda;
- There is a need to examine more closely the challenges in country with resource mapping of donor funding for a further discussion at the next IG.

JOINT SESSION THEMATIC FOCUS: SRHR WITH A FOCUS ON FAMILY PLANNING

Dr. Michele Gragnolati, Practice Manager at the World Bank, and Ms. Beth Schlachter, Executive Director of FP2020, led a discussion on the GFF and sexual and reproductive health and rights with a focus on family planning (GFF-IG4-11 PPT). Dr. Gragnolati presented on the opportunity of the demographic dividend, noting that the countries that are GFF eligible are also those that, with appropriate investments in health, education and creation of employment opportunities, could benefit from a significant increase in longer-term economic growth by converting the demographic opportunity they have into actual demographic dividend.

Ms. Schlachter explained the status of family planning implementation and the acceleration seen in the last decade but also cautioned about the plateauing of ODA in support of family planning. The GFF, with its focus on mobilization of domestic resources and targeted catalytic use of ODA, is an extremely important financing vehicle to support governments in providing family planning counselling and services.

The Investors Group raised the following issues during discussion:

- The importance of integrating family planning within the continuum of care to ensure that women and adolescents are able to access an array of services;
- The need to recognize the demand and supply side barriers to accessing family planning counseling and services;
- The importance of acknowledging the rights-based approach to offering family planning services, so that women and adolescents are able to make an informed choice based on their SRHR needs.

The Chair concluded the session as follows:

- Engaging adolescents and youth voices in the IG is important and this will be addressed through the governance revision;
- SRHR is a key part of the GFF agenda and inclusion of the comprehensive set of interventions in Investment Cases will be essential for the delivery of the GFF's goals;
- The availability of high quality data through, for example, the work of FP2020 and the World Bank work on the demographic dividend will facilitate the inclusion of the SRHR in Investment Cases.

COMMODITIES

Dr. Jennifer Adams, (IG Member representing the USA and Chair of the Commodities Task Team), provided an overview of the work of the task team (GFF-IG4-6). She outlined the task team's four key recommendations for Investors Group action (GFF-IG4-6 PPT), including:

- Strengthen the in-country technical capacity for countries to address RMNCAH commodity bottlenecks and invest in resolving them;
- Support better translation of global knowledge into sustained country level use;
- Support governance mechanisms around commodities;

• Enable the GFF Secretariat to better guide countries to technical resources and partners on RMNCAH commodity issues.

The Investors group had the following feedback on the report:

- There was support for the approach proposed by the task team as this made use of the broader partnership and their contributions on commodities and supply chain at the global level, while rooting the work of the GFF firmly in the countries and through the Investment Cases;
- More extensive guidance was needed for countries, especially to foster cross-country learning and sharing
 of experience including access to global and regional tools and resources;
- It's important to foster more innovation in addressing the bottlenecks in this area and it would be good to see space for innovation in the Investment Cases as part of the solution. This could draw on the experience of Gavi and the Global Fund in innovating on process and not only product;
- Members asked that the Chair request more information on the strengths and limitations of the ISG.

The Investors Group agreed to the following actions:

- The IG agreed that the Chair ask the ISG to coordinate across agencies on efforts to improve access to RMNCAH commodities within the unified supply chain, specifically to improve in-country technical capacity in this area. The IG noted with appreciation that the WHO has agreed to host the ISG.
- The IG requested the GFF Secretariat to strengthen the current Investment Case guidelines to ensure stronger focus on commodity access. In addition, the IG instructed the Secretariat to strengthen its coordination capacity on access to commodities so that it can serve as an efficient interlocutor between the country commodity access needs and the key partners and resources in the commodities and supply chain space.

The Chair concluded that although the GFF is a financier of RMNCAH commodities and will participate in global coordination mechanisms, the GFF TF financing will be focusing on country level investments and will not be used for any global activities in this area. The Chair noted that this completes the work of the Commodities Task Team and thanked the participants for their work.

FINANCING FOR RMNCAH: DOMESTIC RESOURCE MOBILIZATION

The Chair noted that health financing is a recurrent item on the agenda of the GFF Investors Group. Past meetings have explored health financing transitions and trends in development assistance for health and RMNCAH and complementary financing. The focus of the discussion at this meeting was domestic resource mobilization (GFF-IG4-4). Dr. David Evans from the GFF Secretariat offered an examination of the status and prospects for domestic resource mobilization in GFF countries as well as lessons from experience to date with GFF countries.

He noted that increased domestic resource mobilization, not from out of pocket payments but from forms of prepaid and pooled financing, is important to all GFF countries. There is room in all GFF countries for increased DRM, although the potential varies substantially across them. In half of them, government spending could more than double and while the relative size of the potential increases is lower in the other countries, the benefits of the increases in spending in terms of improved health would still be important.

The current GFF countries are, on average, poorer than their counterparts in the income group categories – e.g. the GFF low-income countries are poorer on average than low-income countries as a group and the same is true for GFF lower-middle income countries. On the other hand, the share of government expenditures in GDP (the extent to which the GFF governments raise and spend revenues) is lower than the average in lower-middle income

countries, while the priority given to health in government budgets is higher than the average. Improving revenue (tax and other charges) collection will raise more for health than giving more priority to health in a majority, though not all, of the GFF countries. Complementary quick wins are to improve efficiency in how resources, domestic and externally sources, are spend and to ensure that the Ministry of Health and sub-national units responsible for health fully execute their budgets. Ministries of Finance argue that health ministries should not request additional resources until they show they can spend them, and spend them better, so the focus on efficiency improvements in GFF countries may result in greater allocations from the Ministry of Finance.

The Investors Group had the following questions and comments:

- Given the significance of the role of domestic resources in closing the RMNCAH financing gap, how is the GFF going to track domestic resource trends for health? Is the ambition in this area realistic? How can the GFF build the capacity of Ministries of Health to interact with Ministries of Finance? How to ensure that domestic financing policies benefit the poorest and not only the wealthy?
- What role can partners, and in particular CSOs, play in advocacy and accountability tracking, and working with parliamentarians to ensure domestic resource allocations? Is there a role for the private sector?
- Members pointed out the connection between DRM and CRVS and noted the need for technical assistance to countries to support these efforts;
- There were more calls for cross-country learnings and for countries to be able to benefit from each other's experience in this area.

The Secretariat committed to providing country profiles on the data and analysis to date since this was a key element for each country to define solutions.

The Chair thanked the group for the substantive discussion and noted the need to define some real action on this item. Given that efficiency had emerged as a key factor in ensuring optimal use of funds, it is appropriate that this will be the focus area for the next IG discussion. It would be important to define exactly what role the GFF can play in that regard, taking equity as one of our key principles and focusing on the GFF's added value to that agenda. The Chair noted these follow-up items:

- The specific approach will differ from country to country and the GFF Secretariat will make country profiles available to country clients to facilitate planning;
- Efficiency gains and how they are measured and tracked, is a key theme across the countries and this will be further discussed at the next IG meeting;
- The health financing work needs to be underpinned by a focus on the poor and least-served;
- There is a need to further clarify how the operationalization of the domestic resource mobilization agenda of the GFF will take place, including how it is tracked and measured. This will be discussed at the next IG.

CRVS UPDATE

Ms. Maletela Tuoane-Nkhasi from the GFF Secretariat and Dr. Simon Carter, Regional Director, IDRC, presented update on the importance of Civil Registration and Vital Statistics (CRVS) for the RMNCAH agenda and the GFF's country progress in this area (GFF-IG4-10 and PPT). In recalling that the GFF IG had approved an approach to results measurement at the previous meeting (GFF-IG3-5) she noted that one key element of how the GFF contributes to improving results measurement, is through the strengthening of CRVS systems. Strengthening CRVS systems is a basic human right and provides an important data source for tracking and improving health. In many GFF-supported countries, CRVS systems are weak, with low coverage of birth registration; almost non-existent

information on death registration and causes of death; and no production of statistics from the civil registration system. Many low- and lower-middle income countries face substantial financing gap for strengthening CRVS, requiring high or moderate investments to have well-functioning CRVS systems. The GFF processes have supported growing momentum towards strengthening CRVS systems at country level and facilitated coordinated partnerships between governments and development partners to support country-led priorities and plans.

Dr. Carter explained the role of the Centre of Excellence for CRVS Systems which is housed at the International Development Research Centre in Nairobi. The government of Canada has provided funding to establish the Centre with a mandate to support countries to develop and implement CRVS systems strengthening plans in RMNCAH Investment Cases and to act as a resource hub to broker access to technical assistance, global standards and tools, and good practice.

In response to the presentation, the IG commented:

- It was noted that many partners were engaged in various aspects of the CRVS agenda and that the data gap is a crucial agenda within the SDGs;
- There is a role for innovation and technological solutions that needs to be explored, making this an important area to engage the private sector;
- CRVS is critical to the equity agenda and coordinating efforts in this area would be great value-added.

The Chair concluded by noting the following action items:

- The Centre of Excellence will undertake the mapping of what partners are doing in CRVS and identify gaps;
- The Centre of Excellence will develop guidelines for countries on how to access services and expertise of the Centre.

FRAGILE SETTINGS

Ms. Petra Vergeer from the GFF Secretariat presented the recommendations of the task team on Fragile Settings (GFF-IG4-5). Noting that the questions is not *if* the GFF should engage in fragile settings but *how*, she explained that 24 (39%) of current 62 eligible countries are categorized as fragile states. The current 16 GFF countries include four states considered fragile, three with fragile areas and several recovering from the devastating effects of Ebola. The task team had explored the various ways in which the GFF already engages with these countries and the GFF's comparative advantage in this. Building off current strategies in the GFF, a country tailored approach to fragility can be employed at no or minimal costs, such as strengthening resilience and response capacity. In addition, the task team identified possible new approaches for the future as additional resources become available. The task team requested guidance from the Investors Group on the recommendations contained in the paper.

The Chair thanked Ms. Vergeer for the report and invited two of the task team members to provide any additional reflections. Mesfin Teklu (CSO IG member and task team participant) emphasized that the approach taken had been to focus on the GFF's comparative advantage and look at where the GFF could really add value, especially given the GFF principles to address equity and highest burden areas. He noted that the recommendations were practical and could be revisited if more resources became available. Patricia Strong (of the Canadian Red Cross representing ICRC and IFRC on the task team) expressed appreciation for their participation on the task team and

noted that their input had been considered and incorporated. She cited the extensive need for support to affected communities across the globe and that this need was growing. Appreciating the country-led approach she pointed to the many populations who were living beyond the reach of governments and how disproportionately this affected women and children, expressing her appreciation for the approach chosen in Northern Nigeria. She further noted the importance of enhancing resilience as a means of protecting GFF investments in times of crisis and the role the GFF could play in advocating for RMNCAH investments as part of any new resources that will be available through future IDA18 allocations as well as the new Concessional Financing Facility available to countries hosting refugees. She supported the recommendations and made a plea for the continuation of GFF prioritization of fragile settings going forward.

The Investors Group had the following reflections on the recommendations:

- There was wide support for the approach recognizing that any country can become a crisis country while
 noting that the GFF works primarily through governments and therefore is not best suited to situations
 where government is not functioning;
- Members expressed strong support that the equity approach results in a focus on more vulnerable and fragile areas, and in a focus on the special needs of women and children in these contexts (e.g. genderbased violence); these issues were already evident in the portfolio and should continue to be addressed;
- There was clear support for using a country tailored approach to fragility to enable a focus on preparedness and resilience is taken into account in the ICs, including the need for capacity building and human resources in the medium and longer term;
- Members noted that flexibility, innovation and partnership were essential in these contexts as was the ability to engage the non-state sector;
- PMNCH stated their readiness, in line with their EWEC mandate, to communicate and advocate on the RMNCAH needs and funding gaps in fragile settings, including the sharing of any lessons;
- The Secretariat in its response noted that IDA18 offered an opportunity to leverage more funds for these settings, and also explained the opportunity within the World Bank to trigger a mechanism to fund non-state actors directly in a crisis, providing potential flexibility for the GFF model. The GFF had also been able to catalyze partnerships and domestic resources around the IC in effective ways, as has been the case in northern Nigeria. This provides insight into the role the GFF can play.

The Investors Group then agreed the following:

- Acknowledging that the GFF is already working in fragile settings, the GFF should maintain its current approaches, given that the experience to date indicates that a number of aspects of the GFF model are well-suited to fragile settings; to complement this, more efforts should be placed on documenting and disseminating experiences;
- The GFF should employ a country-tailored fragility approach with no or low additional costs and be intentional about the role of fragility in the development of Investments Cases;
- Focus GFF's engagement to areas of comparative advantages and the value-add of the GFF and communicate clearly what the GFF will not do: rapid response, humanitarian coordination and activities which are beyond the RMNCAH focus;
- In the future, as additional funding becomes available and further learning occurs in the current fragile settings, new approaches that require additional resources can be considered.

The Chair thanked the task team for their excellent work and noted that this completed the mandate of the task team.

PRIVATE SECTOR UPDATE

An update on Private Sector progress was provided by Mr. Toby Kasper from the GFF Secretariat (GFF-IG4-8 and PPT). He noted that progress had made across the agenda since the GFF's Private Sector Strategy was approved in March 2016, the GFF Secretariat and partners have focused on implementation in the current private sector focus countries of Cameroon, Kenya, Senegal and Uganda.

The first GFF partnership between global private sector and countries is being developed around capacity building for governments on effective selection and procurement of health technologies for their needs. This will be done in coordination with the WHO and will leverage the expertise of private medical technology companies in a transparent and non-competitive manner to strengthen government capacity.

The GFF country experiences with the private sector have included private sector integration in large scale reforms in areas such as service delivery and supply chains, as well as in developing innovative solutions to address Investment Case priorities.

The IG welcomed the update and commented:

- How can we engage the private sector in the equity agenda and ensure that the focus remains local?
- Countries need support in defining and executing engagement with the private sector as well as building the capacity to regulate the private sector.

The IG urged the Secretariat to continue the work on implementing the strategy.

RESOURCE MOBILIZATION ANNUAL UPDATE

Dr. Mariam Claeson, Director of the GFF Secretariat, updated the Investors Group with a presentation on Resource Mobilization (GFF-IG4-9 and PPT). Based on the financing model of the GFF, the resource mobilization strategy focuses on four pathways: Domestic Resource Mobilization, Complementary Financing (ODA and Private capital), concessional financing (IBRD/IDA) and catalytic financing (GFF TF). The IG was asked to endorse the approach and to provide advice:

- Members noted the importance of developing a strong value proposition and showing the specific contribution of the GFF and how it fits into the broader health architecture. In doing this the 'smart, scaled and sustainable' arguments need to be better explained and shown to be working;
- Questions were raised on the timeline and the financial target for the Trust Fund replenishment;
- Fund-raising should also take place in 2017 to expand the number of countries receiving funding, especially with the opportunity of IDA18 bringing in significant new resources.

The Chair thanked the IG for a very helpful discussion. He emphasized that the first three components of the RM plan were the daily work of the GFF but that the fund-raising for the Trust Fund needed special attention. He concluded with the following action points:

GFF/IG4/Report

- The IG agreed to adopt the proposed approach for resource mobilization;
- The Secretariat needs to develop a resource mobilization strategy for a successful replenishment of the GFF TF to be discussed at the next IG;
- A 2018 replenishment is a good timing for this replenishment and the plan should be aimed at that timeframe;
- PMNCH and the Bill and Melinda Gates Foundation offered to support the advocacy around the GFF resource mobilization.

CSO UPDATE

Dr. Joanne Carter and Dr. Mesfin Teklu (the CSO representatives on the IG) provided an update on the Civil Society meeting which had taken place before the IG meeting and noted the importance of CSOs being able to engage in the country platform and the implementation of the Investment Cases in country. The CSOs have actively engaged on the development of the Guidance Note on multi-stakeholder country platforms and are hoping this will help provide greater access for CSOs to in-country GFF processes. They informed the IG that they would submit a CSO Engagement Strategy to the next meeting for IG consideration. They also introduced the incoming members for the CSO constituency who had just been selected: Mr. Aminu Magashi Garba and Ms. Angela Mutunga.

The Chair expressed thanks for the informative presentation.

GOVERNANCE UPDATE

Ms. Dianne Stewart from the GFF Secretariat presented a proposal for updating the Governance Document (GFF-IG4-7). She described a short process, which will result in proposed amendments to the Governance Document, which can be presented for adoption at the fifth Investors Group meeting in April 2017. The Investors Group noted some areas where greater clarity would be helpful:

• What is the relationship between the roles of the Trust Fund Committee and that of the Investors Group and what are the decision-making roles of each?

The Chair noted that these issues could be clarified as part of the process. He suggested that the IG proceed as proposed and consult on changes for approval at the next IG meeting. The IG agreed to the approach.

REVIEW CALENDAR 2017

The Chair presented the Calendar for 2017-2018. He noted that the next meeting is planned for 24 April 2017 in Washington, DC, and that the second meeting of the year is planned for November in a location that will be determined. He expressed an interest in convening the second meeting in a partner country.

CHAIR'S SUMMARY AND CLOSURE

The Chair thanked the Investors Group for a highly productive discussion, which he believes usefully advanced a shared agenda. The Chair closed the meeting. The follow-up actions from the Investors Group are outlined in Annex 1.

ANNEX 1: FOLLOW-UP ACTION

Issue	Meeting	Action/Deliverable	Timeline	Responsible
Portfolio Updates	IG4	 Support the governments to identify country coordinators based at the Ministry of Health to support communications and timely engagement of all actors on the country platform; 	Immediate	Secretariat
		 Circulate the list of country focal points within the Secretariat; Strengthen the collaboration between Gavi, The Global Fund and GFF on joint financing of Investment Case priorities as well as the 	Immediate Ongoing	
		 domestic resource mobilization; Continue to convene financiers on a regular basis to further this agenda; Create learning opportunities and exchange between countries on key elements of the 	Ongoing Ongoing	
		 GFF technical agenda; Examine more closely the challenges in country with resource mapping of donor funding for a further discussion at the next IG. 	Agenda item IG5	
Financing RMNCAH	IG4	 Secretariat to make country profiles available to country clients to facilitate planning; Clarify how the operationalization of the domestic resource mobilization agenda of the GFF will take place. 	Immediate IG5	Secretariat
Commodities	IG4	 Chair to ask the ISG to coordinate across agencies on efforts to improve access to RMNCAH commodities within the unified supply chain, specifically to improve incountry technical capacity in this area; GFF Secretariat to strengthen the current Investment Case guidelines to ensure stronger focus on commodity access; 	Immediate Immediate	Chair Secretariat
		 Secretariat to strengthen its coordination capacity on access to commodities. 	Immediate	Secretariat
CRVS	IG4	 The Centre of Excellence to undertake the mapping of what partners are doing in CRVS and identify gaps; 	TBD	Centre of Excellence on CRVS

Issue	Meeting	Action/Deliverable	Timeline	Responsible
		 The Centre of Excellence will develop guidelines for countries on how to access services and expertise of the Centre. 	Immediate	
Fragile Settings	-		Ongoing Ongoing	Secretariat
Resource Mobilization	IG4	 Secretariat to develop a business case for a successful replenishment of the GFF TF to be discussed at the next IG; A 2018 replenishment is a good timing for this replenishment and the plan should be aimed at that timeframe; PMNCH and the Bill and Melinda Gates Foundation offered to support the advocacy around the GFF resource mobilization. 	Q2 2017 Ongoing	Secretariat Secretariat with PMNCH and BMGF
Governance	IG4	 Conduct consultation process to amend Governance Document 	IG5	Secretariat in consultation with IG

ANNEX 2: FOURTH INVESTORS GROUP AGENDA

Wednesday, 2 November

IG and FP2020 Reference Group Bridge Day

(Joint Meeting - GFF IG Members and FP2020 Reference Group Members)

Venue: Hyatt Regency, Kili Marquee Room

Time/Room	Agenda	Presenter		
- 8.30-9.00am	 Welcome and Objectives Provide Reference Group and Investment Group members an opportunity to define ways to ensure that sexual and reproductive health and rights, with a focus on family planning, are integrated within the RMNCAH continuum, and financed by being actively addressed in the development of GFF Investment Cases, budgets and results frameworks by eligible countries. 	 Remarks by: Dr. Chris Elias Hon. Ummy Mwalimu 		
9.00-9.20am	Overview FP2020 and the GFF	Remarks by: – Ms. Beth Schlachter, – Dr. Monique Vledder		
9.20-11.00am	Country Perspective: Learnings from GFF and FP2020 Country Partners Panel discussion with government representatives from six GFF and FP2020 countries	 Panel Moderated by Mariam Claeson Panel members: Hon. Ummy Mwalimu, Tanzania Hon. Dr. Felix Kabange, DRC Hon. Prof. Isaac Adewole, Nigeria Hon. Yah Zolia, Liberia Dr. Wangui Muthigani, Kenya Hon. Awa Coll-Seck, Senegal 		
11.00-11.15am	Coffee Break			
11.15-12.45pm	Discussion	Discussion moderated by Chris Elias		
12.45-1.00pm	Next steps and closing	Remarks and conclusion by Chris Elias		
1.00-2.00pm	Lunch			
2.00 – 4.00pm	Free for bilaterals and consultations			
6.30 pm	GFF Reception (Venue: Kibo Rooftop)			

Thursday, 3 November Venue: Hyatt Regency, Kili Marquee Room					
Time	Agenda Item	Objective	Presenter	Action	
8.30-8.45 am	Opening: (GFF-IG4-1) - Review of the Agenda - Chair's Overview	Agree on agenda	Chair	<u>For approval</u>	
8.45 -10.15 am	Focus Country: Tanzania (GFF-IG4-3)	Sharing of experience from Tanzania	Presentations from MOH of Tanzania	<u>For</u> discussion	
10.15-11.15 am	Portfolio Update (GFF-IG4-2)	Overview of portfolio	Country Representatives GFF Secretariat	<u>For</u> information	
11.15-11.45 am	Break				
11.45 – 1.15.pm	Lessons Learned Country Panel	Lessons learned from existing GFF countries	Panel of country representatives	<u>For</u> information	
1.15 – 2.00 pm	Lunch				
2.00 – 3.30 pm	Joint Session Thematic Focus: Sexual and Reproductive Health and Rights with a focus on family planning	Identify areas of priority and collaboration with FP2020	Panel	<u>For</u> discussion	
3.30- 4.00 pm	Break				
4.00 – 5.30 pm	Commodities (GFF-IG4-6)	Review recommendations from the Task Team	Task Team Chair	For decision	

Friday, 4 November Venue: Hyatt Regency, Kili Marquee Room					
Time	Agenda Item	Objective	Presenter	Action	
8.30 - 10.00 am	Financing for RMNCAH (GFF-IG4-4)	Examination of domestic resource mobilization	GFF Secretariat	<u>For</u> discussion	
10.00- 10.45 am	Civil Registration and Vital Statistics (CRVS) Update (GFF-IG4-10)	Overview of progress on CRVS and emerging issues	GFF Secretariat Centre of Excellence CRVS	<u>For</u> Information	
10.45-11.15 am	Break				
11.15-12.45 pm	Fragile Settings (GFF-IG4-5)	Review recommendations from the Task Team	Task Team	For decision	
12.45– 1.30 pm	Lunch				
1.30 – 2.00 pm	Private Sector Update (GFF-IG4-8)	Overview of progress on Engagement Strategy	GFF Secretariat	<u>For</u> information	
2.00 – 2.45 pm	Resource Mobilization Annual Update (GFF-IG4-9)	Planning for RM	GFF Secretariat	For decision	
2.45 – 3.00 pm	Governance Update (GFF-IG4-7)	Propose updated guidance on Governance	GFF Secretariat	For information	
3.00- 3.15 pm	CSO Update	Briefing on CSO consultation	CSO representative	<u>For</u> information	
3.15 – 3.30 pm	Review Calendar 2017 (GFF-IG4-12)	Agree on meetings and events for 2017	Chair	<u>For</u> information	
3.30 – 4.00 pm	Chair's Summary and Closure	Conclude meeting	Chair		



www.globalfinancingfacility.org



Fourth Investors Group Agenda 2-4 November 2016

Wednesday, 2 November IG and FP2020 Reference Group Bridge Day (Joint Meeting - GFF IG Members and FP2020 Reference Group Members) Venue: Hyatt Regency, Kili Marquee Room					
Time/Room	Agenda Presenter				
8.30-9.00am	Welcome and Objectives Provide Reference Group and Investment Group members an opportunity to define ways to ensure that sexual and reproductive health and rights, with a focus on family planning, are integrated within the RMNCAH continuum, and financed by being actively addressed in the development of GFF investment cases, budgets and results frameworks by eligible countries.	Remarks by: – Dr. Chris Elias – Hon. Ummy Mwalimu			
9.00-9.20am	Overview FP2020 and the GFF	Remarks by: – Ms. Beth Schlachter, – Dr. Monique Vledder			
9.20-11.00am	Country Perspective: Learnings from GFF and FP2020 Country Partners Panel discussion with government representatives from six GFF and FP2020 countries	 Panel Moderated by Mariam Claeson Panel members: Hon. Ummy Mwalimu, Tanzania Hon. Dr. Felix Kabange, DRC Hon. Prof. Isaac Adewole, Nigeria Hon. Yah Zolia, Liberia Dr. Wangui Muthigani, Kenya Hon. Awa Coll-Seck, Senegal 			
11.00-11.15am	Coffee Break				
11.15-12.45pm	Discussion	Discussion moderated by Chris Elias			
12.45-1.00pm	Next steps and closing	Remarks and conclusion by Chris Elias			
1.00-2.00pm	Lunch				
2.00 – 4.00pm	Free for bilaterals and consultations				
6.30 pm	GFF Reception (Venue: Kibo Rooftop)				

Thursday, 3 November Venue: Hyatt Regency, Kili Marquee Room					
Time	Agenda Item	Objective	Presenter	Action	
8.30-8.45 am	Opening: (GFF-IG4-1) - Review of the Agenda - Chair's Overview	Agree on agenda	Chair	<u>For approval</u>	
8.45 -10.15 am	Focus Country: Tanzania (GFF-IG4-3)	Sharing of experience from Tanzania	Presentations from MOH of Tanzania	<u>For</u> discussion	
10.15-11.15 am	Portfolio Update (GFF-IG4-2)	Overview of portfolio	Country Representatives GFF Secretariat	<u>For</u> information	
11.15-11.45 am	Break				
11.45 – 1.15.pm	Lessons Learned Country Panel	Lessons learned from existing GFF countries	Panel of country representatives	<u>For</u> information	
1.15 – 2.00 pm	Lunch				
2.00 – 3.30 pm	Joint Session Thematic Focus: Sexual and Reproductive Health and Rights with a focus on family planning	Identify areas of priority and collaboration with FP2020	Panel	For discussion	
3.30- 4.00 pm	Break				
4.00 – 5.30 pm	Commodities (GFF-IG4-6)	Review recommendations from the Task Team	Task Team Chair	For decision	

Friday, 4 November Venue: Hyatt Regency, Kili Marquee Room					
Time	Agenda Item	Objective	Presenter	Action	
8.30 - 10.00 am	Financing for RMNCAH (GFF-IG4-4)	Examination of domestic resource mobilization	GFF Secretariat	<u>For</u> <u>discussion</u>	
10.00- 10.45 am	Civil Registration and Vital Statistics (CRVS) Update (GFF-IG4-10)	Overview of progress on CRVS and emerging issues	GFF Secretariat Centre of Excellence CRVSS	<u>For</u> Information	
10.45-11.15 am	Break	·			
11.15-12.45 pm	Fragile Settings (GFF-IG4-5)	Review recommendations from the Task Team	Task Team	For decision	
12.45– 1.30 pm	Lunch				
1.30 – 2.00 pm	Private Sector Update (GFF-IG4-8)	Overview of progress on Engagement Strategy	GFF Secretariat	<u>For</u> information	
2.00 – 2.45 pm	Resource Mobilization Annual Update (GFF-IG4-9)	Planning for RM	GFF Secretariat	For decision	
2.45 – 3.00 pm	Governance Update (GFF-IG4-7)	Propose updated guidance on Governance	GFF Secretariat	<u>For</u> information	
3.00- 3.15 pm	CSO Update	Briefing on CSO consultation	CSO representative	For information	
3.15 – 3.30 pm	Review Calendar 2017 (GFF-IG4-12)	Agree on meetings and events for 2017	Chair	For information	
3.30 – 4.00 pm	Chair's Summary and Closure	Conclude meeting	Chair		





PORTFOLIO UPDATE

OVERVIEW

This paper gives an update on the current Global Financing Facility (GFF) portfolio, including the latest information on Investment Cases and health financing strategies.

ACTION REQUESTED

This paper is for information only.

INTRODUCTION

The number of countries engaging with the Global Financing Facility in support of *Every Woman Every Child* has grown from four¹ when it was announced at the UN General Assembly in 2014, to 12² when it was launched in July 2015, to 16³ when the High Level Leaders' Report was launched in September 2016. Collectively, these countries shoulder a large proportion of the burden of maternal and child deaths among the 63 GFF-eligible countries. Their success is therefore critical to the global effort to end the preventable deaths of women, adolescents and children by 2030.



¹ The Democratic Republic of the Congo, Ethiopia, Kenya, and Tanzania.

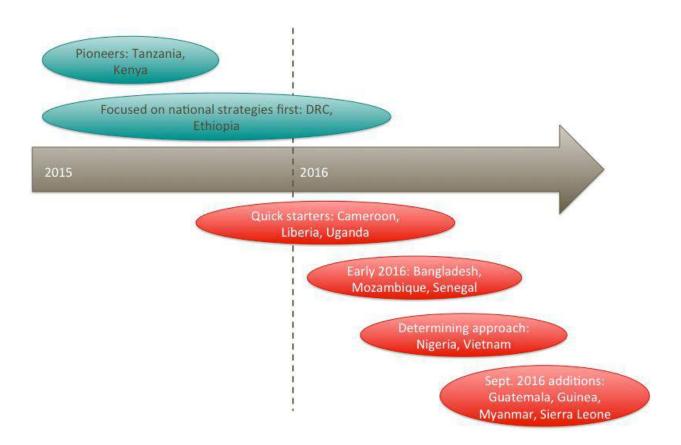
² Bangladesh, Cameroon, Liberia, Mozambique, Nigeria, Senegal, Uganda and Vietnam.

³ The next countries are Guatemala, Guinea, Myanmar, and Sierra Leone

STATE OF THE PORTFOLIO

The GFF process is nationally led: countries adopt different approaches based on existing national planning cycles and other national processes. As a result, progress is country specific, particularly with regard to the development of their Investment Cases and health financing strategies.

The figure below clusters countries into several groups, as they have emerged.



Details for active GFF countries are provided below.

BANGLADESH

The Government of Bangladesh officially launched its GFF engagement in January 2016 with key partners including Canada, JICA, USAID, WHO, the World Bank, civil society, and the private sector.

 Country Platform: Bangladesh is building the GFF process on strong existing partnerships and coordination mechanisms. It also benefits from strong and growing civil society engagement. The government is currently working with a diverse group of over 20 different stakeholders to plan for the Fourth Health Sector Program. It recently organized technical discussions with partners in September 2016.

Investment Case:

- Highlights: Bangladesh investment priorities for progressing on the SDGs are outlined in the Sector Investment Plan (2016-2021), which provides a strong strategic vision as well as a focus on reproductive, newborn, child and adolescent health outcomes, and emphasizes equity, efficiency, and quality. Discussions pertaining to the development of the Fourth Health Sector Program are ongoing, with a particular focus on strengthening governance and stewardship as well as health systems and the provision of quality health services. In addition, innovative solutions, including multisectoral approaches to adolescent health and the climate change/health nexus, continue to be explored.
- Complementary Financing: In the context of the fourth sector program, the Government aims to mobilize US\$10 billion for 2017-2020, with US\$9 billion from domestic sources and an additional US\$1 billion from external sources/partners. Currently, World Bank/GFF Trust Fund financing arrangements are being finalized, with a likely US\$150 million from IDA and a likely US\$20-30 million grant from the GFF Trust Fund. Moreover, a number of bilateral and multilateral partners will pool finances with the Bank or support the sector program with aligned parallel and project support. The sector program is scheduled to be finalized and approved by February 2017.
- Health Financing Strategy: Bangladesh has an existing Health Financing Strategy (2012) and a key challenge is improving domestic resource allocations for the health sector as the country graduates to being a middle income country by 2021. While much progress had been in made in improving health outcomes, Bangladesh is one of the countries with the lowest share of government budget going to health. In the last Bangladesh Development Forum, the government expressed its commitment to ramping up domestic resource for the social sectors.

CAMEROON

Since its launch in October 2015, the GFF process has progressed rapidly in Cameroon.

- Country Platform: Cameroon is using the Health Sector Strategy Steering Committee, supported by two technical working groups, to oversee the work related to both its Investment Case and health financing strategy. Multiple partners including UNFPA, UNICEF, and the World Bank are supporting different elements of the process.
- Investment Case:
 - Highlights: A complete draft of the Investment Case has been finalized; it is currently being used to inform consultations with financiers. Building on extensive analytical work, the Investment Case prioritizes disadvantaged regions (three in the north and one in the east) and key maternal, neonatal and adolescent health issues, nutrition, and CRVS-related issues. It also includes several innovative approaches, including a cash transfer component targeting adolescent girls in the north of the country and a development impact bond that leverages private financing to incentivize kangaroo mother care. The Investment Case is expected to be finalized in October 2016.

- Complementary Financing: Discussions are underway with France, Germany, Gavi, Global Fund and the US Government (PEPFAR). The World Bank IDA financing (US\$100 million) and the support from the GFF Trust Fund (US\$27 million) were approved in May 2016 by the World Bank's Board of Executive Directors. Although the Investment Case was not finalized at the time of the project approval, it drew from the discussions and analytical work carried out in preparation for the Investment Case. It also reserved some financing for priorities emerging from the Investment Case.
- Health Financing Strategy: The development of a health financing strategy in Cameroon is a relatively lengthier and more challenging process as Cameroon has never had a health financing strategy. To inform the development of this strategy, studies on fiscal space, public financial management, and on the political economy have been carried out and completed. Other analytical work is still ongoing, and the process is closely linked to the discussions underway on the financing of universal health coverage. The strategy is expected to be finalized by December 2017.

DEMOCRATIC REPUBLIC OF CONGO (DRC)

The DRC is one of the four GFF frontrunner countries. Over the course of 2015 and part of 2016, the country focused particularly on the development of the five-year national health development strategy, which is the overall framework for the Investment Case.

 Country Platform: The country's well-established multi-stakeholder platform with strong participation from the government, financial and technical partners such as Canada, UNFPA, UNICEF, USAID, WHO, the Gates Foundation, as well as from NGOs, and the private sector constitutes the basis of DRC's in-country and government-led coordination for the GFF.

Investment Case:

- Highlights: A complete draft of the Investment Case is being finalized. The Investment Case includes a focus on scaling up two key service delivery platforms (strategic purchasing and community engagement) and health systems strengthening (particularly human resources for health, supply chain/drugs, and public financial management) to improve RMNCAH outcomes. Programmatically, family planning and nutrition are particular areas of emphasis. Presented to the Minister of Health and Provincial Health Divisions at the end of September 2016, the key priorities of the Investment Case have been validated. The next step is a more detailed budget and resource mapping exercise at provincial level to enable implementation.
- Complementary Financing: GFF discussions on complementary financing build on a strong basis for collaboration in the DRC, with an existing platform bringing together external support from the Gates Foundation, Gavi, the Global Fund, UNFPA, UNICEF, and the World Bank. A number of other partners are also contributing resources to the process, including the governments of Canada, Japan, and Norway. In addition, GFF Trust Fund financing will link to two sources of World Bank funding. The first (US\$220 million financing) is a health systems strengthening project focused on the delivery of RMNCAH services, which will be supplemented with additional financing of US\$100 million in IDA and US\$40 million from the

GFF Trust Fund (to be presented to the Board in February 2017). The second, approved by the Board of Executive Directors in March 2016, is IDA financing of US\$30 million for human development information systems strengthening of which US\$10 million is focused on civil registration and vital statistics (CRVS) and will be linked to US\$10 million from the GFF Trust Fund for CRVS. Both the Global Fund and the US Government are financing trust funds based at the World Bank on RMNCAH.

 Health Financing Strategy: The government is leading the development of a health financing strategy for UHC with support from the World Bank and WHO. The Ministry of Health is organizing a health financing workshop in mid-October to finalize the first draft of the strategy with support from the World Bank/GFF and WHO.

ETHIOPIA

One of the four GFF frontrunner countries, Ethiopia focused primarily on the development of its Health Sector Transformation Plan (HSTP), which was finalized in late 2015. The HSTP is the overarching policy document that guides both the Investment Case and the health financing strategy. A Joint Assessment of the National Strategy (JANS) review was used for the quality assurance of the HSTP.

• Country Platform:

Ethiopia has strong existing systems for partner coordination led by the government. The Joint Consultative Forum (JCF), led by the Minister and co-chaired with HPN Partner, is the platform for higher level dialogue and sharing information. The Joint Core Coordination Committee (JCCC) is the technical arm of the JCF and is the chosen country platform mechanism leading technical discussions around the HSTP and the GFF. In addition, H6 partners and SDG Performance Fund partners are also active in all RMNCAH-related discussions.

Investment Case:

- Highlights: The HSTP includes a strong RMNCAH component, which forms the basis of the Investment Case. It includes a focus on demand-side, supply-side and multi-sectoral interventions such as nutrition and WASH. In addition, there is a strong focus on equity and improving quality of care. Family planning and adolescent health are well reflected in the HSTP and linkages with WASH and education are also emphasized. The country also recognizes the importance of strengthening CRVS as part of its efforts to monitor progress and improve RMNCAH outcomes.
- Complementary Financing: A number of partners have expressed interest in financing RMNCAH scale-up (or technical assistance for it) in Ethiopia, including DFID, the Global Fund, Gates Foundation, the Power of Nutrition trust fund, and USAID. Due to country interest, additional financing for the current P4R project has been agreed to by MOF; IDA funding is likely to be around US\$150 million. The additional financing, will also include support from the GFF Trust Fund (possibly around \$60 million). The concept memo to launch World Bank program preparation was approved by World Bank management in September 2016. Its appraisal is planned for December 2016, and final Board approval is planned for February 2017.

Health Financing Strategy: A health financing strategy is currently under government review and includes a focus on equity. The country is pursuing both a social health insurance scheme for the formal sector and a community-based health insurance scheme for the non-formal sector. The Congressional Proclamation of 2010 created an Ethiopia Health Insurance Agency, which is just becoming operational. Several partners including Gates Foundation, USAID, DfID, EU, etc., have been supporting the health care financing agenda and the plans for expansion of both types of insurance schemes have been discussed with experts. USAID and Gates are providing trust fund resources to the Bank (about \$10 million and \$3 million respectively) to support technical assistance and national capacity building in the area of health financing.

KENYA

Kenya was one of the four frontrunner countries embarking on the development of its Investment Case in early 2015.

Country Platform: The government of Kenya is driving an inclusive coordination platform, involving a wide array of stakeholders including national and county governments, faith-based and civil society organizations, professional associations, the private sector (for-profit and not-for-profit), development partners and financiers for the development of the Investment Case and the health financing strategy. Technical assistance was provided by DfID, JICA, UNAIDS, UNFPA, UNICEF, UN Women, USAID, WHO and the World Bank. Elaboration of the health financing strategy is underway through the support of the Coordinating Technical Working Groups, the Health Financing interagency Coordinating Committee and the UHC Steering Committee.

Investment Case:

 Highlights: Kenya's National Investment Framework for RMNCAH has been finalized and approved. It is available online at: <u>http://globalfinancingfacility.org/sites/gff_new/files/documents/Kenya%20RMNCAH%20In</u> <u>vestment%20Framework_March%202016.pdf</u>. To align the national RMNCAH Investment Framework with the Kenyan devolved health system, counties are now developing county annual work plans focused on evidence-based, prioritized, and locally-relevant solutions.

Intended results (by 2020):

- Maternal mortality ratio from 362/100,000 to 297/100,000;
- Under five mortality rate from 52/1,000 to 42.1/1,000;
- Total fertility rate from 3.9 to 3.3;
- Teenage birth rate from 18% to 11%.
- Complementary Financing: The governments of Denmark, Japan, the United Kingdom, and the United States committed complementary resources for the implementation of the national RMNCAH Investment Framework, in addition to the World Bank with financing from both the International Development Association (IDA) and the GFF Trust Fund. The IDA project of US\$150 million was approved in June 2016; it is linked to a GFF Trust Fund grant of US\$40 million. Discussions are underway between the World Bank, DfID, and USAID around

the best modalities to finance technical assistance to priority counties and to the national government to support implementation of the RMNCAH Investment Framework. This will be paired with results-focused financing, providing an opportunity to further improve the quality of implementation.

Health Financing Strategy: A draft health financing strategy has recently been completed and is currently being reviewed. The strategy brings the strengthening of domestic resource mobilization to the fore—including harnessing the potential of the informal sector—possibly reducing pooling fragmentation and developing strategic purchasing arrangements. Complementing the RMNCAH Investment Framework, the health financing strategy will specifically seek to ensure resource adequacy for efficient and equitable access to affordable essential health care for all Kenyans.

LIBERIA

The government of Liberia is seizing the GFF opportunity to reconstruct and strengthen its health system to increase the utilization of services and enhance its resilience to shock.

Country Platform: The Country Platform will have three components: oversight, management and operational, and it uses existing structures. These structures – which currently functional primarily at the national level – will be strengthened while being mirrored at the sub-national levels. Operationalization at central level will be through the Health Coordination Committee that meets monthly and is comprised of chairs and secretaries of the technical working groups. These oversight committees will be multi-sectoral ensuring that key line ministries, civil society and private sector are included. Functional technical working groups – service delivery, supply chain, health financing, Human Resources for Health and the community health – will have their TORs reviewed for inclusiveness while operationalizing the M&E, CRVS and communications Technical Working Groups. Oversight functions will be fulfilled by the HSCC during its quarterly meetings.

Investment Case:

Highlights: A validation workshop for the RMNCAH Investment Case was held in early September for government officials at national and county level, development partners, international NGOs and local CSOs. The workshop benefitted from the active participation of the six prioritized counties and those from multiple sectors, which increased country ownership. The final Investment Case is expected to be finalized in October 2016.

- Intended results (by 2021):

- Neonatal mortality from 26/1,000 to 19/1000;
- Infant mortality from 54/1000 to 22/10000;
- Under five mortality from 94/1000 to 80/1,000;
- Women 15-19 who have begun childbearing from 31% to 25%.
- Complementary Financing: The MOH spearheaded initial discussions with financiers, led by the Minister of Health and the Deputy Health Minister, to discuss financing and technical assistance following a resource mapping exercise. Discussions are ongoing with development partners, including Gavi, the Global Fund, the US government and the World Bank to align

financing in support of the Investment Case. This support includes a US\$16 million grant from the GFF Trust Fund, linked to an IDA project, which will go to the World Bank Board for approval during the fourth quarter of 2016.

Health Financing Strategy: Liberia already has a health financing policy (National Health Financing Policy and Plan, 2011-2021), the overarching goal of which is to ensure that the health and social welfare services provided to the people of Liberia are affordable to the country while preventing catastrophic household expenditures. The Liberia Health Equity Fund (LHEF) is a strategy that is under development and proposes to support UHC and to address the inequity in the country to improve health outcomes, health outputs, and health inputs for UHC. This is a five year plan (2016-2021) that aims to strengthen revenue generation through improved allocations and coordination and alignment of domestic and international contributions; improved efficiency through pooling of funds and integration of programs; and improved effectiveness through strategic purchasing using performance based financing to strengthen primary health care delivery and an equity based resource allocation formula. A pilot test for a Revolving Drug Fund (RDF) has also been proposed to ensure sustainable and predictable financing for essential drugs for primary health care. Liberia is progressing with the IHP+ process it embarked on earlier in the year.

MOZAMBIQUE

While still at the earlier stages of the GFF process, Mozambique has made a great deal of progress. Because of the revelation of over \$1B of undisclosed debt by the Government, budget support by all donors has been suspended to the country. However, most development partners are continuing to finance projects through other mechanisms. The debt situation, and the already sluggish economic growth, means that Mozambique is currently facing a very challenging economic environment and is under significant pressure to further consolidate the state of public finances to maintain macroeconomic stability. The Government has indicated that spending on critical social programs will be preserved.¹ As of now, there are no indications that the current debt crisis will affect the GFF Trust Fund grant allocation. The Secretariat is monitoring this situation closely.

• **Country Platform:** Mozambique's country platform builds on coordination mechanisms existing under the Sector-Wide Approach. The GFF process is driven by a Task Force established by the Ministry of Health and led by the Director of Public Health.

Investment Case:

- Highlights: A roadmap for the GFF process in Mozambique was endorsed by all partners in the May/June. The development of the Investment Case is currently being spearheaded by the MOH, with the technical support of key development partners. The situational analysis of the IC has been drafted and the work is currently focusing on the identification of priorities.
- Complementary Financing: All key partners are actively engaged in the GFF process, with many health partners expressing interest in financing the Investment Case. A concept note for an IDA/GFF Trust Fund project – with US\$150 million IDA financing and a US\$25 million GFF Trust Fund grant – will be developed in support of the prioritized Investment Case. In the

current macroeconomic environment, the GFF presents an opportunity to strengthen the links between expenditures and results, and to strengthen public financial management.

 Health Financing Strategy: The MOH, in collaboration with partners, developed a first draft of a health financing strategy. The GFF process will contribute to strengthen this draft document. A revised version is expected to be ready by the first quarter of 2016. Additional technical assistance will be provided to further develop the health financing strategy, hold high level consultations with Ministry of Economy and Finance and the Ministry of Health and support the implementation of key reforms outlined in the strategy.

NIGERIA

Nigeria is moving forward on its engagement with the GFF. The approach and scope of the Investment Case, however, still need to be determined – particularly given the size of the country, its federal system and the fact that domestic financing forms a significant part of health spending.

- **Country Platform:** A technical working group created as a result of the new National Health Act serves as the country platform, with a thematic sub-committee on health financing responsible for the development of the health financing strategy. Nigeria has a large and engaged private sector, and it will play a significant role in the process.
- Investment Case:
 - Highlights: The FMOH is leading the development of the Investment Case, which will be integrated into the development of the Nigeria National Strategic Development Plan II (NSHDP II). The Nigeria GFF country platform organized a consultative workshop (9/28-29), the first in a series of iterative consultative meetings, which will lead to developing the Nigeria GFF RMNCAH investment case. This recent meeting took advantage of the UNFPA ED and the DfID Permanent Secretary's visit to Abuja. The Government of Nigeria plans to complete the development of the Investment Case according to an accelerated timetable, ideally before the end of the calendar year. The team is discussing the possibility of a GFF mission to Abuja in the second week of November 2016 in support of the accelerated process for the IC and HFS.
 - Complementary Financing: As Nigeria is still at the early stages of the GFF process, the definition of its complementary financing approach is ongoing. The World Bank provided considerable financing (US\$500 million) to support the Saving One Million Lives initiative. In addition, at the request of the Government of Nigeria, a rapid deployment of US\$20 million GFF Trust Fund resources was made to the World Bank investment (US\$125m IDA) for five conflict-affected States in northern Nigeria. This project was approved by the Executive Board in early June 2016.
- Health Financing Strategy: Nigeria is currently developing a health financing strategy in tandem with the operationalization of the National Health Act (NHAct). The NHAct mobilizes domestic resources through the Basic Healthcare Provision Fund of the National Health Act (BHCPF); at the

last National Council on Health meeting in September, the guidelines for the BHCPF were approved. It emphasizes a benefits package which focuses on mothers and children with a results focus that harnesses the potential for small scale private providers to deliver services.

SENEGAL

Although still at the early stages of the GFF process, Senegal has moved ahead following a launch event which brought the government, partners, and civil society together in February 2016. An early June mission worked with the technical groups that are leading the preparation of the Investment Case and health financing strategy to identify the necessary analytical work and technical assistance requirements.

- **Country Platform:** The country platform builds on existing coordination structures, with an RNMCAH platform created at the end of April. In addition, the Government has expressed interest in appointing a GFF focal point to be located in the MOH in the near future.
- Investment Case:
 - Highlights: The Investment Case will build on existing strategies, which are currently being updated. These include an emergency plan on Maternal, newborn, Child and Adolescent Health; a nutrition strategy and an integrated child health strategy. A workshop took place in Dakar in October with key stakeholders to launch the work on the investment case and provide any clarifications related to the process. During the workshop the inclusion of the private sector in the health system was discussed at length and development partners welcomed the development of the investment case.
 - Complementary Financing: Some partners, including Gavi, the Global Fund, JICA, UNICEF, USAID, WHO and the World Bank have been involved from the onset. It is however too early to determine the full scope of complementary financing. World Bank/GFF Trust Fund financing are being finalized and will likely include a US\$15 million allocation from the GFF Trust Fund.
- Health Financing Strategy: The health financing strategy will integrate the universal health insurance program (Couverture Maladie Universelle) which is currently under development. A large workshop to discuss the development of the Health Financing Strategy was held in October and the work of developing the strategy has now started.

TANZANIA

Tanzania was one of the four frontrunners and was the first GFF country to begin implementation, with support from IDA and the GFF Trust Fund approved in mid-2015. The country-led decision to adopt the One Plan II as its Investment Case made it possible for the country to move faster on the GFF process.

 Country Platform: Tanzania is using the Sector Wide Approach health sector coordination mechanism as the GFF country platform. This platform is led by the government and includes a wide variety of stakeholders such as technical UN Agencies, financiers, multilateral institutions, civil society and private sector. It has technical sub-groups including on RMNCH and on health financing, and these groups have been overseeing the work in their respective areas.

Investment Case:

 Highlights: When the country joined the GFF process, it was already in the process of developing the "One Plan II", which was used as the Investment Case. Additional discussions on strengthening the CRVS system are ongoing with WHO, UNICEF, and other partners; the budget has been revised and a CRVS investment case is being prepared. A UNICEF/Canada pilot focusing on birth registration (only) was rolled out to two additional regions in August 2016.

- Intended results (by 2020):

- Maternal mortality from 432/100,000 to 292/100,000 live births
- Neonatal mortality from 21 to 16 per 1,000 live births
- Infant mortality from 45 to 25 per 1,000 live births
- Under 5 mortality from 54 to 40 per 1000 live births
- Complementary Financing: A number of donors have committed to supporting the One Plan II. The US Government is financing a trust fund based at the World Bank that is providing US\$40 million to RMNCAH, while the Power of Nutrition trust fund is contributing US\$20 million. The IDA financing totals US\$200 million, to which is linked a GFF Trust Fund grant of US\$40 million. This was approved by World Bank Executive Directors in May 2016, and implementation has begun.
- Health Financing Strategy: The health financing strategy was drafted with consultations with key stakeholders, starting in 2012. A Social Health Insurance Act that is aligned with the health financing strategy is being drafted. Both the health financing strategy and the Act are expected to be submitted for parliamentary approval by February 2017. The health financing strategy envisages moving to a single payer system. The strategy emphasizes the creation of a fiscal space through efficiency gains; partner alignment around prioritized investments; leveraging private sector resources; and expansion of performance-based financing to enhance quality, cost-effectiveness and sustainability.

UGANDA

Uganda was among the second set of GFF countries and began work on the GFF toward the end of 2015.

- **Country Platform:** Uganda has been using an existing health sector coordination mechanism for the GFF process.
- Investment Case:
 - Highlights: Uganda has developed a "Sharpened RMNCAH Plan" as its Investment Case. The document is nearly finalized, but there are challenges because of poorly aligned costing and resource mapping. The current political transition has also slowed the finalization process. The Sharpened Plan has five strategic shifts: rolling out a core package of evidence-based high-impact solutions; increasing access for high-burden populations by promoting a set of service delivery mechanisms that operate synergistically; geographical focusing/sequencing; addressing the broader multi-sectoral context with a specific focus on adolescent health; and ensuring mutual accountability for RMNCAH outcomes. The document includes health systems strengthening and capacity building required to successfully deliver services for women and children.

- Intended results (by 2020):

- Maternal mortality ratio from 360 per 100,000 live births to less than 320 per 100,000 live births;
- Under 5 mortality rate from 69 per 1,000 live births to less than 51 per 1,000 live births;
- Infant mortality rate from 54 per 1,000 live births to less than 44 per 1,000 live births;
- Neonatal mortality rate from 23 per 1,000 live births to less than 16 per 1,000 live births teenage pregnancy rate from 24% to less than 14%.
- Complementary Financing: Discussions are still underway around complementary financing, including with Gavi (which has a health systems strengthening grant under preparation), DfID, SIDA, and the US government. In an interesting example of complementary financing, Merck for Mothers is supporting the design of a public-private solution to decongest Kampala's health facilities through the GFF, with a workshop on public-private approaches planned in October. An IDA project (US\$110 million) with a linked GFF Trust Fund grant (US\$30 million) prepared based on the draft "Sharpened Plan" was approved by the World Bank's Board of Executive Directors in in July 2016.
- Health Financing Strategy: The health financing strategy has been approved by MOH senior management, and is awaiting review by the Cabinet. The strategy addresses resource mobilization, pooling and strategic purchasing, among other issues.

VIETNAM

The GFF Trust Fund Committee allocated resources to Vietnam as a new GFF country in July 2016. As it transitions to middle income status, the trust fund resources offer a compelling opportunity to support Vietnam to prioritize health funding with a focus on RMNCAH. The US\$15 million allocation from the GFF Trust Fund will support the buy-down of a US\$100 million IBRD loan to more favorable terms.

The funds will be provided upon achievement of defined performance targets to address the continued challenges of reaching all communities, particularly the poor and ethnic minority groups, with maternal and child health services. The IBRD loan will support Vietnam's National Target Program on New Rural Development (NTP-NRD) through a program-for-results instrument, focusing on the most disadvantaged areas in the country. The NTP program has two health indicators (health insurance coverage; achieving benchmarks for the Commune Health System) and potentially an additional one for malnutrition rates. The proposed Board date for the project is in August 2017.

The upcoming transition of Vietnam to middle income status provides a good opportunity to work on the longer term financing agenda. Increasing efficiency in health spending and ensuring that vertical programs, currently often funded by donors, are integrated into the health financing system are two emerging priorities.

The Vietnam GFF model is likely to look different from other countries given the relatively unimportant role that donors are playing in the health sector (total ODA is only 1.4% of the health budget in Vietnam).

NEW COUNTRIES ANNOUNCED AT THE UNITED NATIONS GENERAL ASSEMBLY

The Trust Fund Committee allocated a total of US\$35 million to Guatemala, Guinea, Myanmar and Sierra Leone, having identified these countries as strong learning opportunities as a prelude to a significant scale up.

- In Guatemala, trust fund resources will be used to buy down IBRD financing to more concessional rates to support the expansion of nutrition services.
- Guinea has been identified in the discussions at the second Investors Group as a country in which disproportionately small amounts of financing (domestic and external) is being directed at reproductive, maternal, newborn, child, and adolescent health, so the GFF Trust Fund investment there will seek to ensure adequate and sustainable financing for RMNCAH.
- Myanmar has recently experienced a significant political transition and is grappling with largescale transformations of its systems, accomplished by a significant influx of new financing, in which setting the GFF can support the government to ensure that these new resources are used in a complementary manner to address the highest-priority issues.
- In Sierra Leone, a strong partnership exists between the government and the H6 organizations, which wrote the GFF Secretariat expressing their desire to participate in the GFF, which lays the foundation for an exciting collaboration in a country recovering from the devastation of the Ebola epidemic, and facing some of the highest RMNCAH indicators in the world.



www.globalfinancingfacility.org

COUNTRY-POWERED INVESTMENTS FOR EVERY WOMAN, EVERY CHILD.

Portfolio update





FOURTH INVESTORS GROUP MEETING

3 November, Dar es Salaam

Progress on key GFF processes



- Finalized: Cameroon, Ethiopia (*national strategy*), Kenya, Liberia, Tanzania (*national strategy*)
- Nearly finalized: Bangladesh (*national strategy*), DRC, Uganda

Health financing

- Strategies awaiting approval: Ethiopia, Kenya, Tanzania, Uganda
- Strategies under development: Cameroon, DRC, Liberia, Mozambique, Senegal
- Focus on implementation of reforms: Bangladesh, Vietnam

IDA/GFF Trust Fund financing Approved: Cameroon, DRC, Kenya, Nigeria (emergency support to northeastern states), Tanzania, Uganda

Recent developments and emerging trends

Shift to implementation

- Implementation beginning in a number of countries
- Tanzania and Kenya pioneers
 - Key question: how to maintain momentum behind coordinated approach

Increasing use of multisectoral approaches

- Education (e.g., PBF pilot in Cameroon, adolescent sexual and reproductive health in Bangladesh, Kenya, Liberia, and Uganda)
- Nutrition (e.g., household food security in Kenya, community-based and mobile delivery in Cameroon, Liberia, and Nigeria)
- Water and sanitation (e.g., hygiene promotion and latrines in DRC)
- Social protection (e.g., cash transfer for adolescent girls in Cameroon)
- Climate change (e.g., exploratory efforts in Bangladesh)

Increasing engagement of private sector

 Work at national level increasing in Cameroon, Kenya, Senegal, and Uganda (*details covered in private sector session*)

New countries

Process just beginning in Guatemala, Guinea, Myanmar, Sierra Leone, and Vietnam

Investment Cases: lessons learned and challenges

Overall, quality of Investment Cases is improving over time

Process

- Strong **government leadership** is key, with clear accountability at appropriately senior level
- Developing a **roadmap** at outset is important to orient all partners
- Different national contexts require different models
- Importance of developing a shared vision at outset
 - Grounding work in **results** to be achieved is essential
- Mental model of "laundry lists" with large gaps is common prioritization most difficult part of process (requires changing mindsets)
- Emphasis on looking at data and addressing underinvestment has worked
 historically neglected areas included in most Investment Cases
- Focus on **equity** has been highly productive
 - Geographical focus has emerged as key way to prioritize
- Some **innovations** but not systematically focused on
- Mixed health systems thinking is not the norm

Technical content

Complementary financing for Investment Cases: lessons learned and challenges

Overall, robust engagement by financiers at national level \rightarrow 3+ financiers supporting Investment Cases in almost all countries

- Key lessons:
 - Involving financiers from outset → greater ownership → greater likelihood of basing financing on Investment Case priorities
 - Cannot only be driven by MOH technical staff need buy-in of MOF and planning/budgeting side of MOH to incorporate into budgets/MTEFs
 - Links between Investment Cases and World Bank projects are critical but timing can be tricky
- Different models for complementary financing have emerged:
 - Basing new bi-/multilateral programs on Investment Case priorities (or realigning existing programs)
 - Establishing trust funds at the World Bank to finance priorities
 - Providing dedicated resources for technical assistance
- Proven to be a good way to engage financiers not on the Investors Group
- Budgeting and resource mapping have proven challenging:
 - Budgeting overly reliant on external support and tools that are not always wellsuited to approach
 - Some partners unable/unwilling to provide information for resource mapping

Health financing: lessons learned and challenges

Overall, GFF has given significant boost to process in many countries, but change is political and takes time

- Very different starting points among countries
 - Some countries have had strategies for years and/or have sense of intended reforms, others have never had strategies/have limited capacity
- Shift underway from emphasizing strategy to implementation of reforms
 - Development of a strategy is **not the end-point**: need to be clear on intended results and then determine best way to achieve them – not always a strategy (typically complicated, time-consuming, political process)
- Good analytical work does not automatically lead to reforms
 - Political economy considerations are key
- Engagement of ministries of finance has been uneven
- GFF can **reenergize agenda** with intense support: financing, TA, peer-topeer learning, capacity building, convening partners

Technical content

- Mix of focus on three health financing functions: domestic resource mobilization, pooling, and purchasing
- Efficiency featuring in most countries, both technical (particularly public financial management reforms) and allocative (e.g., distribution between regions/counties)

Process





www.globalfinancingfacility.org

GFF@worldbank.org







RMNCAH in Tanzania



GFF Investors Group Meeting Dar es Salaam

11/15/2016

Outline

A. RMNCAH in Tanzania

B. Government's Approach to RMNCAH

1. Align all Partners behind a Single Plan

2. Focus on Results

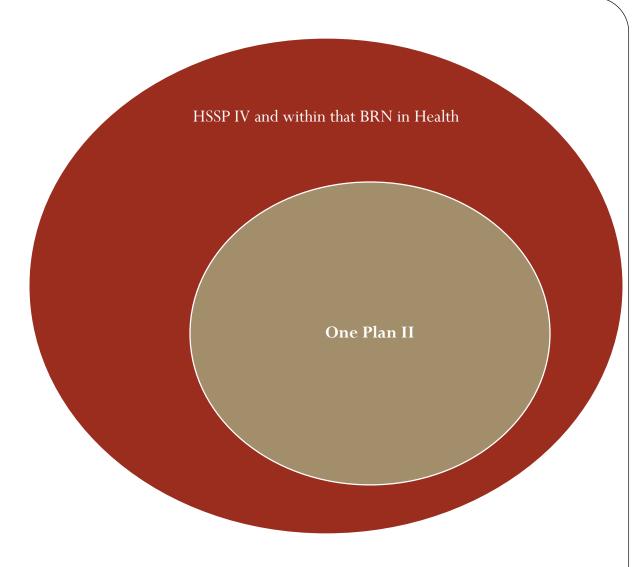
3. Use an Integrated Service Delivery approach to RMNCAH

- **C.** RMNCAH Coordination Platform in Tanzania
- D. GFFTrust Fund in Tanzania (together with World Bank, USAID and Power of Nutrition)
- **E.** Selected Interventions showing Focus on Results for RMNCAH
 - 1. Star Rating Assessment
 - 2. LGA Scorecards
 - 3. Results-based Financing
- F. Health Financing

RMNCAH in Tanzania

Policy Environment

- Health Policy (2007) has prioritized RMNCH services
- RMNCAH services have been built on the HSSP IV which implements Health Policy
- Through One Plan II which was launched
 2016 along with the RMNCAH Score Card



Overview of One Plan II

MISSION: To promote, facilitate, and support in an integrated manner, the provision of comprehensive, high impact, and cost effective RMNCAH and nutrition services, along the continuum of care to men, women, newborns, children, and adolescents

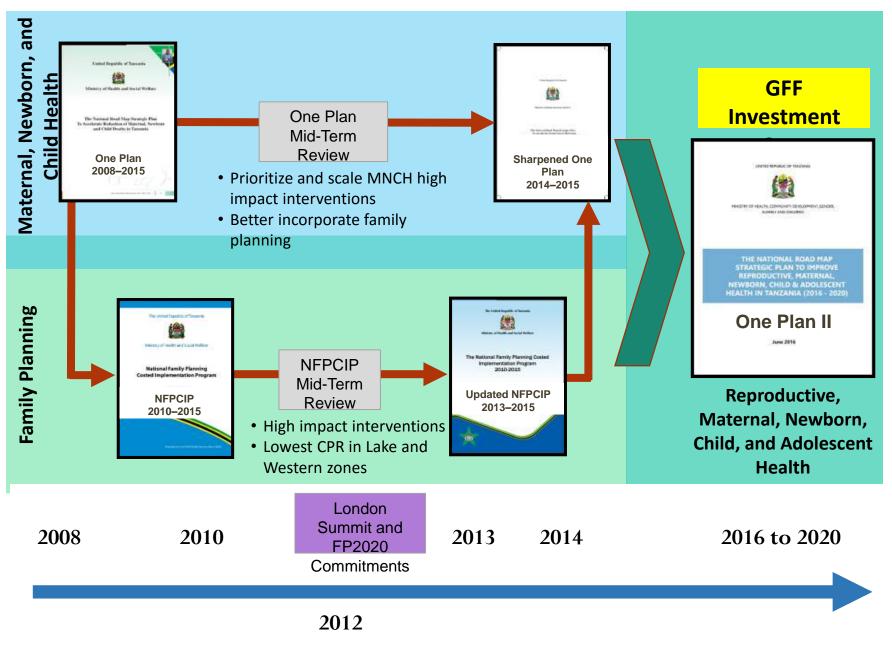
KEY STRATEGIES:

- Strengthen reproductive, maternal, newborn, child, and adolescent health
- Scale-up the child health program
- Strengthen response to cross-cutting issues, e.g., commodities, community involvement, demand, HMIS

"One Plan II" (2016-2020) launched in June 2016 along with the RMNCAH Score Card Guides the implementation of RMNCAH interventions across all levels of the health system

Key areas of focus:Re-defined FP within the broader RMNCAHcontextCare at birth, Post Partum and PNC (HRH - Skilledhealth care providers)Commodity SecurityPrioritized Adolescent and youth SRH services

LINK OF CIP, ONE PLAN II & GFF



Many RMNCAH challenges are related to Service Delivery



Government's Approach

Align all Partners behind a Single Plan

- All partners are obliged to implement "One Plan II" (2016-2020)
- Through SWAp arrangement
- Planning and Monitoring done by RMNCHTWG
- Constitutes the Investment Case for the Global Financing Facility (GFF) for Tanzania

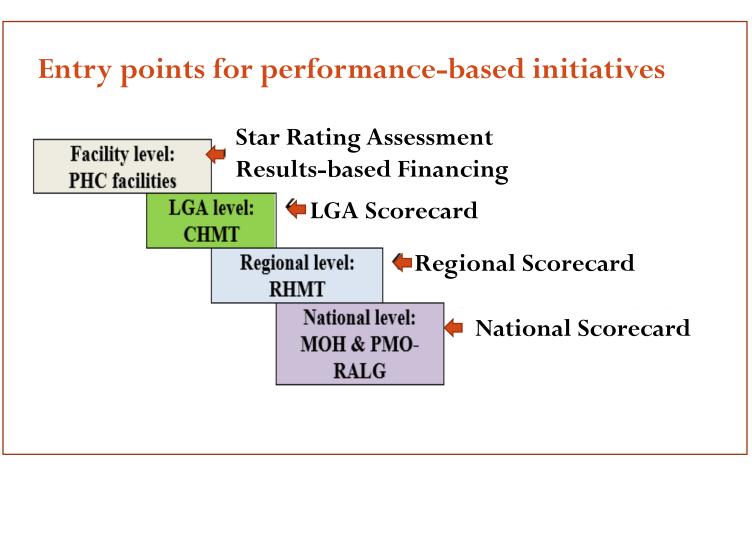
RMNCAH Coordination Platform in Tanzania

Government's Approach Strong Focus on Results

• There have been significant achievements over past decade ...

WHAT WILL DRIVE THE NEXT SET OF GAINS?

- Government increasingly focused on Delivery, Results and getting Value for Money
 Hapa Kazi Tu!
- DPs support to government increasingly results-oriented



Government's Approach

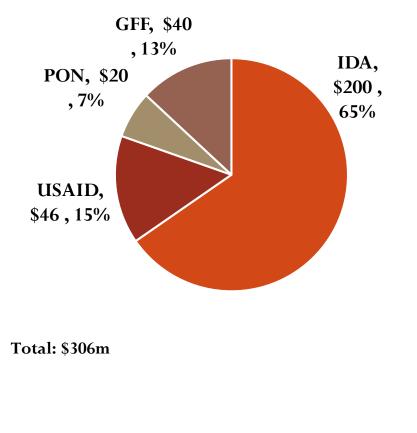
Use an Integrated Service Delivery Approach to RMNCAH

- Performance-based initiatives are all focused on RMNCAH-related indicators or factors affecting RMNCAH service delivery:
- Examples;
 - 1. Star Rating Assessment
 - 2. LGA Scorecards
 - 3. Results-Based Financing (RBF)

What does the GFFTrust Fund Finance in Tanzania?

- PHC for Results (PHC4R) Program is the Bank's program of support 2015-2020 (\$306m)
- Focus of the PHC4R is on RMNCH including nutrition and Civil Registration & Vital Statistics
- No earmarking for specific interventions because of the financing instrument (Program for Results -P4R)
- Main channels:
 - Health Basket Fund (30%)
 - Results-based Financing (33%)
- The rest: Institutional and Capacity Strengthening in support of Service Delivery Capacity

GFF Trust Fund Finances 13% of the Bank's "PHC for Results Program"



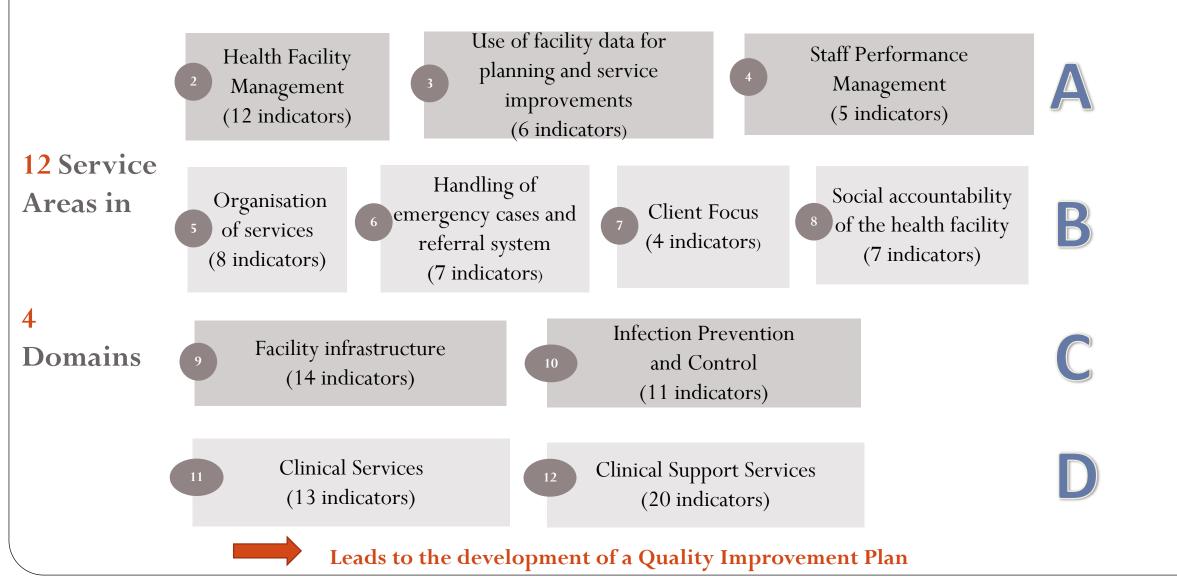
Selected Interventions and Achievements in Service Delivery

Star Rating Assessment
 Results-based Financing
 LGA Scorecards

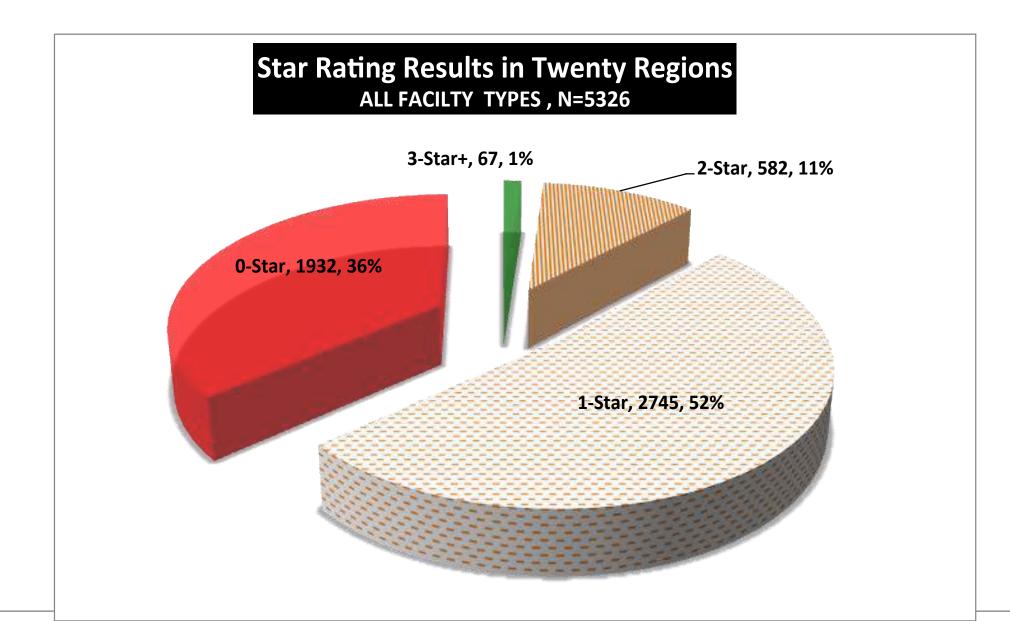
Selected Interventions and Achievements in Service Delivery

Star Rating Assessment
 Results-based Financing
 LGA Scorecards

Star Rating Assessment



Star Rating Assessment



Star Rating Assessment

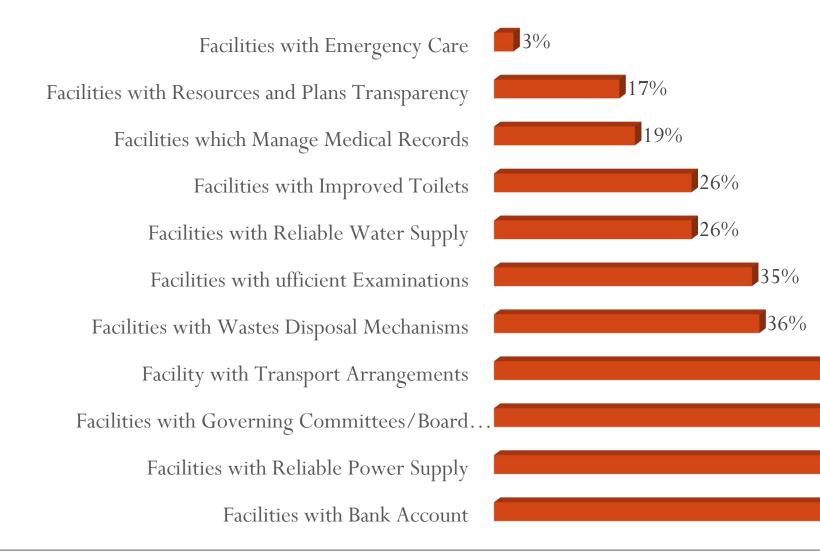
Comparing Facilities Characteristics

46%

51%

55%

59%



Star Rating Assessment Small repairs of infrastructure, waste management etc.



Key Selected Interventions and Achievements in Service Delivery

1. Star Rating Assessment 2. LGA Scorecards

3. Results-based Financing

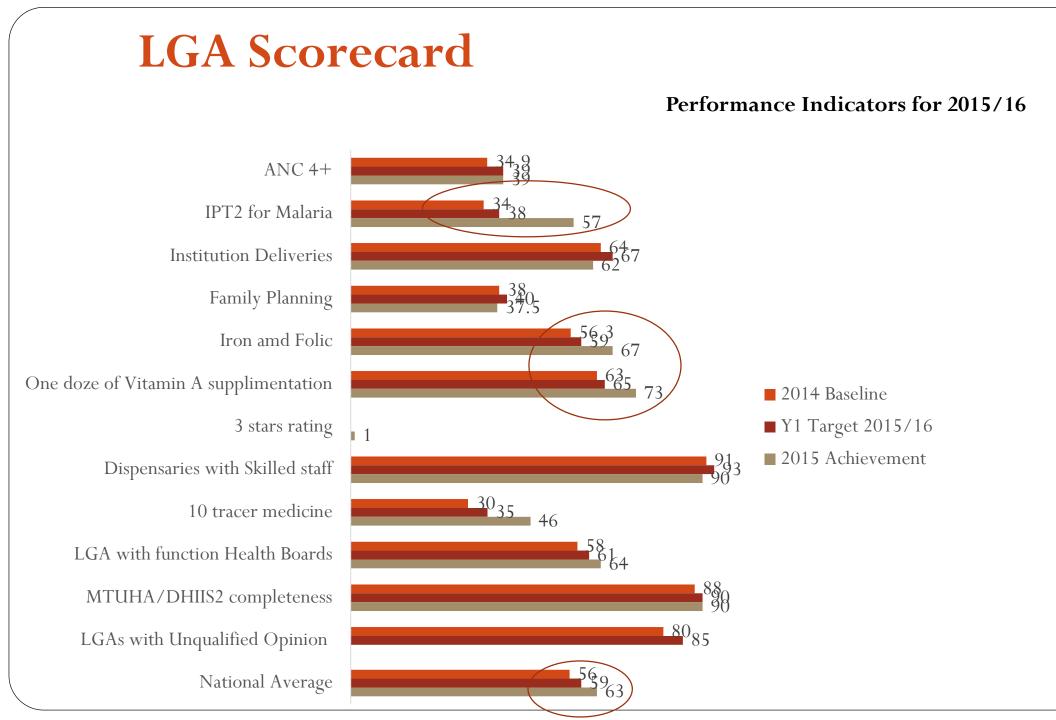
11/15/2016

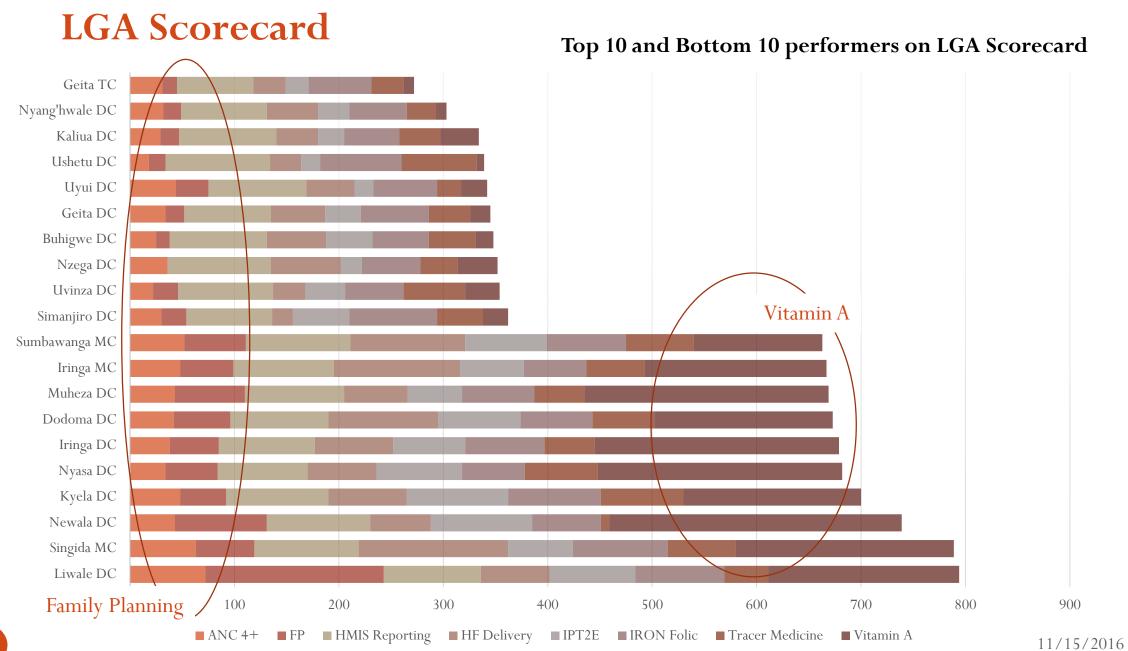
LGA Scorecard

- Spur action by Facilities and LGAs
- Data driven accountability
- Health Basket Fund will continue as a funding modality for HSSP IV 6 quantity 2015 – 2020
- HBF now includes **performance component**
- Third-party verification of (a sample of) reported scorecard results to ensure accuracy and mitigate against incentive to falsify data

	LGA Scorecard
1	4+ antenatal care visits (ANC4)
2	Mothers receiving 2 doses of IPT during pregnancy
3	Institutional deliveries
4	Modern family planning use
5	Pregnant women receiving Iron and Folate tablets
6	Vitamin A supplementation (children aged 12-59 months)
7	PHC facilities with "3 stars" rating or higher
8	PHC facilities with at least one skilled staff
9	Availability of 10 tracer medicines
10	LGAs with functional Council Health Service Boards
11	Completeness of quarterly DHIS 2 entry by LGA
12	Percentage of LGAs with unqualified opinion in the external audit report

* HBF DPs : Canada, Denmark, Ireland, South Korea, Switzerland, UNICEF, UNFPA, World Bank.





Key Selected Interventions and Achievements in Service Delivery 1. Star Rating Assessment 2. LGA Scorecards 3. Results-B ased Financing

Results-Based Financing

- Provides direct funding to Facilities
- Focus on primary health care (dispensaries, health centers and hospitals at district level
- Quantity and Quality indicators
 - 17 quantity indicators for HC and dispensary (14 for health facility & 3 for Community Health Workers).
 - Quantity earning is adjusted by the Quality score
 - Hospital quality indicators only
 - Focus on immediate needs, which will change over time as the needs change
 - Payment to be made after internal verification

Category	Quantity Indicator
OPD	Number of new Outpatient consultations
OPD	Number of TASAF beneficiaries seeking outpatient care
ANC	Number of first antenatal visits, with gestation age < 12 weeks
ANC	Number of pregnant women attending ANC at least 4 times during pregnancy
ANC; Malaria	Number of pregnant women receiving two doses of intermittent presumptive Therapy of Malaria (IPT2)
PMTCT; HIV/AIDS	Number of HIV positive (infected) pregnant women receiving ARVs
Labor/Delivery	Number of institutional deliveries
Postnatal Care	Number of mothers receiving Post Natal Services within 3-7 days after delivery
Immunization	Number of children under one year immunized against measles
Child Health	Number of children underfive yrs receiving mebendazole for deworming
ANC	Number of pregnant women receiving mebendazole for de-worming
Nutrition	Number of under five receiving Vit. A supplements
Family Planning	Number of new users on modern Family Planning methods
HIV/AIDS	Number of clients initiated by health care provider to counsel and Test for HIV (PITC)
HIV/AIDS	Number of HIV exposed infants receiving ARVs
ТВ	Number of TB suspect referred (already screened)*
Community	Number of non-institutional maternal and perinatal deaths reported within 24 hours by TBA or CHW
Community	Number of pregnant women escorted for delivery at a health facility by known or registered TBA or CHW
Community	Number of household visits by CHW

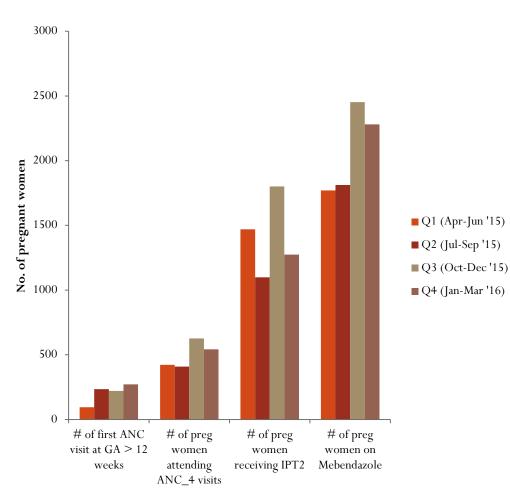
Quality Indicator Hygiene and sanitation Privacy Water supply Waste management ANC Labor ward Post-natal care Maternal death audits Perinatal death audits Family planning Immunization Nutrition for under-five children Pharmacy Community Community health fund Facility profile reports (inc. rbf) Transparency Client Satisfaction

Results-based Financing Use of Start-up funds



Kishapu District, Shinyanga Region

ANC Indicators

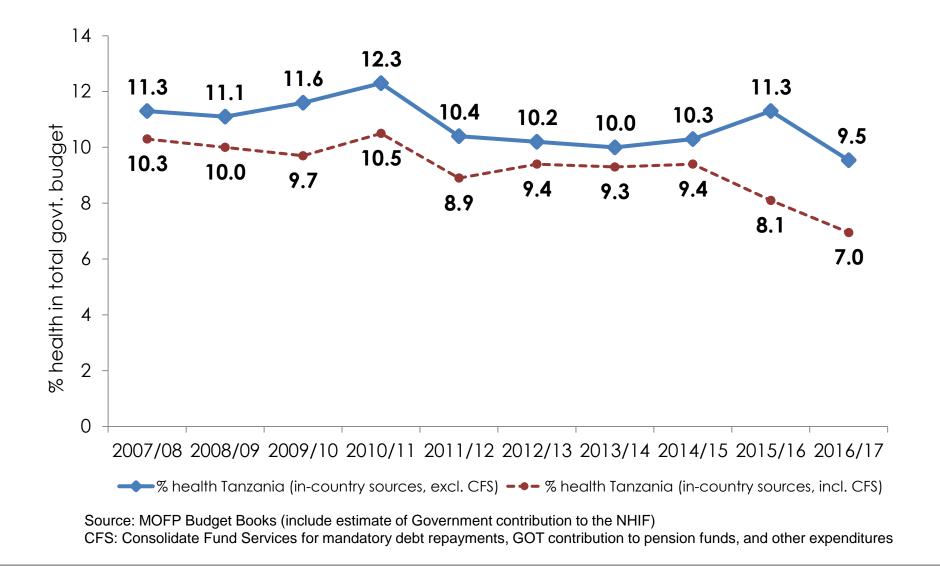


2000 1800 1600 1400 1200 No. of women ■ Q1 (Apr-Jun '15) 1000 ■ Q2 (Jul-Sep '15) ■ Q3 (Oct-Dec '15) 800 ■ Q4 (Jan-Mar '16) 600 400 200 0 # of institutional deliveries # of mothers receiving post natal services

MN Indicators

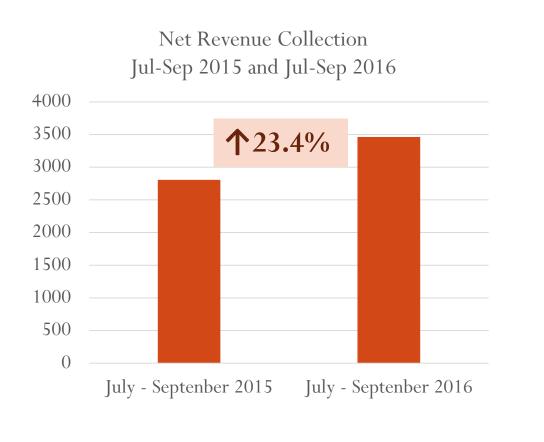
Health Financing in Tanzania

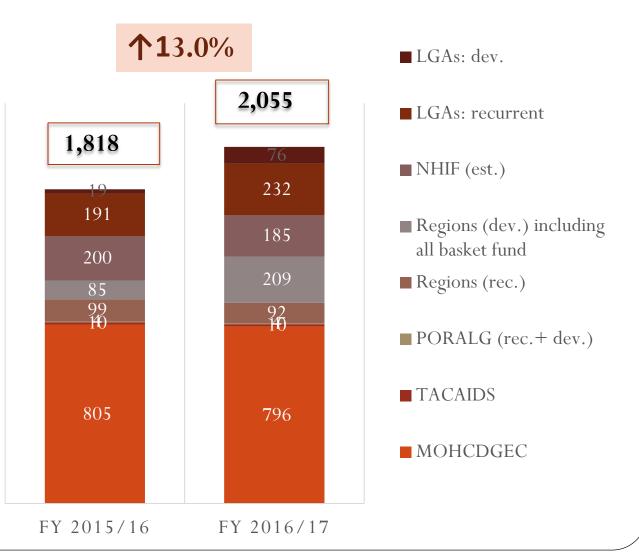
Percentage of Tanzania's National Budget Allocation to Health 2007-2017



Slight Increase in Total Allocation to Health due to increase in government revenue

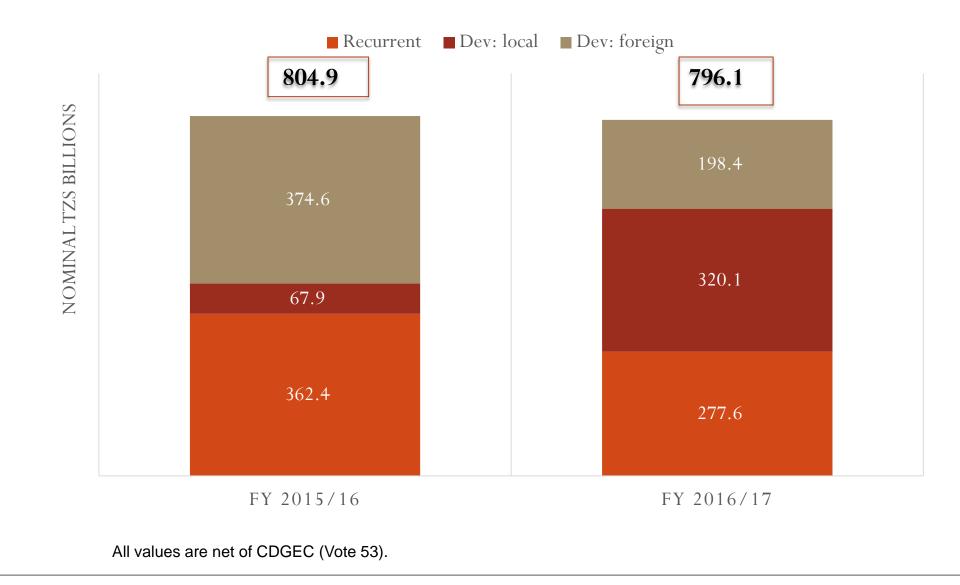
NOMINAL TZS BILLIONS





Total Allocation to Health

Disaggregation of MOHCDGEC Budget Votes (*Health only*)



Tanzanian Health Financing Strategy (2016 – 2025)

Vision

Mission

Goal

• Social Health Protection available to all Tanzanian residents without financial barriers at the time of need

• Put in place a Single National Health Insurance program that will enable all Tanzanian residents to access appropriate and affordable health care at the time of need

• To enable equitable access to affordable and cost-effective quality care and financial protection in case of ill health, according to a nationally defined minimum benefit package

Tanzanian Health Financing Strategy (2016 – 2025)

- Approval process slightly delayed by new leadership including many parliamentarians
- Social Health Insurance Actuarial study is being completed as required per the regulator for any insurance-related reforms
- Next step is to table Cabinet Paper, Draft Bill by February 2017



HEALTH FINANCING: DOMESTIC RESOURCE MOBILIZATION

OVERVIEW

Health financing is a recurrent item on the agenda of the GFF Investors Group. At the second Investors Group meeting, the financing discussion focused on issues related to health financing transitions and on trends in development assistance for health and for RMNCAH, while at the third Investors Group meeting a number of partners shared their experiences with providing complementary financing.

This time the focus is on domestic resource mobilization (DRM). Section 1 of the paper will briefly summarize the objectives of DRM as described in the Business Plan for the GFF. Section 2 then turns towards a review of where the 16 GFF countries stand in terms of Smart, Scaled and Sustainable financing and in terms of RMNCAH spending. Section 3 makes some projections about the feasibility of raising additional domestic funds for health in these countries and the final section reflects on the implications of the analysis for the health financing work under the GFF drawing on the experience to date in GFF countries.

The paper draws on two sources of publicly available data to explore these questions. Data on Gross Domestic Product (GDP) per capita, an indicator of national income, and economic growth rates are taken from the WBG's World Development Indicators. Health expenditure data are taken from the Global Health Expenditure database of WHO, numbers that are also reported in World Development Indicators.

ACTION REQUESTED

This paper is for information only.

SMART, SCALED AND SUSTAINABLE FINANCING

The Business Plan of the GFF estimated that the gap of \$33.3 billion between resource needs and availability for RMNCAH in all GFF eligible countries in 2015 could be reduced to only \$7.4 billion by 2030 through a combination of domestic economic growth (which would automatically increase the resources available for health even without any special attention by governments to DRM provided that governments maintain their current share of the budget allocated to the health sector), increased domestic resource mobilization beyond that linked to economic growth, increased development assistance for health and improved efficiency in health expenditure. Actions by GFF country governments to generate domestic resources beyond those associated with economic growth, and to improve efficiency in resource use, were seen as critical to the success of the GFF strategy, contributing to the production of smart, scaled and sustainable financing as key drivers of the RMNCAH results agenda (Box 1).

Box 1: Smart, Scaled and Sustainable Financing

- Smart financing: interventions proven to have a high impact are prioritized and delivered in an efficient and results-focused way, while seeking to reduce inequities in coverage.
- Scaled financing: mobilizing the additional resources necessary from domestic and international (public and private) sources, while reducing reliance on direct out-of-pocket payments (OOPs).
- Sustainable financing: ensuring that health & RMNCAH funding benefits from economic growth, and addresses the challenges faced by countries transitioning from low- to middleincome status.

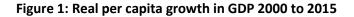
Source: GFF Business Plan

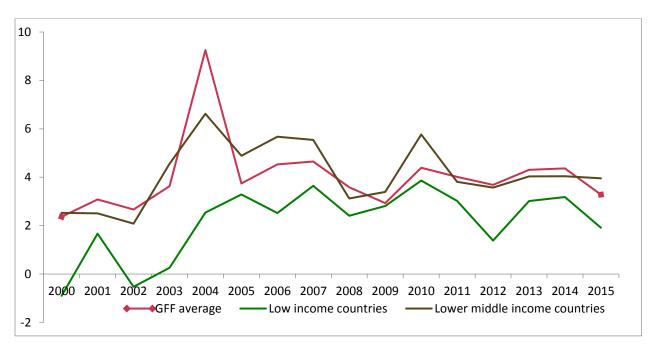
HEALTH FINANCING IN THE GFF COUNTRIES

Relatively low GDPs per capita but strong economic growth until recently. Eight of the current GFF countries (DRC, Ethiopia, Guinea, Liberia, Mozambique, Sierra Leone, Tanzania, Uganda) are classified as low-income in the World Bank Group (WBG) classification, and the remaining 8 are lower-middle income (Bangladesh, Cameroon, Guatemala, Kenya, Myanmar, Nigeria, Senegal, Vietnam). GDP per capita in 2015 current prices) ranged from \$456 in DRC to \$3904 in Guatemala.¹ The countries funded by the GFF are, in general, poorer than countries in their respective income groupings – low and lower-middle income.

However, real (inflation adjusted) economic growth has been relatively strong in the GFF countries as a group since 2000, seemingly offering good potential for DRM. Growth in the GFF countries exceeded that in the low-income countries in all years, and was on a par with that in the lower-middle income countries.

¹ Source: WBG, World Development Indicators.





Source: World Development Indicators, World Bank Group

The average series presented in many of the figures in this paper hide considerable heterogeneity across countries. Moreover, recent falls in oil and commodity prices have taken their toll on both economic growth and government revenues (discussed subsequently) in a number of the GFF countries, something that is shown in Figure 1 with the decline in the rate of economic growth in 2015. Nigeria, for example, actually suffered a decrease in GDP per capita in 2015, following a decade of high economic growth (averaging 6% per year) linked to the decline in oil prices. Sierra Leone also experienced a dramatic decline in GDP per capita of 22% in 2015 due to the Ebola crisis and a decline in iron ore prices. Guinea also suffered a decline in GDP per capita in 2015, although of a much smaller magnitude compared to Sierra Leone (-2.54%). All the countries where natural resources compose a substantial part of GDP have also suffered declines in government revenues, something that is taken up in a later section.

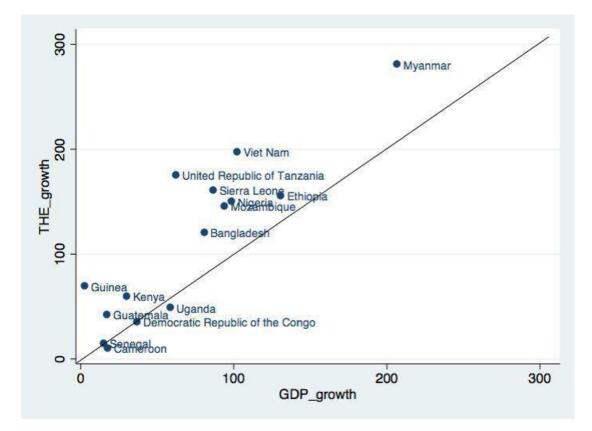
National health expenditures per capita have grown rapidly, but remain low in most GFF countries. The most recent year for which data on total health expenditures is available is 2014.² Total health expenditure per capita also grew solidly from 2000 to 2014 in the GFF countries as a group, reaching \$67.6 per capita on average (weighted, current prices) in 2014. It ranged from \$19 in DRC to \$233 in Guatemala. In 12 of the 16 GFF countries, health expenditures grew noticeably more rapidly than GDP (Figure 2). On the other hand, it grew more slowly than GDP in Cameroon and Uganda, and at the same rate in the Democratic Republic of Congo (DRC) and in Senegal.

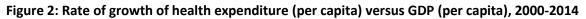
Despite this growth, in 12 GFF countries health spending was still too low to allow coverage for the entire

² As stated in the overview, the health expenditure data used in this paper are taken from the Global Health Expenditure database of WHO. World Development Indicators published by the WBG report the same numbers, although there can be some differences because WHO updates the database in real time whereas the WBG uploads new data once a year.

population with even a basic set of needed health services, estimated to cost \$89 per capita for 2014.³ Although four countries (Guatemala, Nigeria, Sierra Leone and Vietnam) spent more than \$89 per capita, a high proportion of this came from direct out-of-pocket spending paid by households at the time they need services, a requirement that prevents the poor and most vulnerable people from accessing needed services (see subsequent sections). Moreover, these countries continue to struggle to improve the range and quality of health services available to their populations, improve equity and increase or maintain levels of financial protection.

Data are not yet available on total health spending for 2015, but a number of countries report apparent declines in government budgets for health as a result of the declining economic output described above.⁴ This makes it more difficult for ministries of health to argue for more money for health and for RMNCAH in the current economic climate in many of the GFF countries.





Source: WHO Global Health Expenditure Database.

Note: Liberia is an outlier that does not fit easily on the graph. It had negative economic growth over the period but very high increases in health expenditure due in part to recent increases in development assistance for health.

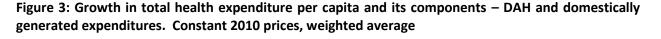
https://www.chathamhouse.org/sites/files/chathamhouse/home/chatham/public_html/sites/default/files/20140300DomesticFundingHealthMcIntyreMeheus.pdf McIntyre and Meheus estimates were for 2012 and we have inflated them to 2014 prices.

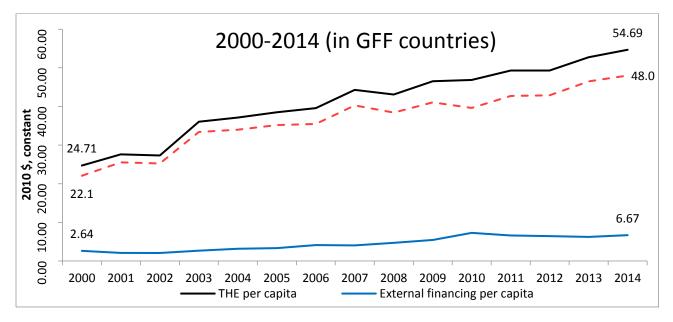
³McIntyre D & F Meheus 2014. "Domestic funding of health and other social services". Chatham House, Centre on Global Health Security, Working Group on Financing, paper 5.

Development assistance for health grew rapidly but domestically sourced funding provided the major part of the increased health expenditures. National health expenditures can be divided into expenditures from external sources (development assistance for health (DAH)) or from domestically generated sources. Here, we explore the extent to which the observed rapid increases in health expenditures in GFF countries was caused more by growth in DAH or in domestically sourced expenditures. In subsequent sections, we consider the components of domestically sourced expenditures.

In 12 of the 16 GFF countries, real (inflation adjusted) development assistance for health (DAH) per capita grew very rapidly from 2000-2014 – by over 100% in the 12, and by more than 400% in 6 of them. However, it grew by only 3% and 43% in Nigeria and Senegal respectively, and fell in both Guatemala and Guinea.

Despite the rapid rises in DAH per capita in most of the GFF countries, the bulk of the increase in country health expenditures was driven by increases in domestic resources taking the GFF countries as a group. Figure 3 reports the growth in total health expenditures, expenditures financed from DAH, and expenditures financed from domestic sources (total minus DAH). All figures are in per capita terms, inflation adjusted (2010 prices), and the weighted average of the GFF countries is reported. Almost 88% of the weighted total health expenditure per capita was derived from domestic resources in 2014, only a small decline from 2001 (89.4%) despite the growth in DAH. Although real DAH grew rapidly, it grew from a low base. It provided only \$4.08 of the additional health expenditures, while domestically generated resourced provided an extra \$25.90.

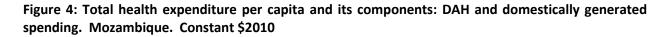


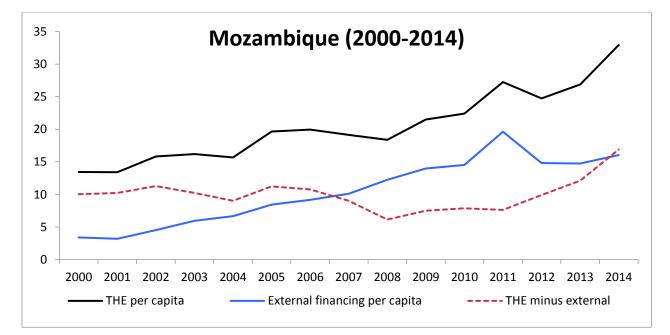


Source: WHO Global Health Expenditure Database

This weighted average again hides considerable heterogeneity across countries. For example, Nigeria, one of the most populous countries (so having a relatively large weight in the reported GFF average), received relatively little DAH compared to the other countries – DAH accounted for only 5% of its national

health spending in 2014 compared to 30% in countries like Ethiopia and Liberia. The relationship between domestic resource mobilization and DAH also varied considerably across countries. An interesting pattern in Mozambique is reported in Figure 4, showing that DRM fell in some years that DAH rose, but rose with increases in DAH in other years. This highlights that the complexity of trends and relationships between the various components of health expenditure can be lost if the focus is only on the start and end year of the analysis.



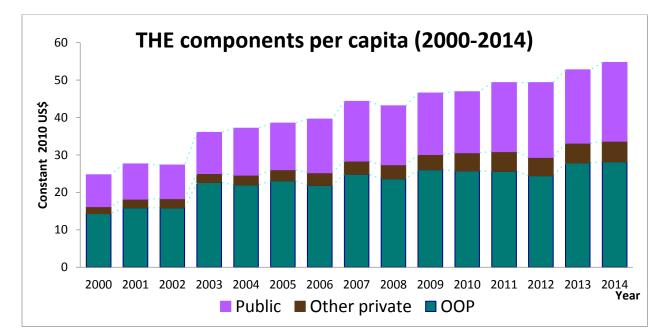


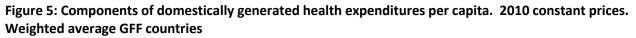
Out-of-pocket payments (OOPs) provide over 50% of total health expenditures. Despite falling as a share of total expenditure, they have risen in per capita terms. Another breakdown available from country health accounts is private versus public expenditures. Private is then divided into OOPs and other private expenditures, while public – called General Government Health Expenditure (GGHE)⁵ - includes expenditure from all compulsory, prepaid sources including the government itself and compulsory health insurance. Mostly, it is not possible to separate out the DAH that flows through GGHE or through private expenditures.

The bulk of spending in the GFF countries as a group continues to come from direct out of pocket health payments (OOPs) made by households to health service providers. These payments not only deter people from obtaining the health services they need but also result in financial catastrophe and impoverishment for many who use services. Although the average share of OOPs in total health spending has fallen since 2000, a good sign, it remains at over 51%. The incidence of severe financial hardship associated with OOPs falls to negligible levels only when the share is lower than about 15-20% - the inverse is that compulsory prepaid and pooled funds need to be around 80% to protect people against financial catastrophe as a result of OOPs.⁶

⁵ This terminology will change when the Global Health Expenditure Database is updated to the new System of Health Accounts methodology shortly (SHA2011). ⁶ WHO, 2000. The World Health Report 2000. Health Systems Performance Assessment. WHO, Geneva, 2000

The rate at which the share of OOPs in total domestic health expenditures has declined has also been slower on average than the increase in total health spending. The result is that per capita out of pocket health payments increased over the period (Figure 5 illustrates). It shows the components of domestically generated health spending, in constant 2010 prices, for the period 2000-2014. The share of public (i.e. compulsory prepaid and pooled) expenditures rose, but the level of real OOPs per capita increased, indicating that households, on average, carry an increasing financing burden in GFF countries.





Not surprisingly, given the considerable variation in health financing strategies followed in many of the GFF countries since 2000, there is again considerable variation in trends in OOPs per capita and the relative share provided by public funds (public fund capture government expenditures plus expenditures from compulsory prepaid and pooled funding sources such as compulsory insurance). Figure 6 illustrates for OOPs per capita in selected GFF countries. Most of the GFF countries show increases in real OOPs per capita over the period, but there are also some complex changes during the period. Uganda, for example, shows a substantial increase in real OOPs per capita from 2003 to 2008, although user fees in public health centres and hospitals were abolished in 2001, but a substantial fall thereafter.

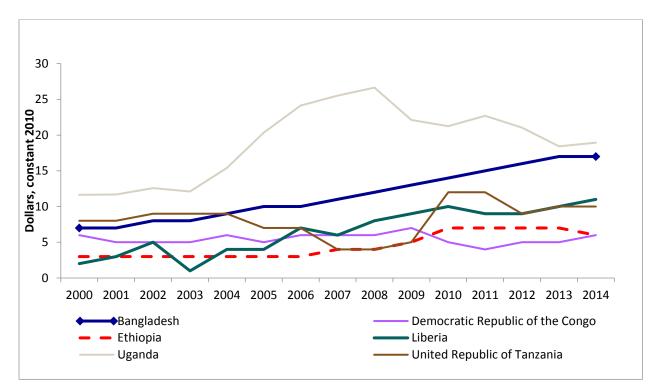


Figure 6: Heterogeneity in real OOPs/capita, selected GFF countries

Box 1: What do we know about RMNCAH expenditures?

Only limited information exists on RMNCAH expenditures in the GFF countries. WHO, in collaboration with partners including those funded by USAID, began to support countries to develop disease specific expenditure accounts using the full distributive matrix as part of the work supported by the Commission on Information and Accountability for Women's and Children's Health. The advantage of using the full distributive matrix for disease accounts is that analysts are forced to ensure that the sum of expenditures across diseases does not exceed total expenditure, a discipline that is not required when disease-specific expenditure estimates are produced in isolation. However, the breakdown for RMNCAH is complicated as it requires disease-specific accounts as well as age-specific accounts.

WHO reports that to date 34 countries (most GFF eligible) have produced disease-specific accounts.⁷ Most of these have reproductive health accounts (RH: including expenditures linked to pregnancy and child birth) and some have child health (CH) accounts. Adolescent health was not included. Of the current GFF countries, data are publicly available for Cameroon, DRC, Ethiopia, Sierra Leone, Tanzania and Uganda for both reproductive health and child health expenditures, and for Liberia on reproductive health. Other countries – e.g. Kenya, Mozambique, Vietnam – have produced disease-specific accounts but they are not yet publicly available. Only a few countries have undertaken multiple exercises which allow an analysis of how these expenditures have changed over time – only DRC and Uganda among the current GFF countries.

⁷ http://apps.who.int/nha/database/DocumentationCentre/Index/en

Across all the countries (GFF and non-GFF) for which data are available, the share of health expenditures allocated to reproductive health ranged from approximately 5% to just over 30%, while for child health the range was from 5% to 40%. Child health expenditures exceeded those on reproductive health in 8 of the 12 countries for which both are available, while in the other 4, reproductive health expenditures are reported to exceed those of child health. Experience, however, suggests that the quality of these data improve over time as country teams get more experience in allocating expenditures by disease – certainly the share of total health expenditures that they are able to allocate to the different diseases increases over time. WHO recently called a meeting with agencies working on health expenditures as part of a process to decide the future of its work in this area, including in disease-specific expenditure tracking.

Source: WHO

Summary: Smart, Scaled and Sustainable Financing. This review of the current status of health financing in the GFF countries is based on publicly available data from national accounts and health accounts. Little can be said from these data about **smart** financing with its efficiency and equity components where more detailed analysis using data from sources such as household surveys and facility surveys is required.

In terms of **scaled** financing, total health expenditures have increased since 2010 in both real and nominal terms. While the rate of increase in DAH exceeded that of domestically sourced health expenditures, the bulk of the increase in spending came from domestic sources. Despite that, in 12 of the 16 countries there are simply insufficient financial resources, from domestic and external sources combined, to assure universal access to even a very minimum set of needed health services at an affordable price. Out of pocket health payments continued to provide the largest share of domestic expenditures although they have been declining as a share of total domestically sourced spending in most countries. On the other hand, per capita OOPs actually rose during the period 2000-2014, suggesting the average financial burden on households has increased. Other sources of private expenditure (e.g. private health insurance, NGOs) remain very small in the GFF countries.

The trends in **sustainable** financing haves been positive to the extent that health expenditures have risen faster than GDP since 2000. Domestically sourced health expenditures have also been rising faster than GDP in most settings. However, the heterogeneity across countries in most of these variables means that the general situation described here might not apply in any given setting, and policy options in health financing need to be tailored to each country.

THE POTENTIAL FOR DOMESTIC RESOURCE MOBILIZATION

The estimates made in this section are based on 2014 data, the latest year for which information on health expenditures is available. Subsequently, the impact of the current slowdown in economic growth will be discussed.

Traditionally, raising additional domestic funding for health (sometimes called increased fiscal space for health) is seen to come from three sources: raising more domestic revenues from which some flows to health; giving more priority to health in the budget; and increased efficiency.⁸ The first two are discussed here, while it has been proposed that efficiency is so important that it should be discussed at the next

⁸ Tandon A. & C. Cashin 2010. "Assessing public expenditure on health from a fiscal space perspective". World Bank Group, Health, Nutrition and Population Working Paper. http://siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Resources/281627-1095698140167/AssesingPublicExpenditureFiscalSpace.pdf

Investor Group meeting. A fourth possibility is also discussed briefly here – improved budget performance.

Raising more domestic revenue can substantially increase health expenditures. Given that increasing OOPs is not desirable in these countries, this section focuses on government revenues. The share of overall government expenditure in GDP for low and lower-middle income countries is shown in Figure 7. Although there is no firm yardstick, many low and middle income countries are able to raise at least 30% of GDP in government revenues, and a number also raise 40% suggesting this target might also be feasible. Interestingly, 12 of the 16 GFF countries fall below the median level of 28.5% for low and lower-middle income countries.

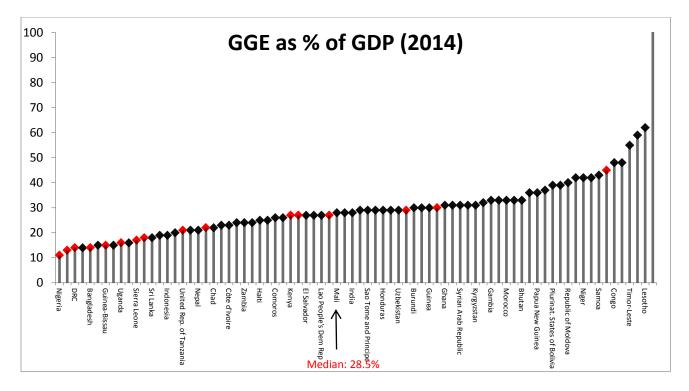
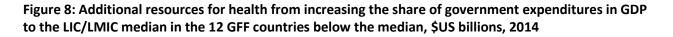
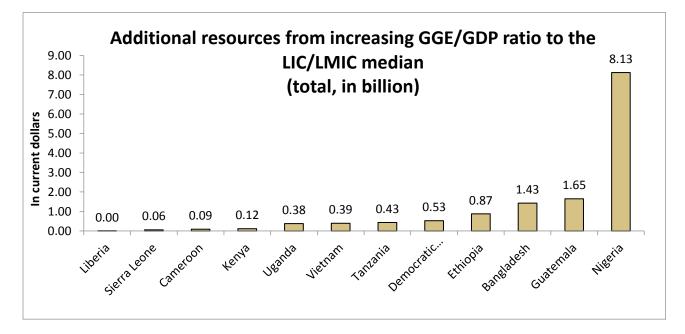


Figure 7: General Government Expenditure (GGE) as a share of GDP, 2014

More domestic resources can be raised through a combination of three options: increasing the efficiency of collection for the current taxes and charges (e.g. reducing tax avoidance or simply collecting more effectively), increasing the tax base (more people or companies must pay taxes or other charges) and introducing additional types of taxes and charges (e.g., value-added taxes, "sin" taxes, natural resource extraction levies, various types of financial transaction levies). Figure 8 reports the results of calculations showing how much additional funding each of the 12 GFF countries below the median could raise for health if they increased revenue mobilization to the median. The assumption here is that each country would allocate the same share of government revenues to health as they do currently, an assumption that is relaxed subsequently.





The 12 countries below the median could raise an additional \$14.1 billion for health between them, although the largest impacts are for Ethiopia, Bangladesh, Guatemala and Nigeria.

Increasing priority to health can also increase health spending, but in most GFF countries this raises less money than the focus on increased government revenues. Here the assumption is that the share of government expenditure in GDP remains as in 2014, but the countries below the median level increase the priority for health in government expenditures to the median. Figure 9 shows interestingly that while 12 of the GFF countries were below the median in terms of the share of government expenditures in GDP, only 7 are below the median in terms of priority for health in overall government expenditures (Cameroon, Bangladesh, Senegal, Nigeria, Mozambique, Guinea, Myanmar).

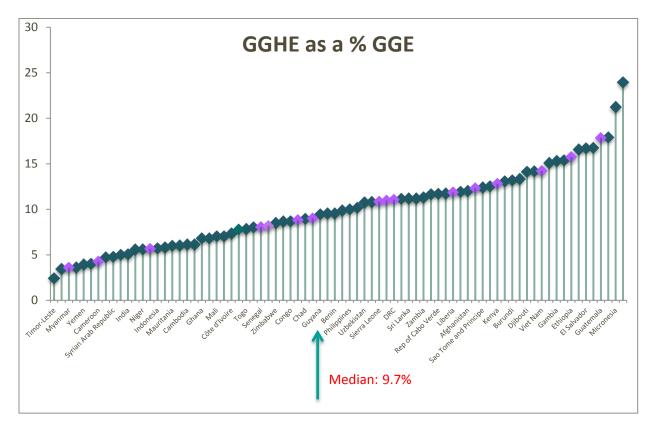
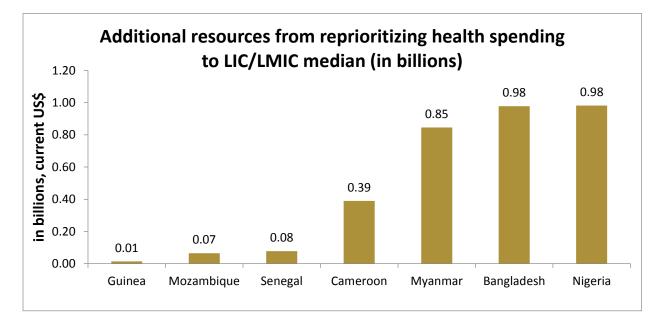


Figure 9: Share of health in overall government expenditures (general government health expenditures (GGHE) as a share of general government expenditures (GGE))

The 7 countries would raise additional \$3.36 billion for health in this manner (Figure 10) with Myanmar, Bangladesh and Nigeria showing the biggest gains.

Figure 10: Additional resources gained by increasing the share of health in total government expenditures to the LIC/LMIC median in GFF countries below the median level, \$US billions, 2014.



Increasing both tax efficiency and the priority given to health together raises more than \$23 billion. We now estimate how general government health expenditures could change with a more ambitious agenda on DRM, where both tax efficiency and priority to the health sector increase. Here we assume that countries first increase the share of GGE in GDP, then increase the share of health in GGE. The assumptions are optimistic in that if countries are greater than one percentage point below the median level of priority for health (share of GGHE in GGE), they increase to the median. All other countries increase the share of health in total government expenditures by one percentage point, except Ethiopia and Guatemala who already allocated more than 15% in 2014. Figure 11 shows current GGHE and potential GGHE in 2014, this time in per capita terms. All 16 countries benefit, to the tune of an additional \$23.03 billion, with the per capita increases ranging from \$1.20 in Guinea to almost \$113.1 in Guatemala.

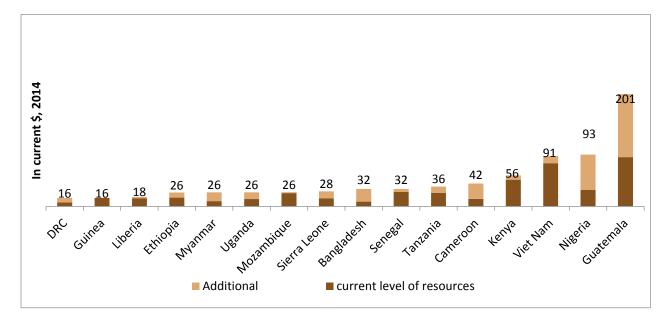


Figure 11: Current per capita government health expenditure and potential government health expenditure from an ambitious agenda on domestic resource mobilization, 2014

In Guinea, the gains are relatively small compared to current levels of general government health spending – an increase of 8%. Similarly, this ambitious type of DRM would allow general government health expenditures to increase by only 11% in Mozambique; by less than 20% in Kenya and Vietnam; and by less than 25% in Liberia and Senegal. While these gains are worth generating, they are much greater in the other countries, and per capita government health expenditures could more than double in Bangladesh, Cameroon, DRC, Ethiopia, Guatemala, Myanmar, Nigeria and Uganda. The estimates presented here are only for 2014. They are repeated each subsequent year: indeed, with economic growth they increase year on year.

Improving budget performance can also increase expenditures. The health financing work to date in GFF countries has shown another possible way to increase domestic health expenditure (as opposed to revenue). A recent analysis of public expenditure reviews suggests that some GFF countries have not fully executed their budgets – DRC (2013) executed just over 40% of its health budget; Guinea (2014) under 70%; Ethiopia (2013) under 80%; while Mozambique (2014) executed over 90% (WHO2016).⁹ The reasons for low/high budget execution rates can be complex. For example, sometimes budgets are not fully disbursed by the Ministry of Finance, or are disbursed so late that the funds cannot be spent in time. Frequently budgets are allocated by line item (e.g. salaries, medicines, equipment), and do not allow flexibility to switch across items. Where salaries account for the bulk of the budget, if public service rules make hiring difficult, or part of the salary budget is to fill posts in outlying areas where it is difficult to recruit, part of the salary budget might remain unspent with no options to shift the funds to other areas. However, this area is currently being explored as another possible way to increase health expenditures in GFF countries.

⁹ WHO, 2016. Public Financing for Health in Africa: from Abuja to the SDGs. WHO, Geneva, 2016. <u>http://apps.who.int/iris/bitstream/10665/249527/1/WHO-HIS-HGF-Tech.Report-16.2-eng.pdf?ua=1</u>

GFF SUPPORTS COUNTRIES TO IMPROVE DOMESTIC RESOURCE MOBILIZATION

The previous sections showed a number of patterns and trends in health financing indicators since 2000, but also heterogeneity across countries re-enforcing the fact that policy options in health financing need to be tailored to each country. The GFF work on health financing supports countries to:

- 1. **Assess** the best options for addressing the DRM agenda for example, by conducting fiscal space analysis or estimating the revenue generation potential of different options for raising additional resources (such as through "sin" taxes);
- 2. **Develop strategies** for increasing domestic resources for health through the support of the preparation of health financing strategies (HFSs). This may involve ensuring that DRM is a key component of the HFS and supporting the Government to commit to indicators related to increasing public financing for health;
- 3. **Provide implementation support** of key DRM strategies. This may involve translation of high-level strategic directions on DRM to implementation plans with actionable steps and support to the implementation of the chosen policies through a combination of technical assistance, financing, capacity building and institutional strengthening.

In all three areas, facilitating dialogue with the Ministry of Finance is critical, something to which close attention is paid in the GFF financing work.

The GFF countries are aware of the need for DRM, although the heterogeneity across countries means that their focuses vary. Bangladesh and Mozambique have, for example, noted the need for increased DRM and Bangladesh is beginning work on this. In Kenya, the health financing work as part of the GFF is linking with the parts of the WBG that work with the Ministry of Finance to support fiscal policy to explore options for either fiscal space increases or greater priority to health.

In some of the countries where economic growth and government revenues have slowed (e.g. DRC, Nigeria, Mozambique), it is proving difficult to argue for increased funds for health in the short run either by raising more government revenues or by greater priority to health. In those circumstances, the GFF will focus initially on other strategies; for example, improving efficiency and budget execution.

While the focus of the health financing work in each GFF country is still evolving, Table 1 provides a short overview of the current state of affairs (the four new countries are not included since it is too early to say what the health financing work will focus on).

Table 1: Summary of ongoing work on health financing supported by the GFF by country

Country	Main focus of HF support
Bangladesh	Health Financing Strategy (HFS) exists and implementation support program is currently being defined. It will likely focus on dialogue with the MOF to re-prioritize the budget in favor of health (DRM), improve PFM and enhance the targeting function of health-related safety net programs.
Cameroon	Background studies (fiscal space analysis, political economy analysis, PFM assessment) are currently being finalized to inform the HFS process. A Health Financing System Assessment (HFSA) will be undertaken and support will be provided to develop a HFS. The role of DRM will emerge from this, while the PFM sets the scene for greater efficiency in the use of resources.
DRC	The HFS is being finalized and implementation support is likely to focus on increasing fiscal space for health by improving efficiency in domestic health spending through PFM reforms. A PFM assessment will be completed in November and inform the MOH on key PFM steps to be taken to improve the domestic health budget execution. Additionally, the recent implementation of a single contract between donors and provincial health authorities in a few provinces ¹⁰ will yield efficiency gains in external spending. Capitalizing on this experience, the HFS is proposing to roll out this approach in several provinces. The HFS also seeks to improve advocacy for DRM and to draw on lessons from a WB governance and tax reform program from which more concrete actions in DRM will be developed.
Ethiopia	The HFS has been completed and is under review. GFF works closely USAID and the Bill and Melinda Gates Foundation with support focused on technical assistance and capacity building in the MOH and national insurance agency, operational and policy implementation analysis (e.g. on ways to improve efficiency), facilitation of knowledge exchange and policy dialogue.
Kenya	The HFS has been completed and is under review. An implementation support program will involve DRM, including an assessment of the feasibility of generating resources from sin taxes, levies and health insurance contributions, improving the efficiency of public spending, institutionalizing expenditure tracking and analyzing equity of public spending and transition issues of vertical programs. Support will also include capacity building in health financing at county and national levels.
Liberia	Support is provided to develop a focused HFS. Implementation support will likely focus on a DRM policy dialogue between the MOF and MOH. This will be informed by GFF support to: a fiscal space analysis; an assessment of the feasibility of sin taxes; the development of a new resource allocation formula for allocating funds to subnational levels; a public expenditure review; and development of strategies to align external financing to improve efficiency in health spending.
Mozambique	The HFS is being finalized, implementation support is being defined and will likely focus on improving efficiency in health spending, strengthening public financial management, reducing fragmentation of external financing and advocacy to reprioritize the budget in favor of health (DRM).
Nigeria	A HFS and HFSA are under development. Support is provided to the HFS process. The focus of subsequent implementation support is yet to be determined.

¹⁰ In some provincial, several donors have signed a memorandum of understanding with Provincial Health Authorities to fund and implement an operational plan at provincial level agreed by donors and provincial health authorities.

Senegal	A HFS is under development and the process and associated background studies are being supported by the GFF. Capacity strengthening on health financing will also be supported. The focus of subsequent implementation support will be determined once this work is completed.
Tanzania	The HFS has been completed and is under parliamentary review. The implementation support program is being prepared in the meantime, and subject to the review process, and will likely focus on: developing a Public Expenditure Review to assess performance and efficiency in the health financing system; supporting the transition to a single national insurance provider; promoting pro-poor coverage of services through establishing of targeting-mechanism linked to financing.
Uganda	A HFS has been completed and is under review. GFF support focuses on: the development of an implementation strategy for the HFS; an assessment of the sources of inefficiency and options for reducing them; analysis and an assessment of options for DRM; and long-term capacity building to the results-based financing/purchasing unit.
Vietnam	A draft HFS exists and an implementation support program is being defined. At the moment, the suggested focus for GFF support is on provider payment reforms, improving efficiency of health spending and other questions related to financial sustainability.

CONCLUSIONS AND GFF HEALTH FINANCING RESPONSES

Increased domestic resource mobilization, not from out of pocket payments but from forms of prepaid and pooled financing (captured in health accounts under the heading of general government health expenditures at the moment), is important to all GFF countries. It is particularly important in the countries with an absolute shortage of funds compared to estimates of need, to those which rely heavily on out of pocket payments to finance health, and to those facing the transition from Gavi and Global Fund grants in the near future.

There is room in all GFF countries for increased DRM, although the potential varies substantially across them. In half of them, government spending could more than double under the optimistic scenario described earlier and while the relative size of the potential increases is lower in the other countries, the benefits of the increases in spending in terms of improved health would still be important. In general, improving tax collection and efficiency will raise more for health than giving more priority to health in subsequent government spending, although this is not true for Guinea, Mozambique, Myanmar and Senegal where government expenditures as a share of GDP are already relatively high and increasing the priority to health in overall government expenditures offers the best option. In Cameroon both options can contribute, but increasing the priority to health will raise more for health than moving to the median share are GGE in GDP.

Guinea and Mozambique, however, pose some challenges for DRM. Their potential to substantially increase domestic revenues for health is smaller than the other countries, and their current levels of spending per capita are still too low to allow universal coverage with a minimum set of interventions at an affordable price. Securing sufficient DAH is still important for them, combined with the measures to make better use of the money that are discussed subsequently.

In most of the GFF countries, a complementary quick win is to focus on ensuring that the ministry of health fully executes its budget and on solving any problems in public financial management that make this difficult. This is one part of the overall efficiency agenda that all GFF countries recognize will allow them to achieve more with the available funds. Ministries of Finance also frequently argue that health ministries should not request additional resources until they show they can spend them, and spend them better, so the focus on efficiency improvements in GFF countries might also result in increased allocations from the Ministry of Finance.



www.globalfinancingfacility.org

COUNTRY-POWERED INVESTMENTS FOR EVERY WOMAN, EVERY CHILD.

Domestic Resource Mobilization: Status and Prospects of GFF countries





FOURTH INVESTORS GROUP MEETING

2-3 November 2016, Dar es Salaam

Topic: Domestic resource mobilization (DRM)

- Part 1: Progress towards Smart, Scaled and Sustainable financing in GFF countries, including RMNCAH spending
- Part 2: Prospects for additional DRM
- Part 3: Lessons from experience to date with GFF countries

 Global Health Expenditure
 Database of WHO, replicated in
 World Development Indicators of the WBG

World Development Indicators for economic growth



Part 1: Progress towards Smart, Scaled and Sustainable financing in GFF countries, including RMNCAH spending

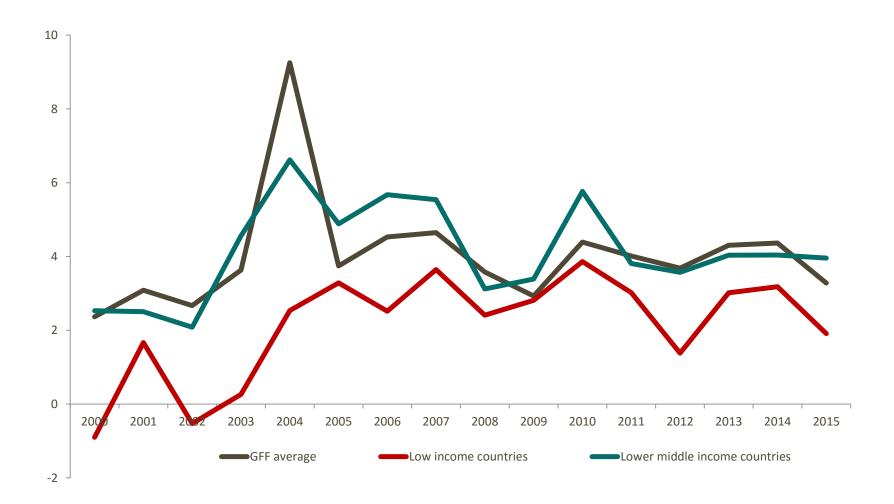
Smart, Scaled, Sustainable Financing

- Smart financing: interventions proven to have a high impact are prioritized and delivered in an efficient and results-focused way, while seeking to reduce inequities in coverage.
- Scaled financing: mobilizing the additional resources necessary from domestic and international (public and private) sources, while reducing reliance on direct out-of-pocket payments (OOPs)
- Sustainable financing: ensuring that health and RMNCAH funding benefits from economic growth, and addresses the challenges faced by "transition" countries

National income for GFF countries

- 8 low income (LIC): DRC, Ethiopia, Guinea, Liberia, Mozambique, Sierra Leone, Tanzania, Uganda
- 8 lower middle income (LMIC): Bangladesh, Cameroon,
 Guatemala, Kenya, Myanmar, Nigeria, Senegal, Vietnam
- GDP per capita in 2015 (current prices) ranged from \$456 in DRC to \$3904 in Guatemala
- In general, the countries are poorer than the average for LICs and LMICs respectively:
 - Among LICs, only Tanzania and Uganda have GDP/cap above the mean for LICs
 - Among LMICs, only Guatemala and Nigeria

Real growth in GDP per capita: GFF, LICs, LMICs (weighted average)

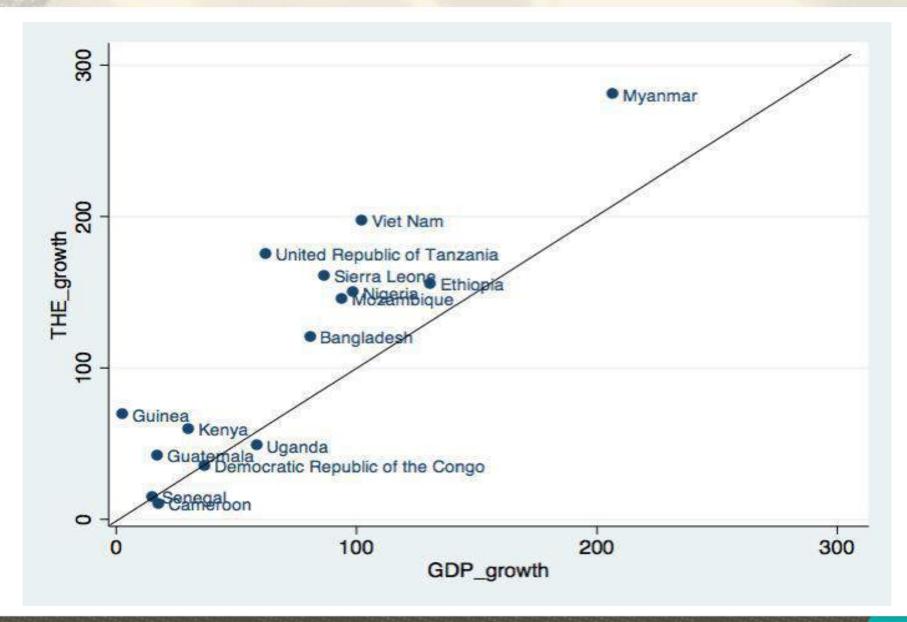


7

Total Health Expenditure (THE) per capita-

- Health expenditure data available to 2014
- Total health expenditure per capita grew 2000-2014 in GFF countries as a group, reaching \$67.6 per capita on average (weighted, current prices) in 2014
- Heterogeneity: range from \$19 in DRC to \$233 in Guatemala
- McIntryre and Meheus: estimated \$89 per capita needed in 2014
 - 12 countries: too little to assure a basic set of health services
 - 4 countries (Guatemala, Nigeria, Sierra Leone and Vietnam) spent more than \$89 per capita but a high proportion from direct out-of-pocket spending – need to increase prepaid and pooled funding

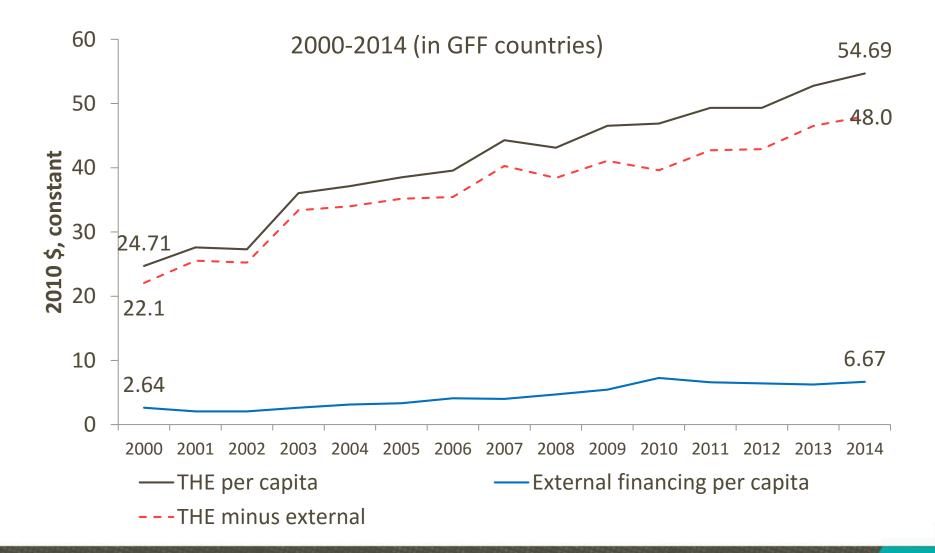
Growth rates of THE/capita vs GDP/capita 2000-14



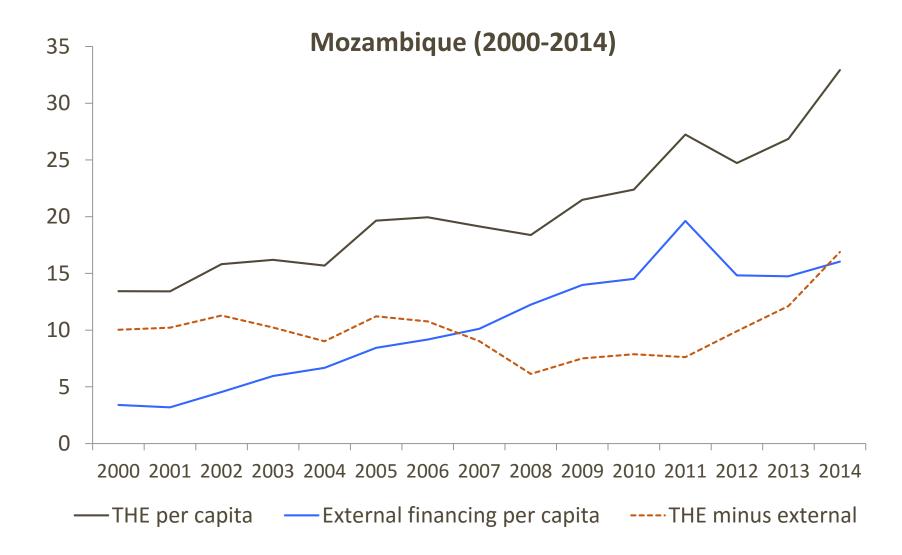
Components of health expenditure growth

- Total health expenditure per capita can be broken into expenditure from external sources (development assistance for health [DAH]) and expenditure from domestic sources
- We initially consider DAH versus external expenditure growth

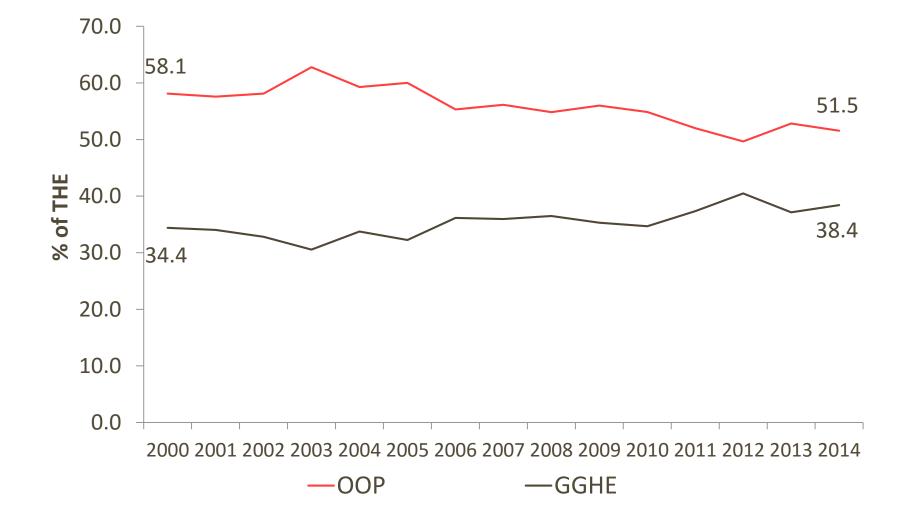
Components of real THE/capita growth: domestic versus external financing

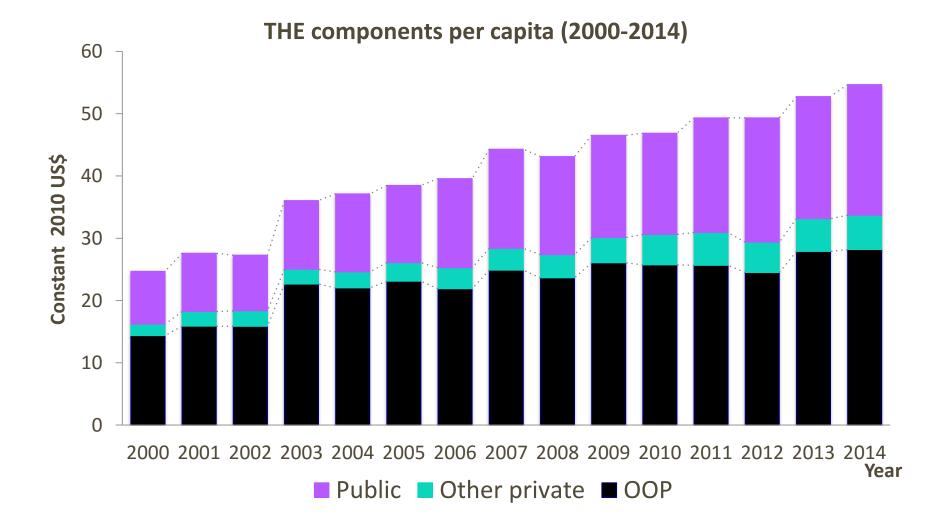


Heterogeneity in domestic versus external financing

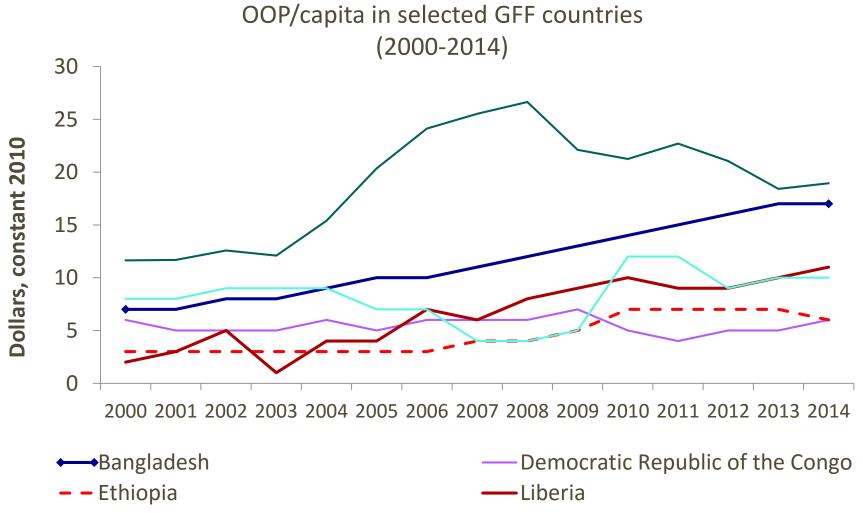


OOPs has fallen and GGHE risen as a share of THE





Heterogeneity in OOPs per capita



— Uganda

- United Republic of Tanzania

What about RMNCAH-related expenditures?

- 34 countries have produced disease-specific accounts almost always included Reproductive Health (RH) but not always Child Health (CH) (WHO website)
- No information on A (Adolescents)
- GFF countries:
 - Public data on both RH and CH expenditures in 6 of 16 GFF countries (Cameroon, DRC, Ethiopia, Sierra Leone, Tanzania, Uganda)
 - 3 have done this but data not available yet (Kenya, Mozambique, Vietnam)
 - 4 in process (Bangladesh, Liberia, Nigeria, Senegal)
 - Only 3 have at least 2 years (DRC, Ethiopia, Uganda) not necessarily the same years

Share of THE for RH and CH expenditures?

- Share of health expenditures:
 - Reproductive health (RH): ranged from ~5% to >30%
 - Child health (CH): ranged from 5% to 40%
- 12 countries (GFF and non-GFF) with both RH and CH:
 - CH > RH in 8 countries
 - RH > CH in 4 countries
- Indicator of quality of data improves over time as countries get more experience in allocating expenditures by disease
 - Share of total health expenditures that they are able to allocate to the different diseases increases

Smart, scaled, sustainable financing: Summary

- **1**. Enormous heterogeneity across countries implications for policy
- 2. Smart: Current levels of spending too low to ensure an essential package
 - Not much available from these data in terms of efficiency
 - Little in terms of equity: need to dig deeper
 - RH and Child account for a substantial share of national expenditures on health: but data lacking for many countries
- **3**. Scaled:
 - THE/capita increasing in real terms
 - OOPs declining as a share of THE but real OOPs/capita increasing except in a few countries
 - Other sources of private expenditure still very low
- 4. Sustainable:
 - Good economic growth
 - THE rising faster than GDP overall, though not in all countries
 - DAH has risen faster since 2000 than domestically sourced health expenditure, but patterns very heterogeneous; in the long run, transition means that domestically sourced financing rises faster than DAH (or DAH declines)



PART 2: The potential for DRM in GFF countries

Importance of Domestic Resource Mobilization (DRM)

- Health expenditure per capita still too low in 12 GFF countries to assure universal coverage with a core package of needed health services, including for RNMCAH
- In the other 4, OOPs is a high share of THE
- Exacerbated by DAH commitments and disbursements falling since 2012 (OECD)
- Transition strategies of Gavi and Global Fund on top of traditional WBG shift when countries move to middle income from low income make DRM more important in those countries

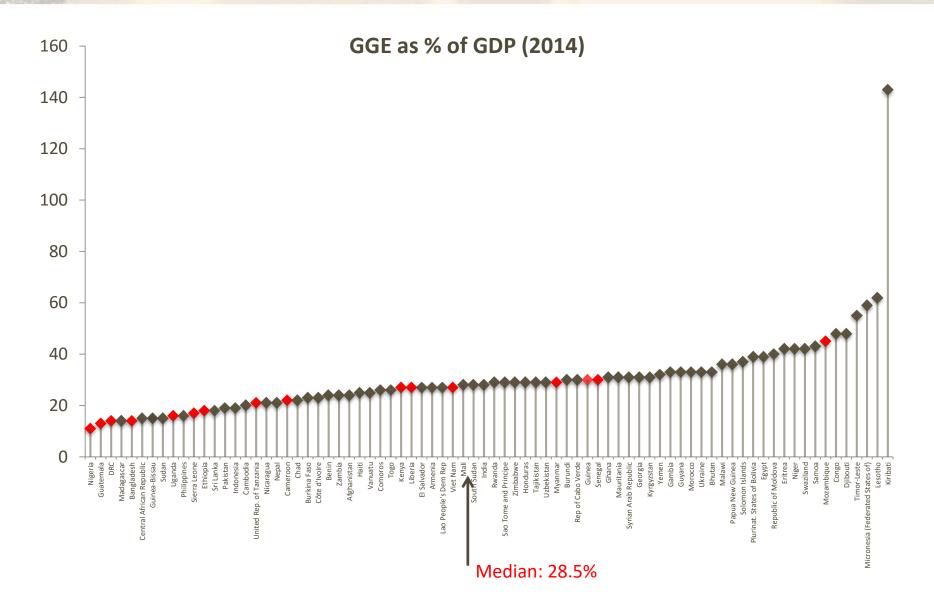
BUT

 Good growth predicted (although IMF economic growth projections have been revised down): for non-high income countries 4.1% 2016; 4.7% 2017 (*heterogeneity*)

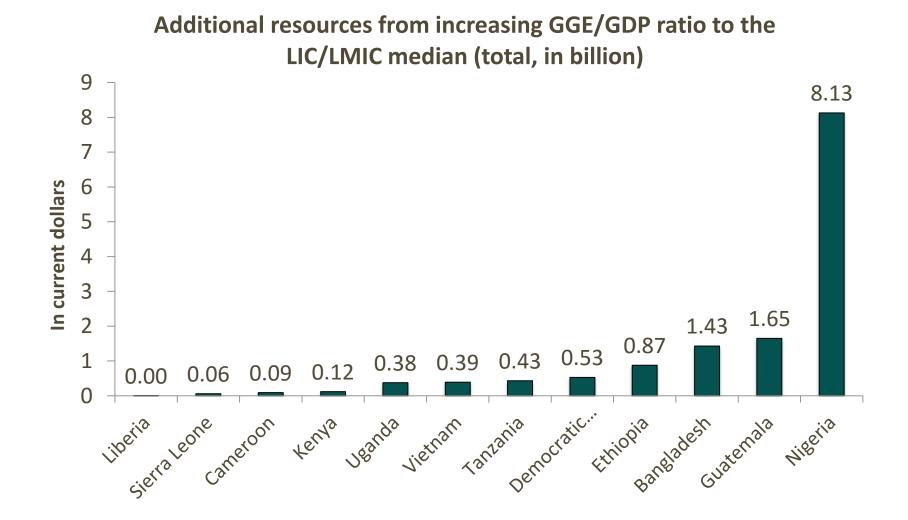
Mechanisms of DRM

- 1. Raising more focus on GGHE (compulsory prepaid and pooled) as we do not want OOPs to increase
- 2. Giving higher priority for health in government expenditure
- 3. Greater efficiency or value for money
 - Efficiency proposed focus for next IG meeting
 - Role of private sector also worth discussing in the future
 - More recently: budget performance is also seen as a source of increased expenditure, though not revenue

Government expenditure as a share of GDP: LICs and LMICs

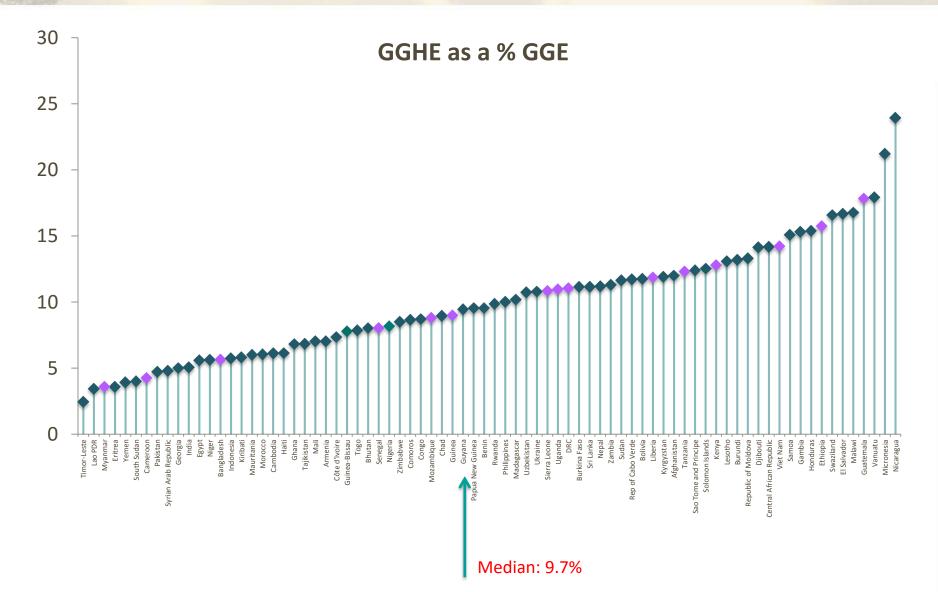


What would happen if GGE/GDP was increased to the median?



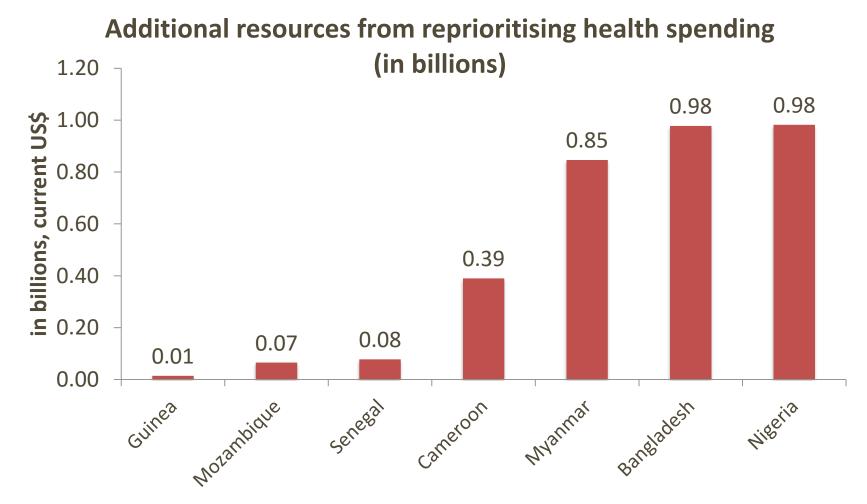
Total of \$14.1 billion additional funding raised annually

Government priority to health: GGHE/GGE



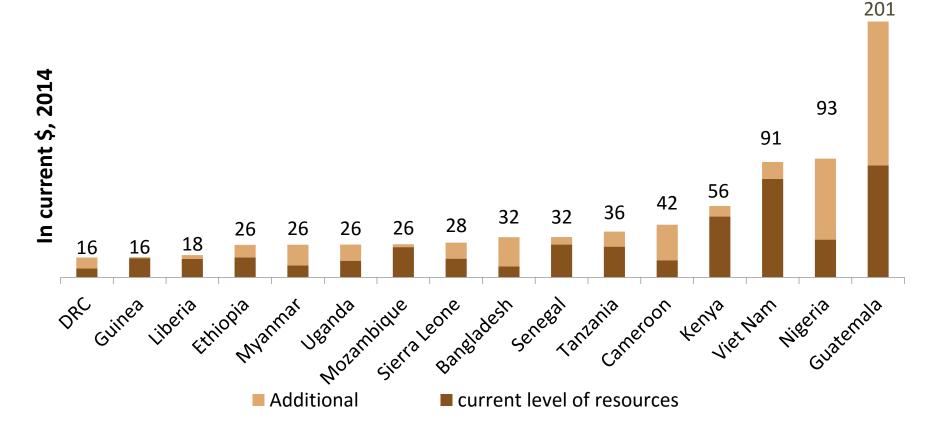
24

Government priority to health: increasing GGHE/GGE to median



Total of \$3.36 billion additional funding generated annually

Let's get ambitious: current + additional \$/capita



1. Countries increase GGE/GDP to 30% where below

2. Then, countries more than one percentage point below the median GGHE/GGE increase to the median

3. Others except Ethiopia and Guatemala (already high) increase by 1 percentage point.

Budget performance & public financial management

- A recent WHO report, using World Bank Public Expenditure Reviews, highlighted that a number of GFF countries have not fully implemented their health budgets in selected recent years:
 - DRC (2013) executed just over 40%
 - Guinea (2014) under 70%
 - Ethiopia (2013) under 80%
 - Mozambique (2014) 90%
- Complex reasons, but better financial performance could effectively increase expenditures in some countries



PART 3: Experience from GFF countries and conclusions

GFF support to domestic resource mobilization

- Significant heterogeneity → need for tailored approaches
- Three main types of support:
 - Assess the best options for DRM: conducting fiscal space analyses, estimating revenue generation potential for different options for raising resources
 - Develop approaches for DRM: supporting government to prepare health financing strategies, supporting development and tracking of indicators related to public financing
 - Provide implementation support: translating high-level strategies into implementation plans, supporting reform efforts through TA, capacity building, institutional strengthening, and financing
- Partnership and dialogue with Ministry of Finance and sometimes IMF critical

In Kenya the GFF in collaboration with external partners...

- Contributed to energizing the HFS process by
 - Working with GoK to set-up HFS coordination structure that ensured buy-in from key players and good dialogue with MOF
 - Providing intense TA to develop specific sections of HFS
 - Offering multiple rounds of comments on proposed strategic directions resulting in stronger focus on domestic resource mobilization and improving efficiency of health expenditure
- Will provide implementation support, focused on:
 - DRM: assessing the feasibility of generating health resources from sin taxes, levies and health insurance contributions in collaboration with the macroeconomic experts, MOH, MOF
 - Transition challenges: assess institutional and financial sustainability of programs funded off-budget
 - Efficiency: expenditure tracking at country level to analyze the efficiency, effectiveness and equity of public spending and development of actions to improve

In DRC, the GFF in collaboration with external partners...

- Contributed to energizing the health financing strategy (HFS) process by:
 - Supporting the WB and development partners to assist Govt with a health financing system assessment feeding the preparation of the health financing strategy.
 - Supported the finalization of the HFS led by the Ministry of Health
- Will provide implementation support, focused on:
 - Efficiency reforms: the Investment Case of DRC is capitalizing on "quick wins" recently implemented in DRC with support of WB and others donors: 1) The "single contract" at provincial level which is to reduce donors fragmentation; 2) The PBF approach which is to enhance management capacity at all levels of the health system; 3) Recommendations to come from a PFM study to improve the health budget execution.
 - DRM reforms: The action plan of the health financing strategy is to examine better tax compliance in collaboration with macroeconomic experts, MOF and the WB governance project.

Summary: the state of the world

THE risen faster than GDP in most GFF countries

 DAH risen faster than domestic sources, but domestic financing has provided the bulk of the increase in real terms

 OOPs has fallen (& GGHE risen) as a share of THE, BUT OOPs per capita increased in most

Summary: DRM

- Considerable potential for DRM in most GFF countries, mostly through GGE/GDP, but also more priority to health in some
 - Guinea and Mozambique less room for this
- Recent falls in economic growth and government revenues are a concern
- Some potential for increased spending through budget efficiency

GFF Health financing lessons and challenges

- Very different starting points among countries
- Shift underway from emphasizing strategy to implementation of reforms
- Good analytical work does not automatically lead to reforms politics
- Key lessons learned
- Engagement of and with ministries of finance has been **uneven**
- GFF can reenergize agenda with intense support: financing, TA, peer-to-peer learning, capacity building, convening partners including MOF
- GFF has given significant boost to process in many countries, but change is political and takes time
- Stronger experience and expertise on analytical work than on implementing reforms
- Syncing up the timing of the health financing work across all partners can be complex
- Dialogue with MOF (and IMF) difficult with the economic slowdown

Ongoing challenges





www.globalfinancingfacility.org

GFF@worldbank.org











THE GFF APPROACH IN FRAGILE SETTINGS

OVERVIEW

The task team on fragile settings presented an initial paper at the February 2016 meeting of the Investors Group. The Investors Group recommended focusing on lessons learned from the GFF's current work in fragile settings as well as the GFF's potential role in emergency preparedness and building resilience. Based on this, the task team (see Annex 2) developed a work plan consisting of Investment Case analysis, country case studies, a literature review, and recommendations to the Investors Group. Based on this, this paper explores the context for the GFF's work in fragile settings (including the needs, challenges, and opportunities), the lessons from the GFF's current engagement in fragile areas, and the options for future engagement. The task team convened two meetings to discuss the work's content and recommendations.

SUMMARY OF FINDINGS

Fragile settings have particularly high reproductive, maternal, newborn, child and adolescent health (RMNCAH) needs, and implementing smart, scaled, and sustainable financing is often challenging in these contexts. The GFF is already actively working in fragile settings, with four of the initial 16 countries supported by the GFF Trust Fund classified as fragile and a further three having zones of fragility. Twenty four of the 62 (39%) GFF eligible countries are classified by the World Bank as fragile or conflict-impacted. The question, therefore, is not *if* the GFF will engage in fragile settings, but *how*.

Decision-making on this should be grounded in both the GFF's experience to date and in a thorough understanding of the GFF's comparative advantages vis-à-vis other actors in the development landscape. This paper does this and reviews a number of possible approaches that the GFF could take in fragile settings, ultimately proposing the following:

- First and foremost, the GFF should maintain its current approaches, given that the experience to date indicates that a number of aspects of the GFF model are well-suited to fragile settings; to complement this, more efforts should be placed on documenting and disseminating experiences;
- The GFF should employ a country-tailored approach to intensifying its existing approaches in fragile settings, in ways that respond to the specific needs of individual fragile settings but have no or low additional costs;
- In the future, as additional funding becomes available and further learning occurs in the current fragile settings, new approaches that require additional resources should be considered;
- There are areas outside the GFF's comparative advantages and therefore should not be considered.

ACTION REQUESTED

The Investors Group (IG) is asked to give guidance on the proposed approach.

INTRODUCTION

There is a disproportionate burden of reproductive, maternal, newborn, child and adolescent health (RMNCAH) challenges in fragile settings, with countries classified as fragile having been less successful in reaching the Millennium Development Goals and having worse RMNCAH indicators than non-fragile countries.

The GFF is already actively working in fragile settings, with four of the initial 16 countries supported by the GFF Trust Fund classified as fragile and a further three having zones of fragility. The question, therefore, is not *if* the GFF will engage in fragile settings, but *how*. This paper examines the context within which the GFF is operating (including both challenges and opportunities) and the experience to date, and uses these to propose options for future engagement in fragile settings.

SMART, SCALED, AND SUSTAINABLE FINANCING FOR FRAGILE SETTINGS: MAJOR NEEDS AND CHALLENGES, BUT ALSO OPPORTUNITIES

Major needs

RMNCAH indicators in fragile settings lags behind those of non-fragile low and middle income countries (LICs and MICs). In countries the World Bank classifies as fragile, conflict, and violence impacted¹, the infant mortality rate is double that in non-fragile LICs and MICs (52 per 1,000 live births as compared to 26 per 1,000 live births). Maternal mortality in fragile, conflict, and violence-impacted states is almost four times that in non-fragile LICs and MICs (434 per 100,000 live births vs. 143 per 100,000 live births). Twelve of the 20 countries with the highest maternal mortality ratios and neonatal mortality rates in the world in 2015 are also among the 35 countries the World Bank classifies as fragile, conflict, and violence impacted.

Women, children, and adolescents are particularly vulnerable in fragile settings. Women's increased risk of mortality and morbidity is a function of weakened health systems and reduced access to services exacerbated by gender inequity, increased risk of gender-based violence, and reduced access to adequate nutrition. Children and infants are at increased risk based on vulnerability to infectious disease and malnutrition, limited access to health services, and the increased health risks their mothers are exposed to, limiting their ability to care for their children.²

Several recent developments have increased international attention to the risk fragility poses to population health and development. First, fewer fragile countries reached the Millennium Development Goals, including those for reducing maternal, infant, and under-five mortality, than non-fragile countries and more fragile countries were seriously off-track for reaching these goals than their non-fragile counterparts.³ Failure to reach MDGs also highlighted that global poverty is increasingly concentrated in fragile states.⁴

¹ The World Bank Group, "World Bank Microdata Library"; The World Bank, "2017 Harmonized List of Fragile Situations." ² Algasseer et al., "Status of Women and Infants in Complex Humanitarian Emergencies"; United Nations Every Woman Every

Child, "Global Strategy for Women's, Children's and Adolescents' Health – EveryWhere 2020 Vision."

³ OECD, States of Fragility 2015.

⁴ Ibid.; World Bank, *Global Monitoring Report 2015/2016*.

Second, all three countries heavily affected by the West African Ebola outbreak (Liberia, Guinea, and Sierra Leone) are currently (Liberia and Sierra Leone) or were until recently (Guinea) classified as fragile. Weak health systems were both unable to respond to the outbreak and struggled to maintain routine care during the outbreak. This highlighted the need for strong, resilient systems for health that can cope with emergencies while maintaining routine functions.

Third, humanitarian refugee crises in the Middle East and North Africa stemming from conflicts in Syria, Iraq and Yemen, have drawn attention to the particular risks to women and children in humanitarian emergencies as well as the significant funding gaps in these settings. Recent figures from the High-Level Panel on Humanitarian Financing estimate at least a US \$15 billion financing gap.⁵ This is expected to rise based on predictions that the cost of humanitarian assistance will double by 2030.⁶

Finally, it is important to recognize that overall trends are clear: poverty and underdevelopment are increasingly going to be concentrated in fragile settings. Currently 21% of the global poor live in fragile states, but this is expected to increase to 50% in 2030.⁷

Major challenges

Smart financing

All GFF countries face challenges ensuring that financing for RMNCAH is "smart"⁸, but fragile settings confront some particular difficulties.

According to the Organization for Economic Cooperation and Development (OECD), Official Development Aid (ODA) to fragile states tends to be more volatile than aid to non-fragile countries.⁹ Figure 1 shows this volatility in Liberia and Democratic Republic of Congo (DRC).¹⁰ The unpredictability inherent in aid volatility limits recipient governments' capacity for medium to long term planning, implementation capacity and ability to maximize resources. Volatility is a particular problem after crises as humanitarian responses tend to receive more funding than the post-crises period, often resulting in sharp funding falls as acute crises end.¹¹

⁵ "High-Level Panel on Humanitarian Financing, Report to the Secretary-General. Too Important to Fail – Addressing the Humanitarian Financial Gap."

⁶ One Campaign, "Financing Stability: How Humanitarian and Development Assistance Must Rise to the Challenge."

⁷ Bank Group, IDA 18: Special Theme: Fragility, Conflict, Violence, IDA Resource Mobilization Department, May 31 2016.

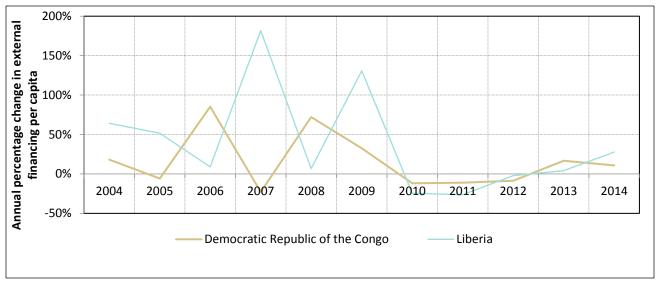
⁸ See the GFF Business Plan for more information about smart, scaled, and sustainable financing.

⁹ OECD, "Fragile States 2014: Domestic Resource Mobilization in Fragile States."

¹⁰ Data used from: World Health Organization. "Global Health Expenditure Database." World Health Organization, 2016. http://www.who.int/health-accounts/ghed/en/.

¹¹ Newbrander, Waldman, and Shepherd-Banigan, "Rebuilding and Strengthening Health Systems and Providing Basic Health Services in Fragile States"; Canavan and Vergeer, *Fragile States and Aid Effectiveness*.

Figure 1: Aid Volatility in DRC and Liberia



A large number of vertical programs further compound government stewardship challenges and health financing fragmentation. Vertical programs can alleviate the burden of specific diseases and offer measureable, quickly achievable results, but involve substantial investment in duplicative non-integrated systems that fail to strengthen the overall health systems and build resilience.¹²

Scaled financing

RMNCAH needs in fragile settings, particularly those of vulnerable populations such as refugees, are underfunded. Despite worse health indicators than their non-fragile counterparts, between 2005 and 2011 development partners did not increase funding to fragile countries at the same rate as in stable LICs.¹³ Patel et al. (2016) found that conflict-affected countries received lower reproductive health official development aid (ODA) disbursements than those not impacted by conflict.¹⁴ In emergencies, donors are unable to raise sufficient funds for response. In Syria, the health component of the Humanitarian Response Plan requires approximately US\$441 million, yet only one fifth (US\$82 million) is funded.¹⁵

Sustainable financing

Currently, most health financing in fragile settings is focused on immediate needs and is not sustainable in the long-term. Much of the external aid in fragile settings is off-budget. Governance capacity is often weak and overstretched, underpinned by limitations in stewardship and management capacity.¹⁶ In part

¹² Ranson et al., "Promoting Health Equity in Conflict-Affected Fragile States"; Ayee, "Social Inclusion and Service Delivery in a Fragile and Post-Conflict Environment in Africa."

¹³ Graves, Haakenstad, and Dieleman, "Tracking Development Assistance for Health to Fragile States."

¹⁴ Patel et al., "Tracking Official Development Assistance for Reproductive Health in Conflict-Affected Countries."

¹⁵ OCHA, "Syrian Arab Republic: OCHA."

¹⁶ Tulloch, Raven, and Martineau, "HUMAN RESOURCES FOR HEALTH IN POST-CONFLICT SETTINGS"; Eldon, Waddington, and Hadi, "Health Systems Reconstruction and State-Building"; Newbrander et al., "A Tool for Assesasing Management Capacity at the Decentralized Level in a Fragile State"; Brinkerhoff, "Developing Capacity in Fragile States," February 2010.

due to these challenges, development and humanitarian assistance in fragile settings often bypass national governments, instead going directly to national and international non-state actors.¹⁷ This offbudget funding further limits national governments' ability to develop and execute health financing strategies and plans, making sustained health programming and financing difficult.

Fragility also negatively impacts country capacity to generate revenue. Due to limited absorptive capacity, few tax collection mechanisms, and low investor confidence, fragile states have little fiscal capacity to generate revenue from domestic resources.¹⁸ These conditions limit private sector engagement, further constraining economic growth. On top of this, health tends to receive less attention and fewer resources than other sectors in fragile settings, in favor of security priorities.¹⁹ These conditions limit the potential of domestic resource mobilization (DRM) for health.

Financing opportunities

While there are major challenges to smart, scaled, and sustainable financing in fragile setting, there are also new financing opportunities that can address some of these challenges, particularly with regard to scaled financing.

Dedicated fragile setting financing

Given the growing humanitarian and development needs in fragile settings, donors are increasingly prioritizing programing in fragile settings. For example, the UK Aid Strategy in November 2015²⁰ allocated 50 percent of all Department for International Development (DFID) spending to fragile states and regions.

IDA18 replenishment includes a doubling of resources to fragile states with a new window for refugees

The World Bank Group's IDA18 replenishment affecting low and lower middle income countries will be finalized in December 2016 and includes a strong emphasis on funding for fragile settings. The proposed replenishment asks for US\$14.4 billion for fragile states for the coming three years, which is a doubling of IDA commitments under IDA 17. IDA 18 also includes a proposed US\$2 billion Regional IDA sub-window to finance projects benefiting refugees and their host communities in IDA countries.²¹ This money would assist several countries in Africa hosting large refugee populations, but may not be available to host countries in MENA who are grappling with the fallout of the Syria crisis (e.g., Lebanon, Jordan).

The availability of increased IDA funding for fragile states has direct implications for the GFF. Since GFF Trust Fund grants are linked to IDA commitments at the country level, an increased IDA envelope can enable countries to spend more resources on RMNCAH.

¹⁷ Anderson et al., "Measuring Capacity and Willingness for Poverty Reduction in Fragile States"; Dietrich, "Bypass or Engage?" ¹⁸ OECD, "Fragile States 2014: Domestic Revenue Mobilisation in Fragile States, Paris, OECD-DAC, 2014."; Giordano and Ruiters, "Closing the Development Finance Gap in Post-Conflict and Fragile Situations"; Ohiorhenuan and Stewart, *Post-Conflict Economic Recovery*.

¹⁹ Ayee, "Social Inclusion and Service Delivery in a Fragile and Post-Conflict Environment in Africa

²⁰ Department for International Development, UK Aid: Tackling Global Challenges in the National Interest, November 2015. Available at

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/478834/ODA_strategy_final_web_0905.pdf ²¹ World Bank Group, IDA 18: Special Theme: Fragility, Conflict, Violence, IDA Resource Mobilization Department, May 31 2016.

World Bank Group Global Concessional Financing Facility

At the United Nations General Assembly in September 2016, the World Bank launched a new Global Concessional Financing Facility (CFF) that aims to raise US\$6 billion in concessional financing for development projects in middle income countries affected by refugee crises around the globe over the next five years.²² Each dollar of grant money raised for this facility will be leveraged to raise four dollars of concessional financing. The initial focus of the CFF is on Lebanon and Jordan, but the fund will be available to other middle income countries dealing with the consequences of protracted crises.

While the CFF initiative is to be lauded as an innovative approach to help bridge the large humanitarian financing gap, early experience is suggesting that recipient countries are more willing to borrow for host communities than refugees. This creates an opportunity to link grants for refugees residing in host countries to CFF financing for the host communities. For example, a proposed project in Lebanon to provide a basic package of health services to host communities that is being supported through concessional financing can be augmented by a grant to expand the same package to refugees, 80 per cent of whom are women and children.

GFF ENGAGEMENT IN FRAGILE SETTINGS

Overview of engagement

The GFF's mandate to address countries with the highest RMNCAH needs necessarily involves engagement in fragile settings. Twenty four of the 62 (39%) GFF eligible countries are classified by the World Bank as fragile or conflict-impacted. The GFF is currently working in a number of fragile settings: of the GFF's 16 initial countries, four (DRC, Liberia, Myanmar, and Sierra Leone) are classified by the World Bank as fragile, three (Cameroon, Kenya, and Nigeria) have fragile areas, and one (Guinea) was until recently classified as fragile and has a health system severely stressed by the Ebola outbreak. Given this current engagement in fragile settings, the question for the GFF going forward is not *if* the GFF will engage in fragile settings, but *how*.

The GFF's work in fragile settings has been guided by a common set of principles and approaches, as initially outlined in the GFF Business Plan. This means that the GFF engagement has been driven by an emphasis on providing smart, scaled, and sustainable financing aimed at improving the health outcomes of women, children, and adolescents, rather than a specific emphasis on addressing the root causes of fragility or explicitly attempting to build the resilience of health systems (with a few exceptions, as discussed later).

Despite fragility not being an explicit focus of the GFF's work to date, experience has shown that the GFF model is well-suited to fragile settings. In particular, the following elements are employed across GFF countries but are particularly relevant in fragile settings:

- An emphasis on health financing reforms;
- A data-driven approach that focuses on equity;
- A horizontal approach that supports health systems strengthening;

²² https://menafinancing.org/overview/concessional-financing-facility

- A concerted effort to improve coordination, particularly of financiers;
- A multisectoral lens.

The way in which each of these has been used in fragile settings is discussed below with examples from the GFF experience to date. The annex to this paper contains case studies on the GFF's experience in the DRC, Liberia, and Nigeria, to complement the experiences highlighted below.

Importantly, the GFF process is country-led, which means that countries can draw upon different parts of the business model to address different aspects of fragility in accordance with local needs. This ability to adapt to each individual context is particularly critical in fragile settings, as fragility is an overarching concept encompassing a diverse set of situations. One important element of this is the ability to support decentralized implementation at the sub-national level, something that has be a focus in a number of GFF countries.

Country experiences

Health financing reforms

Working on health financing in fragile settings is complicated by the uncertainty and rapidly changing contexts of many fragile settings, which make long-term planning challenging. The GFF has addressed this through a combination of working on full-fledged health financing strategies where the conditions are ripe and focusing on concrete reforms that can be implemented despite challenging situations.

In the DRC, for example, while work is underway on the long-term agenda, the GFF has also prioritized some immediate steps that can improve efficiency and the use of current resources. This includes scaling up strategic purchasing through a results-based financing approach (which is also useful for strengthening local autonomy) and addressing weaknesses public financing management so as to improve budget execution rates (which are extremely low). Strategic purchasing was also employed in conflict-affected northeastern Nigeria, in that case to move quickly to address emergency service delivery needs. During the next phase of the health financing work in Nigeria the focus will be on working with the Ministry of Finance to establish a sustainable mechanism for long term financing of primary care, including in the conflict affected areas of the country.

Liberia is another country in which work is progressing on a health financing strategy. At the same time there is an immediate focus on a key reform, the implementation of a revised resource allocation formula that assigns resources to counties as determined by evidence-based needs and as such improves equity between counties. There is also a focus on improving donor harmonization and reducing aid volatility.

A data-driven approach that focuses on equity

A data-driven approach is at the heart of the GFF's approach to developing Investment Cases. Equity is a particular focus, with equity analysis and tools (e.g., UNICEF's EQUIST) employed in many countries to ensure that disadvantaged and vulnerable populations are identified and prioritized. This approach was not explicitly designed to address fragility, but the effect of its application has been a significant focus on fragile parts of GFF countries.

In Cameroon, for example, the analytical work underpinning the Investment Case led to a focus on four regions, three of which comprise the conflict-affected northern part of the country. Kenya is another country in which the use of a data-driven approach during the development of the country's Investment Framework led to a focus on a set of counties that include the most fragile parts of the country because they had the worst RMNCAH indicators. In Nigeria, IDA and GFF Trust Fund financing focused on the states impacted by Boko Haram because the health indicators there are particularly poor, and explicitly includes tailored approaches based on the extent to which the health system is disrupted, to ensure an equitable level of service delivery in the region.

Although there is generally significant overlap between the parts of a country that are highlighted by a data-driven equity approach and those identified by focusing on fragility, the experience in the DRC provides an interesting case study in the fact that they are not necessarily identical. The analytical work for the DRC Investment Case identified 14 provinces with high RMNCAH needs, which includes one of the provinces most affected by the protracted conflict in the DRC (South Kivu) but not the adjacent province that is also grappling with long-term instability but that has managed to maintain better health indicators (North Kivu).

A horizontal approach that supports health systems strengthening

Health service delivery in fragile settings is generally constrained, as a result of both supply and demand challenges. Although the GFF is focused on improving the health outcomes of women, children, and adolescents, it does not approach this in a verticalized manner but rather looks at both the specific RMNCAH interventions that are needed and the broader health systems strengthening that is necessary to improve health outcomes.

This focus on strengthening systems is particularly beneficial in fragile settings, where capacity constraints are often significant. Specific investments in health systems strengthening are identified in Investment Cases and so focus on different building blocks of the health system depending on individual national contexts.

Human resources for health has been a major emphasis in a number of countries, including to address the challenge of ensuring adequate numbers of trained health personnel in fragile parts of countries. In the DRC, for example, the health workforce is inequitably distributed between provinces. To address these challenges the Investment Case outlines plans to redistribute personnel through a health worker census and revised incentives. This is paired with strategies to increase health worker quality through training programs for medical and logistics personnel, improved training program quality control.

The DRC is also grappling with challenges related to another building block, with weak provincial and health facility level governance a key bottleneck that limits RMNCAH service delivery. To address this, the Investment Case includes capacity building for district and provincial level managers, along with improved systems for accountability to communities. In Kenya, capacity in the underserved and conflict-impacted counties is particularly weak. To address this, two key donors are establishing trust funds to finance capacity building for county level health sector governance.

Liberia is confronting major challenges with another building block, infrastructure, to the extent that 29% of the population must walk more than five kilometers to reach a health center. The Liberia Investment

Case prioritizes increasing the number of health facilities in rural areas and more effectively reaching people in rural areas through a nation-wide community health worker program.

In the DRC, Liberia, and Kenya there are few age-disaggregated data, resulting in limited information on health among the large youth populations. In each of these countries, steps to improve data systems are outlined in the Investment Cases, with particular attention to disaggregated data to increase information on underserved populations.

Across all of these areas, the entry point was not addressing fragility but the investments driven through the process of developing and implementing Investment Cases will nonetheless make significant contributions to building capacity in ways that over the medium to long term contribute to improving systems and institutions and thereby contribute to addressing some of the root causes of fragility. When combined with the equity focus described above, these health systems strengthening efforts can also contribute to reducing inequity, which is a significant driver of fragility.

Most of the GFF countries have taken this broader approach to strengthening capacity rather than explicitly addressing fragility by building the resilience or focusing on preparedness. The major exception to that is Liberia, where the GFF process has been shaped by the context of the Ebola epidemic. As a result, the Investment Case includes as one of its six priority investment areas "emergency preparedness, surveillance, and response", with a particular focus on integrated disease surveillance and response. The Investment Case also incorporates the lessons learned from the Ebola response by including an explicit focus on community engagement. These efforts should improve the resilience of the health sector and so reduce its susceptibility to shocks in the future.

Concerted effort to improve coordination, particularly of financiers

A cornerstone of the GFF approach is the process of aligning financing behind a set of priorities identified in the Investment Case. This approach is particularly valuable in the context of fragile settings, as they are often characterized by a proliferation of donors and a lack of coordination that results in both gaps in financing key areas and duplication of efforts.

This process has occurred in almost all of the fragile settings in which the GFF is currently operating, and has been highlighted as a key way in which the GFF adds value by a number of senior officials in these countries, such as the ministers of health of the DRC and Cameroon.

One particular technique that the GFF is using to promote this is resource mapping, in which key financiers share information about their current and planned financial contributions in an effort to understand the gaps and duplications related to Investment Case priorities. This has the potential to be especially valuable in fragile contexts given the generally weak information systems in these countries and the limits on the part of governments to gather this information given the fact that a significant volume of external financing in fragile contexts is off-budget.

Although most of the emphasis to date in GFF countries has been at the national level, sub-national efforts to improve coordination are underway in the DRC and Kenya. In the DRC, the emphasis has been on working at the provincial level to implement a "single contract" system to simplify relationships between provincial governments and donors to fund a basic package of services, which helps ensure donor

harmonization and reduces off-budget financing. In Kenya, counties are developing their own investment cases within the parameters set out by the national Investment Framework.

Multisectoral lens

Half of the gains in child mortality from 1990-2014 were as a result of non-health factors such as economic growth, education, and sanitation.²³ In fragile settings, health sector weaknesses are compounded by limitations across other sectors.²⁴ The GFF's multisectoral mandate is therefore an important strength in fragile settings. The full potential of this approach has not yet been realized, but there are some emerging examples of multisectoral collaboration in the GFF context that show the exciting opportunities for further work.

Adolescent health has emerged as a major area of multisectoral collaboration. In Liberia there is clear recognition that adolescent health programs are required to collaborate with the ministry of education and youth, sports, and culture to improve reproductive health education, while in Cameroon conditional cash transfers will target adolescent girls and a results-based financing pilot in the education sector is included in the Investment Case.

Nutrition features in every Investment Case developed to date, with approaches that include addressing household food security in Kenya and using community-based and mobile service delivery teams in Cameroon, the DRC, Liberia, and northeastern Nigeria. In the DRC, the Investment Case includes a significant focus on water and sanitation services.

In an interesting example of an attempt to work on something that is emerging as a key longer-term driver of health outcomes – and which is also a rapidly increasing cause of fragility – Bangladesh is starting to look at the intersection of climate change and health.

There is considerable scope to increase multisectoral efforts in these and in other sectors, such as infrastructure and transport. In both Liberia and Kenya road and water sanitation weaknesses are described as underpinning health system challenges, yet the Investment Cases do not incorporate multisectoral action in these areas even though the World Bank and other partners may be addressing these as part of broader engagement in the country (such as the case of Kenya where road development to the northern counties is a major priority) highlighting further opportunities to address multi-sectoral aspects as part of the GFF.

OPTIONS FOR FUTURE ENGAGEMENT IN FRAGILE SETTINGS

As the preceding section demonstrates, the GFF is already making significant contributions in fragile settings. However, given the needs and the trends discussed earlier, there is a key strategic question about how the GFF engagement in fragile settings should evolve over time.

²³ Kuruvilla, S., et al., "Success factors for reducing maternal and child mortality", Bull World Health Organ 2014;92:533–544.
²⁴ Kruk et al., "Rebuilding Health Systems to Improve Health and Promote Statebuilding in Post-Conflict Countries"; Li, "The Immediate and Lingering Effects of Armed Conflict on Adult Mortality"; Ghobarah, Huth, and Russett, "The Post-War Public Health Effects of Civil Conflict"; Pavignani and Colombo, "Analysing Disrupted Health Sectors."

Decision-making on this question should be grounded in both the GFF's experience to date and in a thorough understanding of the GFF's comparative advantages vis-à-vis other actors in the development landscape. This section reviews a number of possible approaches that the GFF could take in fragile settings, and proposes the following:

- First and foremost, the GFF should maintain its current approaches, given that the experience to date indicates that a number of aspects of the GFF model are well-suited to fragile settings; to complement this, more efforts should be placed on documenting and disseminating experiences;
- The GFF should employ a country-tailored approach to intensifying its existing approaches in fragile settings, in ways that respond to the specific needs of individual fragile settings but have no or low additional costs;
- In the future, as additional funding becomes available and further learning occurs in the current fragile settings, new approaches that require additional resources should be considered;
- There are areas outside the GFF's comparative advantages and therefore should not be considered.

Each of these four areas is described in turn below.

Maintain current approaches

As reviewed above, many of the GFF's current approaches appear to be appropriate for fragile settings. Maintaining these approaches described above therefore should be at the core of the GFF's approach in fragile settings going forward.

To maximize the benefits of this approach, a stronger emphasis will be placed on capturing and disseminating lessons learned, as documentation of what works in fragile settings is extremely limited. The GFF places a strong emphasis on results measurement and so as part of this will support implementation research that builds the evidence base on what works in fragile settings. There is broad need for evidence in relation to specific goals such as equity, efficiency, and effectiveness, developing specific competencies such as capacity and health systems resilience, techniques including contracting out and technical assistance, and the most effective methods to improve each component of the health system.²⁵ South-to-south networks can also support innovative approaches and effective implementation strategies in fragile settings.

Intensify existing approaches: country-tailored fragility approach

The GFF's current approach in fragile states addresses many key challenges across fragile settings. To more systematically and rigorously address these challenges at no or minimal cost, the GFF will employ a country-tailored fragility approach. The approaches described below are extensions of the GFF's current work rather than entirely new activities and so represent an intensification of the existing engagement with fragile settings rather than a departure from it. Given that, they can be implemented at no or minimal cost.

²⁵ Waldman and Lopez-Acuna, "Neglected Health Systems Research: Health Policy and Systems Research in Conflict-Affected and Fragile States"; Woodward et al., "Health Systems Research in Fragile and Conflict-Affected States."

Being "country-tailored" means that the approaches below will not be systematically rolled out in all GFF countries. Rather, these represent a menu of options that can be deployed selectively based on the context of individual countries, which is particularly important given the diversity of fragile settings.

Contribute to strengthening the humanitarian-development nexus in areas of GFF comparative advantage

In the global discourse on fragility, the conceptual approach to the relationship between the humanitarian and development spheres is evolving, out of recognition that conflicts and displacements are increasingly protracted. Additionally, in many countries, the distinction between "humanitarian" and "development" phases is increasingly blurry.

These shifts necessitate thinking about long-term development issues even in the midst of acute crises, rather than assuming that these can be thought of as two distinct phases. The GFF is well-positioned to contribute to this in two ways.

First, the GFF can build on its existing health financing work to more proactively support ministries of finance and of health to smooth the transition between humanitarian and development financing. As illustrated earlier in the cases of the DRC and Liberia, fragile settings often have highly volatile aid flows, much of which are off-budget. This would go beyond the support that the GFF is currently providing but fits well with the broader GFF agenda of focusing on smart financing.

Second, the GFF can engage further in supporting the coordination of development partners. In most acute crises, well-established protocols exist for coordination (typically led by the UN Office for the Coordination of Humanitarian Affairs) and (as discussed further below) the GFF would not seek to replicate that work. However, these structures are often not set up to facilitate the link to a long-term development agenda, and in particular do not contribute to strengthening the stewardship of ministries of finance and health or facilitating the links between humanitarian and development actors. In line with the GFF's broader emphasis on supporting coordination among financiers, the GFF could more proactively engage on this agenda to strengthen coordination mechanisms and contribute to sustainable financing.

Explicitly contribute to strengthening response capacity, by building resilient health systems and linking with emergency preparedness efforts

Health systems strengthening is an important pillar of the GFF approach, but as discussed earlier these efforts are generally not aimed specifically at building response capacity by strengthening resilience or addressing emergency preparedness. In fragile settings, the GFF can more proactively work with countries to include an explicit focus on strengthening response capacity.

Refining the Investment Case guidance note to highlight some of the ways that response capacity can be strengthened is one approach that can be implemented without additional costs, and then supporting countries that are particularly interested in this area to learn and document lessons. For example, Kruk et al.²⁶, describe five key attributes of a resilient health system: awareness, diversity, self-regulation, integration, and adaptability. Many of the investments described in Investment Cases will contribute to

²⁶ Kruk et al., "What Is a Resilient Health System?"

improving these, but more benefits could be garnered if more deliberate thinking about these aspects informed the selection of priorities in Investment Cases.

For example, results-based financing features in many Investment Cases and this can play an important role in strengthening modularity (i.e., the ability of a system to function in a decentralized manner if parts are cut-off in an emergency), but at the moment this is rarely positioned as an explicit strategy to improve the resilience of the system, which means that it may be a missed opportunity to be considered in a country's broader preparedness approach.

Finally, based on country-specific needs, GFF can link with other emergency preparedness and resiliencebuilding bodies such as the Pandemic Emergency Facility (PEF) to incorporate emergency preparedness in Investment Cases.

Ensure focus on RMNCAH is retained in case of crisis

Any stable GFF country in a development stage may unexpectedly face a crisis that brings it into the humanitarian phase. The GFF's attention to RMNCAH is critical, as women, children, and adolescents in countries that experience emergencies face disproportionate burdens in the transition from development to a humanitarian phase. The GFF is ideally suited to ensuring that the financial needs associated with the health of women, children, and adolescents in emergencies are adequately addressed in government systems (e.g., through dedicated contingency funds or budgetary line items) and the elaboration of longer-term sustainable plans that will last beyond the humanitarian phase.

Encourage programming on the fertility-fragility nexus

The relationship between fertility and fragility is complicated and operates in both directions. Research suggests a higher rate fertility rate among women but lower survival rate among children in some subgroups in fragile settings (e.g., refugees).²⁷ This has significant implications both on the RMNCAH status of women and children as well as the broader contours of the current debates on migration. This particular vulnerability needs to be explored further which can be supported through analytical work and addressed through pilot interventions.

On the other hand, addressing high fertility rates can be an important component of harnessing the demographic dividend and starting a virtuous cycle (particularly when paired with efforts such as educating girls and creating jobs for youth) that puts countries on a trajectory to economic growth and increased societal stability. There are considerable opportunities to scale up approaches to address the root causes of fragility by addressing high fertility, such as in countries in the Sahel. These are also countries that are traditionally underfinanced from both domestic and external resources as compared to the RMNCAH needs.

²⁷ Verwimp P and J V Bavel, "Child Survival and Fertility of Refugees in Rwanda", *European Journal of Population*, June 2005, Volume 21, Issue 2, pp 271–290. Available at http://link.springer.com/article/10.1007/s10680-005-6856-1

Possible new approaches in future, as additional resources are available

As the GFF learns from its current approach in fragile settings, achieves results in stable countries, and mobilizes additional resources, it will be worth considering expanding the approaches that the GFF uses in fragile settings. The approaches described below would come with additional costs so are not proposed for the time being but could add value if additional financing is available.

Consider fragility-specific innovative financing

In fragile settings, innovative resource mobilization mechanisms can be key to address constraints on domestic resource mobilization and provide financial support in case of natural disasters or other emergencies. Innovative financing mechanisms in humanitarian contexts are relatively new and there is currently limited evidence on their effectiveness, but there are some innovations that could be particularly well-suited to fragile settings. For example, development impact bonds as a means to frontload financing to scale up priority interventions and to share risk across public and private sectors. As part of the Investment Case in Cameroon, a development impact bond will be used to support kangaroo mother care. Similarly some humanitarian organizations, such as the International Committee of the Red Cross, are exploring using humanitarian impact bonds in fragile settings.

Prioritize fragility in country selection

The Investors Group agreed to a set of criteria to guide the selection of new countries at its third meeting in Geneva in June 2016. Fragility was not a criterion included at that time, but it could be added to strengthen the GFF's focus on fragility.

Change GFF country eligibility criteria to capture high-need populations not in GFF eligible countries

The universe of countries that are part of the GFF are those contained on the list of 75 countries facing high RMNCAH burdens, as assessed by the Countdown to 2015 initiative. The list was further narrowed by removing high and upper-middle income countries, leaving 63 countries. Jordan, Lebanon, Libya, and Syria are not included among these, but are grappling with serious emergencies (or the consequences of serious emergencies in neighboring countries) that are seriously undermining health systems and resulting in increased health risks for women, children, and adolescents. Syria has particular poor RMNCAH indicators and is experiencing such a significant deterioration in its economy that it may switch from being a country that can only access IBRD financing to become IDA eligible in the near future. The GFF eligibility list could be expanded to include these countries or others with populations with high needs.

Areas outside the GFF's comparative advantage

Some approaches have arisen in discussions related to fragility that have been assessed and determined to be outside the GFF's comparative advantage and so will not be pursued.

Rapid fund disbursement in emergencies

The GFF is not designed to quickly disperse funds for emergency situations. While the facility can finance targeted projects in short timeframes, as happened in northeastern Nigeria, it is important to differentiate between this type of non-emergency response and the quick release of funds over a period of days which is required for an emergency response. Explicit commitment to engaging in the latter may put the GFF in a difficult position if it is unable to quickly release lifesaving funds for emergency situations.

Humanitarian actor coordination

Although the GFF has a key role in supporting the coordination of financiers, in fragile settings that are confronted with acute crises this is under the mandate of the United Nations Office for the Coordination of Humanitarian Affairs, which facilitates the humanitarian cluster system, coordinating actors by sector. As discussed above, in some countries the GFF may have a role in supporting links between humanitarian and development financing, but this is a specific role that does not conflict with the broader mandate of OCHA.

Non-RMNCAH health needs

Fragile settings often feature increased morbidity and mortality due to a broad range of factors (e.g., injuries). The GFF is not the appropriate vehicle to take on this broader agenda.

ANNEX 1: CASE STUDIES

Democratic Republic of Congo (DRC)

Context

In recent years, the Democratic Republic of Congo (DRC) made considerable progress in reducing the under-five mortality rate from 148 deaths per 1,000 live births in 2007 to 104 deaths in 2013. Despite this reduction, the maternal mortality ratio remains high with 846 deaths per 100,000 live births, and other reproductive, maternal, newborn, child, and adolescent health (RMNCAH) indicators continue to perform poorly with, for example, contraceptive prevalence rate remains low at 8.1% for all women of reproductive age and 7.8% for women in a union (unmet needs is estimated at 28%) and chronic malnutrition among children under-five persisting at 43 percent (DHS, 2013-2014). This poor performance is further compounded by economic and geographic disparities. For example, only 36 percent of children in the poorest wealth quintile are immunized compared to 65 percent in the richest wealth quintile (DHS, 2013-2014).

Health expenditure is low, \$13 per capita compared to \$140 in sub-Saharan Africa. The health sector is financed primarily by external sources (40%), out of pocket (40%), and limited public financing (15%). Prevalence of catastrophic health expenditures at national level is 9.2%, however the incidence of catastrophic payment is 12.1 among the poorest 20% (lowest quintile).

RMNCAH service availability, demand, and quality are low. For example, most health facilities do not provide family planning services with almost 33% of health zones covered by functional family planning services. Furthermore, despite the fact gender based and sexual violence (GBSV) is quite high nationwide with 52% of women who have experienced physical violence, 27% sexual violence and more than 52% spousal violence, integrated GBSV is almost inexistent country wide except for the conflict areas (such as the Kivus). Health facility-level governance capacity is limited. Information systems are weak, with efforts to expand CRVS still in the early stages. The health workforce is insufficient (<2 midwives/1000 people) with key specialties not available such as midwives. Furthermore, the health workforce is poorly distributed, poorly remunerated (only 30% of the workforce receives a salary), and under-qualified. Supply chains is fragmented and inefficient with limited capacity, thus resulting in poor availability and quality of drugs, particularly at the provincial level. Despite the health sector challenges, community engagement in the health sector is relatively strong.

GFF added value

The Investment Case takes an equity lens, prioritizing 14 underserved provinces. Strong accent is put on improving public financial management (PMF) to improve budget planning, execution and maximize funding utilization. Efficiency is at the core of the Investment Case, which will be done through resource pooling at the provincial level via contracting in through the "Contrat Unique" (single contract), the objective of which is to have a one budgeted plan of activities at the provincial health administration that is financed through domestic and external funds available at the province level with single fiduciary arrangements (accountability, internal audits, etc.), and one single monitoring and evaluation system as well as reporting mechanism. The single contract system addresses fragmentation of external funding at the provincial level and improve accountability and transparency. In turn, performance based funding

(PBF) contributes to financial management capacity development at the health facility level (both health centers and referral hospital) though open data, autonomy, and payment made to bank accounts rather than in cash and strong verification and counter verification systems. Along with PBF, fixed fee for service schedule will be defined (including cost of drugs) will be defined and subsidized in order to make services more accessible to the population. Access to a minimum package of services will be made available to the most vulnerable free of charge in an effort to make services accessible to the bottom 20% of the population. Along with equity and efficiency gains, both of these financing reforms improve governance and transparency.

To address state capacity challenges, the Investment Case outlines a strategy to build institutional capacity by reinforcing existing system and putting performance contracts at all the level of the health management system to improve the governance and capacity of key actors in the sector focusing on the supply chain, service delivery and provincial health administration. Such emphasis aims at improving provincial governance capacity to manage contracts including accountability systems and community engagement. Community based engagement and incentivization is at the core of the Investment Case, with community platforms being reinforced to not only provide IEC but also RMNCAH services. Multisectoral interventions to address malnutrition and gender based violence are introduced as well interventions to strengthened health information systems, including CRVS. Improvement of the health information system will improve quality of data availability at the provincial and national level on population health status.

How the Investment Case is financed

It is expected that the Investment Case will be financed through government resources as well as a broad ranges of the partners investing in the health sector (and beyond, as some of the activities are outside the health sector and so resources will be drawn from water and sanitation, agriculture and education). To date a new allocation to contribute to filling the gap of the Investment Case has been made by the World Bank, which is investing \$150 million in new IDA grant resource in addition to the current \$220 m IDA project. A grant from the GFF Trust Fund of US\$40 million will be linked to this project.

Liberia

Context

Liberia's health system was severely damaged by the country's civil war and further weakened by the recent Ebola outbreak. Liberia's maternal mortality ratio (1,072/100,000), neonatal mortality rate (26/1,000), and under 5 mortality rate (94/1,000) are high. Challenges run throughout the health system.

Total health expenditure is low with government expenditures well below needs. Out of pocket expenditure is high and regressive. Over fifty percent of Total Health Expenditure (THE) in fiscal year 2011-2012 was from out of pocket expenditures and people in the lowest wealth quintile paid almost as much as those in the highest quintile according to the 2013 Liberia Demographic and Health Survey. External sources provided about eighty percent of the FY 2015/2016 health resources. There are a large number of donors and a need for improved alignment and harmonization. Resource allocations across counties is not evidence based or coordinated, resulting in inequities between counties as well as inefficiencies. There is lack of coordination between community structures and many vertical efforts focusing on different interventions and services.

Both health workforce and supply chains are under-developed. County level leadership, management and governance capacity, as well as accountability systems, require improvement. Data collection and use is limited, particularly disaggregated data. Quality of care at health facilities requires particular improvement with, for example, only 30% of newborns receiving skilled care. There are large regional disparities in service delivery. The south-east region is the poorest and least-served, while generally facilities are concentrated in urban areas. Liberia has a large young population and high teenage pregnancy with limited availability of adolescent health services.

These health service delivery and demand challenges are underlined by weaknesses outside of the health sector including limited road infrastructure and low secondary school enrolment, particularly among girls. Gender inequity, including gender-based violence, is a major issue in Liberia.

Several innovative initiatives helped stop the country's Ebola outbreak including a successful community mobilization effort and a public-private partnership to mobilize resources towards stopping the outbreak.

GFF added value

The Liberia Investment Case was developed in a process designed to be inclusive and government-led. It prioritizes programs to six underserved counties, addressing geographic inequities, with phasing to additional counties depending on available resources. The case also prioritizes adolescent health services. The Investment Case defines a coordinated, efficiency focused financing strategy moving towards UHC. An improved resource allocation formula aims to allocate resources across counties based on needs.

Health systems strengthening and capacity building are incorporated in all aspects of the case. Technical assistance (TA), peer-to-peer learning, and increased support for health facilities based on performance assessments are proposed in the Investment Case. It also outlines results based financing (RBF) at the county and health facility level. The Investment Case includes multisectoral programming, particularly for adolescent health and addressing GBV norms.

Community engagement is a priority area, based on the Ebola response's successes. Performance measurement and accountability mechanisms are incorporated throughout the Investment Case. Emergency response, specifically strengthened integrated disease surveillance and response systems, as well as a data use and reporting framework, are incorporated within the Investment Case. Disaggregated data collection is also included.

How the Investment Case is financed

The Government of Liberia, US Agency for International Development (USAID), the UK Department for International Development (DFID), the German Government, Japan International Cooperation Agency (JICA), the European Community (EC), the Global Fund for AIDS, TB, and Malaria (GFATM), the World Bank (WB), and the Global Alliance for Vaccines and Immunizations (GAVI) will each support different components described in the Investment Case. The GFF Trust Fund will support this with a US\$16 million grant.

Northeastern Nigeria

Context

There is active insecurity in Nigeria's northeastern region. Health services have stopped in some areas and service functionality is limited in others: health facilities are damaged and many health workers have left. Some local administrations have completely collapsed. On top of this, there is substantial internal displacement. Northeastern Nigeria has worse health indicators than most other zones in Nigeria.

GFF added value

The GFF has a regionally focused project aimed at re-establishing health services in the northeastern region using an equity-focused strategy that emphasizes access for the poor. The program uses a tiered approach based on the level of health service disruption due to the conflict, with flexibility to respond to the emergent situation.

In areas with minimal disruption the program supports results based financing (RBF), to ensure service quality and accountability, along with local governance capacity building. In areas with moderate disruption, the program uses RBF with mobile health teams for remote areas. In areas with substantial health service disruption, the program contracts out non-state service providers along with mobile health teams for difficult to access areas. Strengthened community outreach to improve government trust, along with psycho-social support to address the conflict's impacts are important components of the strategy.

The project finances Nigeria's Federal MoH and National Primary Health Care Development Agency (NPHCDA) to contract Civil Society Organizations (CSOs) for health service delivery in target areas. Contract Management and Verification Agencies (CMVAs) manage contracts within local governance areas and Independent Verification Agencies (IVAs) evaluate contract performance. Both CMVAs and IVAs are also CSOs. The State Primary Health Care Development Agency (SPHCDA) selects and manages delivery organizations, CMVAs, and IVAs. State MoHs provide overall stewardship for the project.

How the project is financed

The initial project is financed with 20 million dollars from the GFF Trust Find and 125 million dollars from the International Development Agency (IDA). The GFF has provisionally committed an additional 20 million dollars with IDA funding under consideration for the Investment Case, which will be integrated into the Nigeria National Strategic Development Plan II (NSHDP II).

WORK CITED

- Algasseer, N, E Dresden, G Keeney, and N Warren. "Status of Women and Infants in Complex Humanitarian Emergencies." Journal of Midwifery & Women's Health 49, no. 4 (July 2004): 7–13. doi:10.1016/j.jmwh.2004.05.001.
- Anderson, Michael, Andrew Branchflower, Magüi Moreno-Torres, Marie Besançon, and others. "Measuring Capacity and Willingness for Poverty Reduction in Fragile States." PRDE (Poverty Reduction in Difficult Environments) Working Paper, no. 6 (2005). http://core.ac.uk/download/pdf/7062307.pdf.
- Ayee, Joseph R. A. "Social Inclusion and Service Delivery in a Fragile and Post-Conflict Environment in Africa." Occasional Papers. The African Capacity Building Foundation, 2011. http://elibrary.acbfpact.org/acbf/collect/acbf/index/assoc/HASH7438.dir/file%20095.pdf.
- Brinkerhoff, Derick W. "Developing Capacity in Fragile States." Public Administration and Development 30, no. 1 (February 2010): 66–78. doi:10.1002/pad.545.
- Canavan, Ann, and Petra Vergeer. Fragile States and Aid Effectiveness: An Expanded Bibliography. Royal tropical institute (KIT). Development, policy and practice, 2009. http://www.kit.nl/health/wp-content/uploads/publications/1446_Fragile%20states%20expanded%20bibliography%20May%2 02009.pdf.
- Dietrich, Simone. "Bypass or Engage? Explaining Donor Delivery Tactics in Foreign Aid Allocation*." International Studies Quarterly 57, no. 4 (2013): 698–712.
- Eldon, Jack, Catriona Waddington, and Yasmin Hadi. "Health Systems Reconstruction and State-Building." Health & Fragile States Network 58 (2008).
- Ghobarah, Hazem Adam, Paul Huth, and Bruce Russett. "The Post-War Public Health Effects of Civil Conflict." Social Science & Medicine 59, no. 4 (August 2004): 869–84. doi:10.1016/j.socscimed.2003.11.043.
- Giordano, Thierry, and Michele Ruiters. "Closing the Development Finance Gap in Post-Conflict and Fragile Situations: What Role for Development Finance Institutions?" Development Southern Africa 33, no. 4 (July 3, 2016): 562–78. doi:10.1080/0376835X.2016.1179102.
- Graves, Casey M, Annie Haakenstad, and Joseph L Dieleman. "Tracking Development Assistance for Health to Fragile States: 2005–2011." Globalization and Health 11, no. 12 (December 2015). doi:10.1186/s12992-015-0097-9.

- "High-Level Panel on Humanitarian Financing, Report to the Secretary-General. Too Important to Fail Addressing the Humanitarian Financial Gap.," 2016. https://consultations.worldhumanitariansummit.org/whs_finance/hlphumanitarianfinancing.
- Kruk, Margaret E., Lynn P. Freedman, Grace A. Anglin, and Ronald J. Waldman. "Rebuilding Health Systems to Improve Health and Promote Statebuilding in Post-Conflict Countries: A Theoretical Framework and Research Agenda." Social Science & Medicine 70, no. 1 (January 2010): 89–97. doi:10.1016/j.socscimed.2009.09.042.
- Kruk, Margaret E., Michael Myers, S. Tornorlah Varpilah, and Bernice T. Dahn. "What Is a Resilient Health System? Lessons from Ebola." The Lancet 385, no. 9980 (2015): 1910–12.
- Li, Q. "The Immediate and Lingering Effects of Armed Conflict on Adult Mortality: A Time-Series Cross-National Analysis." Journal of Peace Research 42, no. 4 (July 1, 2005): 471–92. doi:10.1177/0022343305054092.
- Newbrander, William, Chavanne Peercy, Megan Shepherd-Banigan, and Petra Vergeer. "A Tool for Assessing Management Capacity at the Decentralized Level in a Fragile State: ASSESSING DECENTRALIZED MANAGEMENT CAPACITY IN A FRAGILE STATE." The International Journal of Health Planning and Management 27, no. 4 (October 2012): 276–94. doi:10.1002/hpm.1108.
- Newbrander, William, Ronald Waldman, and Megan Shepherd-Banigan. "Rebuilding and Strengthening Health Systems and Providing Basic Health Services in Fragile States." Disasters 35, no. 4 (October 2011): 639–60. doi:10.1111/j.1467-7717.2011.01235.x.
- OCHA. "Syrian Arab Republic: OCHA," 2016. http://www.unocha.org/syria.
- OECD. "Fragile States 2014: Domestic Resource Mobilization in Fragile States." OECD, 2014. https://www.oecd.org/dac/governance-peace/conflictfragilityandresilience/docs/FSR-2014.pdf.
- — . "Fragile States 2014: Domestic Revenue Mobilisation in Fragile States, Paris, OECD-DAC, 2014.,"
 2014. https://www.oecd.org/dac/governance-peace/conflictfragilityandresilience/docs/FSR-2014.pdf.
- ———. States of Fragility 2015. OECD Publishing, 2015. http://www.oecdilibrary.org/development/states-of-fragility-2015_9789264227699-en.

- Ohiorhenuan, John FE, and Frances Stewart. Post-Conflict Economic Recovery: Enabling Local Ingenuity. United Nations Development library, 2008.
- One Campaign. "Financing Stability: How Humanitarian and Development Assistance Must Rise to the Challenge." One Campaign, May 2016. https://s3.amazonaws.com/one.org/images/PR%20-%20Financing%20Stability%20EN%20WEB.pdf.
- Patel, P, M Dahab, M Tanabe, A Murphy, L Ettema, S Guy, and B Roberts. "Tracking Official Development Assistance for Reproductive Health in Conflict-Affected Countries: 2002—2011." BJOG: An International Journal of Obstetrics & Gynaecology 123, no. 10 (September 1, 2016): 1693–1704. doi:10.1111/1471-0528.13851.
- Pavignani, Enrico, and Sandro Colombo. "Analysing Disrupted Health Sectors." WHO, 2009. http://www.who.int/entity/hac/techguidance/tools/disrupted_sectors/adhsm.pdf.
- Ranson, Kent, Tim Poletti, Olga Bornemisza, Egbert Sondorp, and others. "Promoting Health Equity in Conflict-Affected Fragile States." Prepared for the Health Systems Knowledge Network of the World Health Organization's Commission on Social Determinants of Health, 2007. http://www.who.int/entity/social_determinants/resources/csdh_media/promoting_equity_con flict_2007_en.pdf.
- The World Bank. "2017 Harmonized List of Fragile Situatios." The World Bank News, 2016. http://pubdocs.worldbank.org/en/154851467143896227/FY17HLFS-Final-6272016.pdf.
- The World Bank Group. "World Bank Microdata Library." The World Bank, n.d. http://microdata.worldbank.org/index.php/home.
- Tulloch, Olivia, Joanna Raven, and Tim Martineau. "HUMAN RESOURCES FOR HEALTH IN POST-CONFLICT SETTINGS." ReBuild Consortium, 2011. https://rebuildconsortium.com/media/1020/hrh-in-postconflict-a-literature-review.pdf.
- United Nations Every Woman Every Child. "Global Strategy for Women's, Children's and Adolescents' Health – EveryWhere 2020 Vision." United Nations Every Woman Every Child, April 4, 2016.
- Waldman, Ronald, and Daniel Lopez-Acuna. "Neglected Health Systems Research: Health Policy and Systems Research in Conflict-Affected and Fragile States," n.d.
- Woodward, Aniek, Egbert Sondorp, Sophie Witter, and Tim Martineau. "Health Systems Research in Fragile and Conflict-Affected States: A Research Agenda-Setting Exercise." Health Research Policy and Systems 14, no. 1 (December 2016). doi:10.1186/s12961-016-0124-1.

World Bank. Global Monitoring Report 2015/2016: Development Goals in an Era of Demographic Change. The World Bank, 2015. http://elibrary.worldbank.org/doi/book/10.1596/978-1-4648-0669-8.

ANNEX 2: MEMBERS OF THE TASK TEAM

TASK TEAM MEMBERS				
NAME	TITLE	CONSTITUENCY	EMAIL	
Patricia Strong Senior Advisor, Global Health Policy International Operations		Canadian Red Cross (ICRC/IFRC)	patricia.strong@redcross.ca	
Mesfin Teklu Vice President, Health and Nutrition World Vision International		CSO representative on Investors Group	<u>Mesfin_teklu@wvi.org</u>	
Christina Buchan Director Humanitarian Organizations and Food Assistance		Canada	<u>Christina.Buchan@internati</u> <u>onal.gc.ca</u>	
Meena Gandhi	Sexual and Reproductive Health and Rights team	DFID	<u>m-gandhi@dfid.gov.uk</u>	
Rajat Khosla	Human Rights Adviser for Department of Reproductive Health Research	WHO	<u>khoslar@who.int</u>	
Ugochi Daniels	Chief, Humanitarian and Fragile Contexts Branch	UNFPA	<u>daniels@unfpa.org</u>	
Petra Vergeer	Sr. Health Specialist World Bank	GFF Secretariat	pvergeer@worldbank.org	
Andrew Sunil Rajkumar	Sr. Health Specialist, HNP Fragile States Focal point	World Bank	arajkumar@worldbank.org	



www.globalfinancingfacility.org

COUNTRY-POWERED INVESTMENTS FOR EVERY WOMAN, EVERY CHILD.

GFF in fragile settings





FOURTH INVESTORS GROUP MEETING

November 4, 2016, Dar es Salaam



1. Context

- 2. GFF experience to date
- 3. Options for further engagement



1. Context

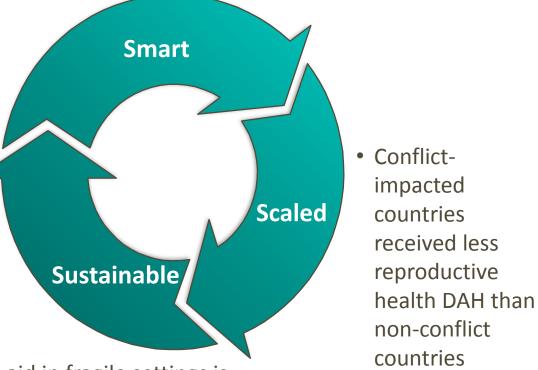
3

Major needs and challenges delivering smart, scaled, and sustainable financing in fragile settings

<u>Major needs:</u>

- Fragile countries were less likely to meet MDGs than non-fragile countries
- Ongoing, acute, refugee crises in Europe, Middle East, and Africa
- The Ebola pandemic and severe impacts to health systems in West African countries
- Poverty increasingly concentrated in fragile settings (currently 21% of global poor, expected to be 50% in 2030)

- Aid volatility → inefficient, difficult for MOH to plan
- Vertical programs → generally do not strengthen broader health systems or build resilience



- Significant share of external aid in fragile settings is off-budget → difficult to sustain
- Fragility dramatically affects revenue generation

Considerable financing opportunities

New funding opportunities	Ways GFF can maximize impact	Applicable countries
A number of donors are increasingly dedicating financing for fragile settings	Investment Case can be an entry point for coordinating and leveraging complementary financing	Fragile LICs and MICs
IDA18 replenishment: resources for FCV countries will increase	Larger IDA envelopes enable countries to allocate more resources to RMNCAH	Fragile LICs and IDA- eligible MICs
World Bank Concessional Financing Facility (CFF): Provision of concessional line of credit to middle income countries hosting refugees	Countries use CFF for host communities, but are reluctant to take out a concessional line of credit for health needs of refugees, which a linked GFF grant could help address	MICs with refugee populations (e.g., Jordan, Lebanon)



2. GFF experience to date

Question is not *if* GFF will engage in fragile settings but <u>how</u>

- 24 (39%) of current 62 eligible countries are categorized as fragile states
- GFF is already operating in fragile settings: among first 16 countries:
 - 4 countries on World Bank Group list of fragile countries:
 DRC, Liberia, Myanmar, Sierra Leone
 - 3 countries with fragile areas: Cameroon, Kenya, Nigeria
 - 1 country with health system severely stressed by Ebola:
 Guinea

Current GFF engagement in fragile settings (1/2)

- Challenging given complex, rapidly-changing contexts
- Two-track approach common:
 - DRC: focus on immediate reforms to improve efficiency (PFM, strategic purchasing) while developing long-term strategy
 - Liberia: immediate work on equity among counties via new resource allocation formula while developing long-term strategy
 - Nigeria: strategic purchasing in emergency context in NE; long-term vision to work on sustainable financing of PHC
- Data-driven approach at heart of Investment Case model
- **Equity** central to process; not designed to focus specifically on fragility but has increased focus on fragile parts of countries
 - Cameroon, Kenya: conflict-affected parts prioritized
 - Nigeria: initial trust fund allocation on conflict-affected parts (poor RMNCAH indicators)
- Does not always result in prioritization of fragile regions (e.g., DRC)

Health systems strengthening

Health

financing

Data-driven

approach,

focusing on

equity

- Core part of all Investment Cases
- Entry point is generally not fragility but particularly important in fragile contexts because of limited capacity

Current GFF engagement in fragile settings (2/2)

Coordination of financiers

- Aligning financing behind priorities of Investment Case is particularly important in fragile settings (many donors, duplication)
- Primarily national but sub-national in some countries (DRC, Kenya)
- Resource mapping is key tool
- Generalized weaknesses in fragile settings mean most sectors need support → strength of GFF model
 - Growing set of experiences:
 - Adolescent health key area of focus (Cameroon, Liberia)
 - Nutrition appearing in all countries
 - Water and sanitation (DRC)
 - Climate change and health (to address emerging root cause of fragility in Bangladesh)

Multisectoral lens



3. Options for future engagement in fragile settings

Options for future engagement in fragile settings

Maintain current approach:

- Many **core GFF approaches are highly relevant** in fragile settings (e.g., focus on equity, sustainable financing, multi-sectoral programs, context-specific approach)
- Emphasis on learning from implementation, including innovative service delivery

Employ a country-tailored fragility approach (no/minimal cost):

- Contribute to **strengthening humanitarian-development nexus** in health financing and development partner coordination
- Explicitly contribute to strengthening response capacity/resilience in fragile settings through refined Investment Case guidance and links with emergency preparedness bodies (e.g., Pandemic Emergency Facility, PEF)
- Ensure focus on RMNCAH in case of crisis, given disproportionate burden on women, infants, and children in emergencies
- Address fertility-fragility intersection (high fertility but lower survival rates among refugee populations, demographic dividend)

Possible new approaches in future as additional resources are available:

- Consider fragility-specific innovative financing (e.g., humanitarian impact bonds)
- Prioritize fragility in new country selection by adding fragility to selection criteria
- Change eligibility criteria to include countries with large, high-need displaced populations (e.g., Jordan, Lebanon, Libya, Syria)

Areas outside of GFF's comparative advantage

Interventions outside of GFF's comparative advantage	Rationale
Rapid emergency fund disbursement	GFF is not designed to release funds for emergency response
Humanitarian actor coordination	UN-OCHA already addressing (GFF may contribute specifically around humanitarian-development financing nexus)
Non-RMNCAH health needs (e.g., injuries, chronic conditions)	GFF approach has been designed to address RMNCAH health needs rather than all health aspects in fragile settings

Guidance requested of the Investors Group

- Three pronged strategy for future engagement:
 - Retain current strategies
 - Country-tailored fragility approach at no/minimal cost
 - Additional approaches in the future as resources and lessons learned become available
- Focus GFF engagement to areas within comparative advantage and away from those outside of this advantage





www.globalfinancingfacility.org

GFF@worldbank.org









IMPROVING ACCESS TO RMNCAH COMMODITIES

OVERVIEW

At the request of the Investors Group, a small task team of technical experts (see Annex 1) was convened in May 2016 to discuss the role of GFF and its partners in improving access to reproductive, maternal, newborn, children's and adolescent health (RMNCAH) commodities. The task team had presented preliminary findings from its first few weeks of work at the Third Investors Group meeting in Geneva in June 2016. This paper provides an overview of the task team's further deliberations and recommendations to the Investors Group.

RECOMMENDATIONS

- Strengthen the in-country technical capacity for countries to address RMNCAH commodity bottlenecks by facilitating stronger collaboration with the Inter-Agency Supply Group (ISG) around relevant and timely issues, especially to help countries move towards a unified supply chain. Work done by the ISG to strengthen the various components of supply chains can be aligned to benefit RMNCAH commodities as well. The ISG have expressed their willingness to collaborate with the GFF, countries and partners in this role, noting the benefit of leveraging the ISG as a platform for coordination across agencies on investments and technical assistance.
- It is crucial to support better translation of global knowledge around commodity access issues into sustained country level use. GFF IG should explore the impact of different mechanisms for addressing this. Supporting a global knowledge network, regional collaboration platforms, and knowledge transfer/ TA built around the GFF Country Platform are options to consider.
- GFF IG should support stronger governance mechanisms around commodities by creating linkages between RMNCAH commodity procurement and distribution to existing programs engaged in good governance of medicines and encouraging Civil Society Organization (CSO) partners to be more engaged in activities related to governance of the commodity sub-system.
- GFF Secretariat to guide countries to technical resources and partners on RMNCAH commodity issues so that investment cases have sufficient level of technical detail on commodities and Investment Case (IC) guidelines are strengthened in this respect. GFF Secretariat should also point countries to the right tools, processes, partners and resources for resolving commodity bottlenecks.

ACTION REQUESTED

- On behalf of Investors Group, the Chair to request the ISG to coordinate across agencies on efforts to improve access to RMNCAH commodities within the unified supply chain, specifically to improve incountry technical capacity in this area.
- The Investors Group requests the GFF Secretariat to strengthen Investment Case guidelines to ensure stronger focus on commodity access.

BACKGROUND

Gaps in the availability and access to reproductive, maternal, newborn, children's and adolescent health (RMNCAH) commodities have been identified as a major barrier to improving the lives of women, adolescents, and children. Barriers include the lack of information on financing, procurement, weak supply chains, inadequate regulatory capacity, and lack of coordination across different stakeholders. At the request of the Investors Group, a small task team of technical experts (see Annex 1) was convened to discuss activities for a potential GFF role in improving access to RMNCAH commodities. The task team's specific mandate was to

- Map and assess what kind of global public goods on commodities are most relevant for GFF countries currently.
- Review the landscape to understand what global-level actions are already well-addressed by existing efforts.
- Identify and prioritize key work streams that the GFF can potentially advance.

The task team presented its preliminary findings at the Third Investors Group meeting in June 2016. The Task team highlighted to the IG that improving access to RMNCAH commodities requires a range of in-country and global activities and while there were some commonalities, procurement and supply chain issues were often different at regional, national and subnational level than at global level. The task team presented a preliminary summary of the commodity access related activities being carried out by partners and demonstrated that GFF partners are currently involved in most of these activities through existing mechanisms. Some of these activities may require more adequate resourcing in the future and the platforms for carrying out some of them may be coming close to the end of their tenure. The task team also underscored the need for stronger coordination and collaboration across agencies working in this area.

The IG requested that the task team, with some membership composition modifications, should continue with this work and present its final summary of findings at the Fourth IG meeting in November 2016.

The IG made a two-fold request to the task team:

Global

- Develop a landscape of key activities and organizations involved in improving access to RMNCAH commodities
- Based on this landscape analysis, help identify areas where there are gaps and/or areas that require greater coordination

Country Level

- Review country investment cases (that were final or close to final)
- Identify common bottlenecks and potential options for global/regional interventions to support a needed RMNCH commodity agenda across countries.

This paper provides an overview of the task team's work on the above areas.

TASK TEAM MEMBERSHIP AND PROCESS

The Commodity Task Team was chaired by Jennifer Adams, Senior Deputy Assistant Administrator in the Bureau for Global Health, USAID, and the expanded task team included fifteen members from different IG partner countries/agencies, including representatives from CSOs, Private Sector, GAVI and Global Fund as requested by the IG (please see Annex 1 for member names and affiliation). The task team conducted three formal meetings/consultations (via conference calls). The discussions focused on providing inputs to the global landscape of RMNCAH commodity access, understanding commodity bottlenecks in Investment cases and developing recommendations for GFF IG consideration. The need for stronger global coordination was a common theme in many of the discussions.

The task team focused its efforts on the specific asks from the IG to identify the main issues common across countries. There was interest from some task team members to delve deeper into recommending detailed implementable solutions to resolve RMNCAH commodity access, but this was beyond the scope of the task team due to the short time frame.

While the task team agreed on a majority of the issues, in instances where the task team members were not in full consensus, the GFF secretariat, under the guidance of the Chair, summarized content to best reflect collective viewpoints. Please note that the outcomes may not reflect organizational positions of task team members.

GLOBAL LANDSCAPE OF CURRENT ACTIVITIES

Based on inputs from task team members, additional technical experts and a comprehensive review of documents and technical reports, a final landscape of activities being carried out by GFF partners was prepared. This landscape of activities focuses primarily on RMNCAH commodities, but as recommended by the IG it also includes larger system wide activities such as those carried out by the Global Fund, GAVI and UNITAID.

Improving access to RMNCAH commodities requires a range of in-country and global activities. GFF partners are focused on improving access to RMNCAH commodities through a variety of approaches and investments. Some of these activities are mostly at a global level and others are focused on resolving bottlenecks in specific countries. Historically, actors have been often limited to specific activities or commodities, which may limit success and sustainability. Also, RMNCAH commodities must be viewed in the context of current trends where demand for medicines is increasing significantly and where the impact on country systems will require broader approaches.

Annex 2 provides a summary of these activities and key partners engaged. A detailed list of activities is provided in Annex 3.

The landscape analysis suggests that leveraging knowledge and information developed at global level needs greater support and more effective targeting to be effectively used at the country level.

Task team deliberations agreed that approaches to improve commodity access from vertical programs such as HIV, Malaria, Immunization and contraceptives may not be the best fit for an overall RMNCAH commodity strategy due to technical and cost reasons. Procurement for many RMNCAH commodities is largely carried out using domestic resources, nationally or often sub-nationally from a combination of local, regional and global suppliers

Also, many RMNCAH medicines have multiple indications, requiring different forecasting, treatment guidelines and system optimization approaches.

REVIEW OF INVESTMENT CASES

A review of seven investment cases¹ that were either fully developed or in advanced stages of development was carried out over a four-week period in August/September by the GFF Secretariat. It was informed by multiple sources, including the task team, relevant supplemental documents on commodity access and interviews with incountry commodity experts. The objective of the review was to identify critical RMNCAH commodity barriers and interventions in each country and explore commonalities in the challenges across countries.

The review revealed that Investment Cases were more focused on broader health system constraints (HRH, infrastructure, and service delivery weaknesses) and as such did not delve deeper into commodity procurement and distribution. The key issues highlighted in the investment cases included frequent stock-outs of select RMNCAH commodities at national and sub-national levels resulting from:

- Poor planning and budgeting for commodities
- HMIS and LMIS challenges including lack of consistent and harmonized data collection
- Lack of funding for training workers for logistics management, warehousing, and supply management.
 Last mile distribution challenges
- Product registration challenges
- Weak governance and transparency
- Additional challenges identified during the analysis of ICs were also included

Additionally, the analysis demonstrated that investment cases do not usually include commodities as a line item in the proposed budgets. General medicines procurement systems, which is where RMNCAH commodities are most often purchased, do not easily accommodate visibility into individual commodities. Furthermore, subnational procurement and financing posed unique challenges to RMNCAH commodity access in decentralized settings.

PRELIMINARY RECOMMENDATIONS

1. Strengthen the in-country technical capacity for countries to address RMNCAH commodity bottlenecks and invest in resolving them

A large number of activities required to improve access to RMNCAH commodities entail strong engagement at the country level. They are best undertaken under the leadership of national governments using existing structures and with partner engagement in specific areas. It is therefore imperative to strengthen the incountry technical capacity for countries to address RMNCAH commodity bottlenecks and invest in resolving them.

¹ Cameroon, DRC, Ethiopia, Kenya, Liberia, Tanzania and Uganda

The Inter-Agency Supply Group is a platform where different agencies (many of them GFF partners) collaborate around relevant and timely issues, especially to help countries move towards a unified supply chain. Work done by the ISG to strengthen the various components of supply chains can be aligned to benefit RMNCAH commodities as well. The ISG has expressed their willingness to collaborate with the GFF, countries and partners in this role, noting the benefit of leveraging the ISG as a platform for coordination across agencies on investments and technical assistance.

The task team seeks guidance from IG on supporting the ISG in their facilitation of collaboration around relevant and timely issues, especially to help countries move towards a unified supply chain.

2. Support better translation of global knowledge into sustained country level use

The landscape analysis shows that while there are multiple activities at the global level, leveraging knowledge and information developed at global level needs greater support and more effective targeting at the country level. Feedback from countries and the task team also confirms that additional efforts are required to improve commodity market, procurement and supply chain knowledge transfer to countries.

A *Life-Saving Commodities Practitioners Network* was launched in August 2016 with the aim of bringing together knowledge and expertise among and between global and country level. Some members expressed a strong need to equip and augment this knowledge network to carry out the role of translating global knowledge into sustained country use. Others expressed reservations against a global network and felt that country based platforms and targeted TA may be better at achieving this.

Also, some agencies working on RMNCAH commodity access are exploring the development of an *RMNCAH Healthy Markets Consortium*. Discussions for the structure, activities and hosting of such a consortium are still in early stages.

The task team therefore recommends that the IG should explore the impact of different mechanisms for addressing this. The ones that were discussed by the task team included:

- Global knowledge network
- Regional collaboration platforms- Regional cooperation bodies, such as EAC, ECOWAS and SADC could be effective partners for advocacy on healthy markets for RMNCAH
- Country based knowledge networks (building on the GFF Country Platform)
- Targeted national and sub-national technical assistance including support for stronger country level Procurement and Supply Management coordination (building on the GFF Country Platform)

3. Support governance mechanisms around commodities

Improving access to RMNCAH commodities sits in the context of overall demand for health products increasing significantly, and along with it the associated risks for poor governance and monitoring failures.

Better data on medicines flow is crucial for better governance. Medicines shortages are noted in *WHA69.25* which should be used to leverage agendas around improved data quality and supply management. GFF should also create stronger linkages of RMNCAH commodity procurement and distribution to existing programs

engaged in good governance of medicines. CSO partners also need to be more engaged in activities related to governance of the commodity sub-system.

4. GFF Secretariat to better guide countries to technical resources and partners on RMNCAH commodity issues

If future investment cases are to be more developed and precise on RMNCAH commodity access issues, the GFF Secretariat needs to have some internal capacity to be able to point countries to where the appropriate technical resources exist (which partners/entities).

It is important that Investment Cases have sufficient level of technical detail on commodities and that IC guidelines are strengthened in this respect. It should also point countries to the right tools, processes, partners and resources for resolving commodity bottlenecks.

ANNEX 1

Commodities Task Team Composition (in no particular order)

Name	Organization
Jennifer Adams (Chair) Debbie Armbruster Aye Aye Thwin	USAID
Andre Dawe Aminur Rahman	Canada
Lisa Hedman	WHO
Pascal Bijleveld	RMNCH Trust Fund
David Sarley	Bill & Melinda Gates Foundation
Sennen Houten Gifty Addico	UNFPA
Meena Gandhi	DFID
Mari Grepstad	Norad
Mark Young David Muhia Athieno Ojoo	UNICEF
Amie Batson	Path
Farouk Shamas Jiwa (Mato)	Merck (Private Sector)
Viviana Mangiaterra	Global Fund
Lauren Franzel Aurelia Nguyen	GAVI
Rama Lakshminarayanan	GFF Secretariat
Prashant Yadav	Expert Consultant

ANNEX 2

Summary Landscape of Commodity Access Activities and Key Partners Involved



ANNEX 3

Detailed Landscape of Activities

Category	Agency/Organization	Activities
Market Shaping- General	CHAI	Multiple projects focussing on improving supply competition, supplier quality, better global forecasts, improving visibility of market demand to suppliers, identifying and executing volume guarantees for RMNCAH products
	UNCOLSC/TRTs	Information, Tools and Resources for Market Shaping. Track market trends for key RMNCAH commodities. Manufacturer mapping for select commodities
	РАТН	Market Dynamics Department that works with partners across the value chain to monitor and analyze key markets and address market inefficiencies for vaccines, drugs, diagnostics, and medical devices across the RMNCAH spectrum. Also works at national and subnational levels to build enabling policy environments for well-functioning markets.
	RHSC	Market Development Approaches Working Group (MDA WG) acts as a forum for discussion on overall market health for RH products. NURHT Caucus focuses on developing markets for new and underused RH products. Tools and resources to help manufacturers. Global Markets Visibility Project with CHAI
	FP2020	Market shaping working group brings together different stakeholders to improve coordination regarding market dynamics on FP commodities
	UNICEF Supply Division	Influences markets through its position as strategic purchaser of RMNCAH products. Information and trends on key product markets. Secured financing for suppliers. Special contracting models for improving market health when needed. LTAs with most suppliers designed with market health considerations.
	UNFPA	Market shaping strategy embedded in procurement. RH Interhcange data as a key tool for market information. Strategic procurement and market shaping partnership with the Global Fund. Procurement Planning Tool

USAID	USAID-CII provides Information, Tools and Resources for Market Shaping. Also provides technical and analytical expertise to market shaping discussions. USAID projects to coordinate procurement across agencies and support creation of global forecasts. Mapping studies in multiple countries to understand procurement and financing. New GHSC award includes market shaping under procurement services
Concept Foundation	Facilitate new supplier entry/competition and quality improvement through technical assistance. Quality of Reproductive Health Medicines (QuRHM) project.
Gates Foundation	Develop new knowledge and consolidate existing knowledge on successful approaches to market shaping. Financing for market shaping
DFID	Financial Support to CHAI and other groups for creating better- functioning markets
Norway	Financial Support to UNCOLSC, RMNCH-ST and other groups for improving market health
Canada	Support to Global Fund for Wambo.org and related market shaping efforts
GAVI	Market shaping a distinct strategy goal. Strong in-house team and demonstrated success in multiple products
Global Fund	A new market shaping strategy. In-house sourcing and supplier analystics teams. Demonstrated success in a number of categories. http://www.theglobalfund.org/en/sourcing/info/
UNITAID	Creating healthier markets is main organizational objective. Demonstrated successes in second line ARV, pediatric ARV, TB Diagnostics, malaria drugs.
Country stakeholders	Part of market shaping forums, involved in local market shaping in some instances, but limited direct engagement in global market shaping efforts.
Jhpiego	Accelovate Project includes market shaping for maternal health commodities.

	Population Council	Develop and introduce new products in global markets, e.g. LNG IUS, implants, vaginal rings for women, and a topical contraceptive gel for men, while working with WHO, national governments and major suppliers to expand the choices available to women and men. Pop Council influences markets and related service delivery and quality.
	Results for Development	Market Dynamics Practice that engages with all levels of the marketplace to address market and delivery barriers for essential MCH commodities. Areas of focus include creating an enabling policy environment, developing robust forecasts, improving market transparency to suppliers, supporting resource mobilization, and providing visibility on in-country registration processes for suppliers.
Global Procurement Coordination	UNICEF Supply Division	Coordination with multiple stakeholders to ensure procurement strategy of key commodities is synchronized across procurers. LTAs with many suppliers.
	UNFPA	Coordination with USAID and other stakeholders to ensure procurement of key commodities is aligned. Strategic procurement and market shaping partnership with the Global Fund
	USAID	Coordination with UNFPA and other procurers
	Country procurers	Not always a part of global procurement coordination discussions
	Interagency Pharmaceutical Coordination group (IPC)	Coordinate across agencies on technical aspects of procurement, quality standards and regulation
	WHO	Information sharing and coordination to address global stockouts
	Global Fund	Pooled Procurement Mechanism for GF recipients. New wambo.org procurement platform offers a simplified ordering process and has potential to expand to other products. The team is actively working towards expanding benefits to non-GF recipients. Also key member of the Pediatric ARV procurement consortium

	RHSC	CARHs (Coordinated Assistance for Reproductive Health Supplies) group of the RHSC works to avoid country-level stock- outs of select RH products e.g. DMPA by shifting orders between procurers or reallocating stock. The RHSC also works to coordin
	Country procurers	EAC, SADC initiating some coordination across countries. PAHO in LatAm
	Canada	Support to Global Fund for Wambo.org (MoU with UNFPA for procurement of non HIV/AIDS, TB, Malaria commodities)
	DFID	Support for SARPAM (regional pooled procurement in Southern Africa)
Procurement cash flow smoothing	USAID	Address cash flow timing gaps through PGH. Exploring other mechanisms
	UNICEF Supply Division	Address cash flow timing gaps through bridge financing for procurement of vaccines and selected products.
	RMNCH SCT	Pilot of bridge financing + supplier financing for procurement of RMNCAH commodities through domestic resources
In-country procurement	USAID	TA for in-country procurement through training and staff secondment.
	UNFPA	TA for in-country procurement through training
[WB	Procurement managers training. CPAR for assessing procurement. TA for med devices in 3 GFF countries
	DFID	Procurement technical support in select country programs
	UNDP	Procurement for country programs in special circumstances. TA to countries on procurement.
	Concept Foundation	Procurement of quality-assured generic supplies.
	UNICEF Supply Division	In-country staff to provide TA on procurement
Quality Assurance- Global	WHO	Prequalification program for select medicines including many RMNCAH products

		Coordination of a coalition of trusted technical partners for regulatory system strengthening
[Categorizing regulatory systems according to levels of maturity/performance.
ſ		Training and capacity building of national regulators
		Model plans for post market surveillance and pharmaco- vigilance
[UNFPA	ERP support for some RMNCAH products where there are not enough WHO Pqed suppliers or products outside the purview of WHO-PQ
[UNICEF	ERP support for some RMNCAH products where there are not enough WHO Pqed suppliers or products outside the purview of WHO-PQ
[Conduct supplier quality audits, inspections
[for non-PQd products – develop ERPs, monographs, guidance on bioequivalence studies
	WHO	Technical support for AMRH and regulatory harmonization with regional blocs (EAC, ECOWAS)
	Gates Foundation	Support for the African Medicines Registration Harmonization (AMRH) initiative and regulatory harmonization within regional blocs (EAC, ECOWAS)t
[World Bank	Technical support and implementation for AMRH and regulatory harmonization with regional blocs (EAC, ECOWAS)
	Global Fund	Design QA policy and Facilitate ERP for select products
[US Pharmacopeia	Provide training on quality procurement for maternal health supplies.
	Concept Foundation	Train local procurers to procure quality-assured maternal and reproductive health commodities.
Quality-in country	WHO	Strengthening all aspects of the national medicine regulatory system through training and other resources

	USAID	Promoting the Quality of Medicines (PQM)-Technical assistance for medicines quality assurance mechanisms
		Training on the Quality Assurance of Reproductive Health Medicines
	[Inspections to assess quality of products
	UNCOLSC/TRTs	Quality of distribution, cold chain for select products
	US Pharmacopeia	Improving quality of local production cGMP. Enhance capacity of NDRA to assess efficacy and quality of select RMNCAH products e.g. implants
In-country registration & EML inclusion	UNCOLSC/TRTs	Technical Support & Advocacy to update Essential Medicines Lists and Registration of New RMNCAH Products
	RHSC	Database to capture registration and EML status of RMNCH commodities. NURHT Caucus discusses registration and EML status and related strategies
	USAID	Technical support to create better pathways for new product registration
	Jhpiego	Representatives are included in many national EML committees in LMICs; also maintain files for guidance on many products across LMICs.
	Family Care International	Maintain EML Search a searchable database of national EMLs (focused on maternal and reproductive supplies, but country EMLs can be downloaded and searched for other products).
	IPAS	Country registration of misoprostol and mifepristone for obstetric care and abortion care
	РАТН	Advocacy for updating Essential Medicines Lists and Registration of New RMNCAH Products
	UNICEF	Technical support to countries and MOH's on updating national policy and nEMLs
	Results for Development	Advocacy for updating Essential Medicines Lists and Registration of child health products

Forecasting- Global	USAID	Participate in development of aggregated forecast for procurement	
	UNFPA	Participate in development of aggregated forecast for procurement	
	СНАІ	Develop aggregate forecasts for select commodities	
	UNITAID	Global forecasts for ACTs, RDTs and other select categories	
	WHO-AMDS	Global forecasts for ARVs	
	GAVI	Strategic Long Terms forecasts for Vaccines	
	RHSC	Facilitate development of aggregate consensus forecasts for select commodities	
	Results for Development	Develop aggregate forecasts for select MCH commodities	
	UNCOLSC/TRTs	Technical resources for development of global forecasts from rolled up country plans	
	Concept Foundation	Design forecasting methodology	
Forecasting-in country	USAID	Technical assistance to countries to estimate Country Level Commodity Needs for select commodities. Procurement Planning and Monitoring Report (PPMR)-JSI.	
	UNFPA	Technical assistance to countries to estimate Country Level Commodity Needs for select commodities	
	UNCOLSC/TRTs	Technical Guides to estimate Commodity Needs at the Country Level	
	Global Fund	Technical assistance through relevant partners to countries to estimate country level commodity needs for GF funded commodities	
	GAVI	Technical assistance through UNICEF and other partners to countries to estimate country level commodity needs for Vaccines and Immunization supplies	
	UNICEF	Technical assistance to countries to estimate Country Level Commodity Needs for select commodities	

	Concept Foundation	Developed forecasting methodology for select RMNCAH products.
Supply Chain- Global	Interagency Supply Chain working Group (ISG)	Coordination platform across agencies to address supply chain problems in-country
		Review of KPIs currently in place by different agencies, organizations in different countries and look to harmonize
		Conduct joint supply chain assessments
	UNCOLSC- Supply Chain TRT	Knowledge briefs and case studies documenting supply chain integration, best practices, private sector role
	UNICEF	Repository to share UNICEF expertise on procurement, warehousing, inventory management, transportation, and system design. Convenes forums of national supply chain staff to facilitate horizontal learning.
	RHSC	Technical briefs on better systems for forecasting, warehousing, distribution, and information management.
		StopStockouts project to create global advocacy on stockouts
ſ	Global Fund	Developing an "In-country supply chain investment strategy"
	World Bank	Knowledge product on supply chain deficiencies and successful approaches
	Gates Foundation	Supply chain resource hubs
		Supply chain technical knowledge on cost effectiveness of different models, future of health commodity supply chains
	1	Facilitate new partnerships e.g. P&G, Coca-Cola, Unilever
	Private sector	Secondment of senior supply chain staff to GAVI, Global Fund. Best practice sharing
	People That Deliver	Advocacy for strengthening SC leadership, conducting HR assessments, competency mapping and developing roadmaps for supply chain capacity development.

Supply Chain- in-country including Last Mile	USAID	Help countries develop good national Supply Chain Strategic Plans
	1	Technical assistance including staff secondment at Ministries of Health on multiple aspects of in-country supply chain
]	Tools, Guidelines and Job Aids for in-country supply chain
	1	Performance based financing e.g Mozambique
	World Bank	Performance based financing eg Nigeria
	1	Support for supply chain TA as part of select country programs
	DFID	Financial assistance to improve essential medicines supply chain in Malawi, Sierra Leone, Zambia
	UNICEF	In-country TA for vaccine, RMNCAH supply chain functions in many countries
	UNFPA	In-country TA for RH supply chain in many countries
	Gates Foundation	Projects in South Africa, Nigeria, DRC, Senegal to improve supply chains through multistakeholder collaboration. Support for SWEDD2.2
	Global Fund	Supply chain integration and strengthening projects in select countries most notably Nigeria and Tanzania
	Private sector	Merck for Mothers & Gates Foundation project in Senegal to improve last mile delivery of contraceptives and other RMNCAH products
	1	Coca-Cola Last Mile Partnership in Ghana, Tanzania and Mozambique
		P&G, Unilever and UPS staff secondment to GAVI, Global Fund, Gates Foundation
Supply Chain Information Systems	USAID	Development and implementation of LMIS systems in multiple countries and overall OpenLMIS

Co-development of OpenLMIS

	1	Procurement Planning and Monitoring Report (PPMR) stock visibility
	UNCOLSC	Inventory of ICT tools for supply chain management
]	Knowledge brief on integration of health management information and logistics
	1	Combining data from LMIS and DHIS2 to create RMNCAH dashobard
	RMNCH ST	Commodity dashboard to identify key bottlenecks across the supply chain
	GAVI	Information systems improvement investments in multiple countries. Data for decision making projects in multiple countries.
	Global Fund	Investments to Improve Logistics Information System as part of supply chain strengthening work. Strong asks for LMIS improvement at country proposal stage
	Gates Foundation	Supply chain control tower projects in 2 countries. Support to LMIS vendors
Governance/ Transparency- Global	WHO	Guidance on Good Governance for medicines including prevention of corruption
	DFID	Initiation of multistakeholder approach for pharmaceutical sector i.e Medicines Transparency Alliance
	USAID	Training and capacity building around medicines/pharmaceutical sector governance
	RHSC	The Advocacy and Accountability Working Group provides a forum for global discussion on accountability for family planning and maternal health supplies.
	The International Budget Partnership	Activities to ensure national budgets are more comprehensive for improved accountability

	World Bank	Activities to ensure national budgets are more comprehensive for improved accountability
Governance/ Transparency- in Country	WHO	In country translation of good governance for medicines program
	Concept Foundation	Training national procurement and regulatory agencies to prioritize quality over price.
	RHSC	Advocacy and Accountability Working Group country members as a whole are working to hold government accountable for commitments to family planning and maternal health.
	MSF	StopStockouts project to create global advocacy on transparency across the procurement and distribution cycle
	UNCoLSC	Galvanised local players around commodity governance issues



www.globalfinancingfacility.org

COUNTRY-POWERED INVESTMENTS FOR EVERY WOMAN, EVERY CHILD.

Commodities Task Team on Access to RMNCAH Commodities





FOURTH INVESTORS GROUP MEETING

3 November, Dar es Salaam

- GFF Investors Group (IG) request to the Commodities Task Team was two-fold:
 - GLOBAL
 - Develop a landscape of key activities and organizations involved in improving access to RMNCAH commodities
 - Use landscape analysis to help identify areas where there are gaps and/or areas that require greater coordination
 - COUNTRY LEVEL
 - Review country investment cases (that were final or close to final)
 - Identify common bottlenecks and potential options for global/regional interventions to support a needed RMNCH commodity agenda across countries

Commodities Task Team Membership

Name	Organization
David Sarley	Bill & Melinda Gates Foundation
Andrew Dawe and Aminur Rahman	Canada
Meena Gandhi	DFID
Prashant Yadav	Expert Consultant
Lauren Franzel and Aurelia Nguyen	GAVI
Rama Lakshminarayanan	GFF Secretariat
Viviana Mangiaterra	Global Fund
Farouk Shamas Jiwa (Mato)	Merck (representing private sector)
Mari Grepstad	NORAD
Amie Batson	PATH (representing CSOs)
Pascal Bijleveld	RMNCH Trust Fund
Gifty Addico and Sennen Hounton	UNFPA
David Muhia, Athieno Ojoo and Mark Young	UNICEF
Jennifer Adams* (Chair), Debbie Armbruster and Aye Aye Thwin	USAID
Lisa Hedman	WHO

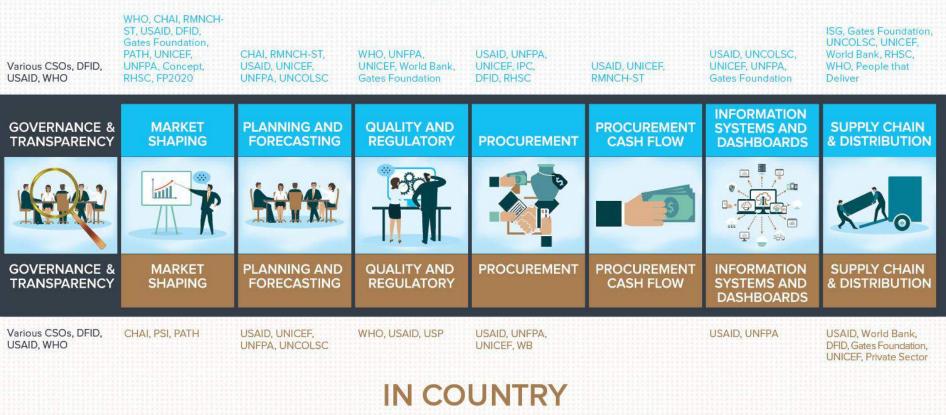
Commodities Task Team Process

- The Task Team had 3 conference calls (July 28, September 15 & October 11) since the last IG meeting in June 2016.
- Given the limited time-frame, the Task Team focused its efforts on the specific asks from the IG to identify the main issues common across countries. Please note that it did not delve into detailed implementable solutions to resolve RMNCAH commodity access.
- In instances where the Task Team members were not in full consensus, GFF secretariat, under the guidance of the Chair, included content to best reflect collective viewpoints. Please note that the outcomes may not reflect organizational positions of task team members.

Global Landscaping of Commodity Activities

- Preliminary landscape developed based on inputs of GFF Commodity Task Team members and quick review of technical reports, presented to the IG in May 2016
- Detailed review included additional inputs from GFF Commodity Task Team members, additional technical experts and a more comprehensive review of technical reports
- Landscape focuses primarily on RMNCAH commodities but also includes activities which are system wide or may have a strong indirect implication on RMNCAH commodities

GLOBAL



- Further details regarding each activity are available in the attached spreadsheet
- Range of activities and actors are different for globally-funded commodities versus domestically-funded commodities

* Typically market shaping would include forecasting, planning, quality and all such aspects. However, given the nature of actors involved, these are spelt out separately from market shaping which here includes only activities that create risk-sharing, long-term contracting, volume guarantees and other innovative instruments.

Global Landscaping: Discussion Points

- Commodity access is achieved through a continuum of activities across markets that affect multiple countries.
- Historically, actors have been often limited to specific activities or commodities, which limits success and sustainability.
- RMNCAH commodities must be viewed in the context of current trends where demand for medicines is increasing significantly and where the impact on country systems will require broader approaches.
- The global landscape analysis coupled with the analysis of GFF investment cases suggests that leveraging knowledge and information developed at global level needs greater support and more effective targeting to be effectively used at the country level.
- Approaches to improve commodity access from vertical programs such as HIV, Malaria, Immunization and Contraceptives may not be the best fit for overall RMNCAH commodity strategy due to technical and cost reasons:
 - Many RMNCAH medicines have multiple indications, requiring different forecasting, treatment guidelines and system optimization approaches.
 - Procurement for many RMNCAH commodities is largely carried out using domestic resources, nationally or often sub-nationally from a combination of local, regional and global suppliers.

Country Investment Case Review

- Investment cases that were final or close to final were reviewed
- The review looked at the following areas within ICs:
 - Regulatory and quality strengthening
 - Importation and customs challenges
 - Financing for RMNCAH commodities
 - Quantification and planning
 - Procurement
 - Storage and Inventory Management
 - First-level distribution
 - Last-mile distribution
 - Registration and Governance
- In addition to review of ICs, supplemental documentation available at country level was reviewed and interviews with in-country key experts were conducted.

Investment Case Review: Discussion Points

- Investment cases primarily focused on broader health system constraints (HRH, infrastructure, service delivery weaknesses) and were not designed to delve deep into commodity procurement and distribution.
- Key issues identified included frequent stock-outs of select RMNCAH commodities at national and sub-national levels resulting from :
 - Poor planning and budgeting for commodities
 - HMIS and LMIS challenges including lack of consistent and harmonized data collection
 - Lack of funding for training workers for logistics management, warehousing, and supply management.
 - Last mile distribution challenges
 - Product registration challenges
 - Weak governance and transparency

Investment Case Review: Discussion Points

- Additional challenges identified in the analysis of ICs included
 - ICs do not usually include commodities as a line item in the proposed budgets
 - Historic and persistent gaps in data have led to financing scenarios in ICs that cannot be substantiated in terms of demand or need
 - General medicines procurement systems, which is where RMNCAH commodities are most often purchased, do not easily accommodate visibility into individual commodities.
 - Sub-national procurement and financing posed a unique challenge in decentralized settings

Strengthen the in-country technical capacity for countries to address RMNCAH commodity bottlenecks and invest in resolving them.

Rationale: With the increasing demand on medicines, the supply chain for RMNCAH commodities and other essential medicines faces tremendous pressures. Additional vertical supply chains have high opportunity costs and may not be feasible.

- Seeking guidance from IG on supporting the Inter-Agency Supply Group (ISG) in their facilitation of collaboration around relevant and timely issues, especially to help countries move towards a unified supply chain. Work done to strengthen the various components of supply chains can be aligned to benefit RMNCAH commodities as well.
- The ISG has expressed their willingness to collaborate with the GFF, countries and partners in this role, noting the benefit of leveraging the ISG as a platform for coordination across agencies on investments and technical assistance.

Support better translation of global knowledge into sustained country level use

Rationale: Feedback from countries and the task team confirms that additional efforts are required to improve commodity markets, procurement and supply chain knowledge transfer to countries. This will require a multi-pronged approach.

- IG to note that a Life-Saving Commodities Practitioners Network was launched in August with the aim of bringing together knowledge and expertise among and between global and country level.
- IG to note that some agencies working on RMNCAH commodity access are exploring the development of a RMNCAH Healthy Markets Consortium. Discussions for the structure, activities and hosting of such a consortium are still in early stages.
- GFF IG should explore the impact of different mechanisms for addressing this. Below are some options:
 - Global knowledge network
 - Regional collaboration platforms- Regional cooperation bodies, such as EAC, ECOWAS and SADC could be effective partners for advocacy on healthy markets for RMNCAH
 - Country based knowledge networks (building on the Country Platform)
 - Targeted national and sub-national technical assistance including support for stronger country level PSM coordination (building on the Country Platform)

Support governance mechanisms around commodities

Rationale: Improving access to RMNCAH commodities sits in a context where overall demand is increasing significantly, including the associated and increased risks for poor governance and monitoring failures.

- Create stronger linkages between RMNCAH commodity procurement and distribution to existing programs engaged in good governance of medicines.
- Medicines shortages are noted in WHA69.25 which should be used to leverage agendas around improved data quality and supply management.
- GFF IG should support existing platforms for governance and data quality for better use of data in commodity supply related decision making.
- CSO partners to be more engaged in activities related to governance of the commodity sub-system.
- IG should receive periodic status and progress updates from GFF partners working on commodity access issues.

GFF Secretariat to better guide countries to technical resources and partners on RMNCAH commodity issues

Rationale: If future investment cases are to be more developed and precise on RMNCAH commodity access issues, GFF secretariat needs to have some internal capacity to be able to point countries to where the appropriate technical resources exist (which partners).

- Important that investment cases have sufficient level of technical detail on commodities and IC guidelines are strengthened in this respect
- Pointing countries to the right tools, processes, partners and resources for resolving commodity bottlenecks, linking to global and regional platforms

Action Points for IG

 On behalf of IG, the Chair to request the ISG to coordinate across agencies on efforts to improve access to RMNCAH commodities within the unified supply chain, specifically to improve in-country technical capacity in this area

 GFF secretariat to strengthen Investment Case guidelines to include stronger focus on commodity access







CLARIFICATIONS ON GFF GOVERNANCE

OVERVIEW

The Investors Group adopted the *Governance Document for The Global Financing Facility in support of Every Woman and Every Child* (GFF-IG1-3) at their first meeting noting that there were aspects of the governance of the GFF that may require further elaboration. The document explicitly stated that the composition and appointment of Investors Group Members would be reviewed after the first year. Several clarifications have been sought by Investors Group members over the course of the first few meetings that need to be addressed by additional guidance. This paper proposes a short process which will result in proposed amendments to the Governance Document which can be presented for adoption at the fifth Investors Group meeting in April 2017.

ACTION REQUESTED

The Investors Group is requested to agree to the proposed process and participate in consultations on any amendments to the Governance Document.

OBJECTIVE

The Investors Group adopted the *Governance Document for The Global Financing Facility in support of Every Woman and Every Child* (GFF-IG1-3) at their first meeting noting that there were aspects of the governance of the GFF that may require further elaboration. The document explicitly stated that the composition and appointment of Investors Group Members would be reviewed after the first year. Several clarifications have been sought by Investors Group members over the course of the first few meetings that need to be addressed by additional guidance. This review will result in proposed amendments to the Governance Document which will be the subject of consultation with IG members before being presented for adoption at the fifth Investors Group meeting in April 2017.

PRINCIPLES AND PURPOSE

The process of reviewing and adjusting the governance document for the GFF is intended as a light touch review of areas where the document explicitly requests adjustments to be made after one year's experience, namely in the composition and appointment of IG members. It provides the opportunity to address gaps that may have emerged in the governance mechanism, and provide greater clarity and guidance on how the IG should operate.

There are two primary guiding principles inherent in the GFF governance process. The first is that the Investors Group's main role is to provide a forum for coordination of financing for RMNCAH and to focus on both mobilizing additional resources and ensuring alignment and complementarity of funding for RMNCAH. The second is to actively engage and collaborate with a wide range of partners to support the mission of the GFF.

Initial experience of the Investors Group has shown that discussions at the Investors Group are in line with these principles, however there is work to be done in ensuring a deeper and more comprehensive dialogue oriented towards solutions. To enrich the discussions it may be necessary to adjust the composition of the Investors Group to include representation from experts engaged in development financing who can help define the health financing agenda within broader financing for development processes. In addition, Ministers of Finance from partner countries could bring a needed perspective to the conversation. It is also not clear how new donors to the GFF, who contribute either to the GFF TF, or by aligning their financing to the Investment Case, will be accommodated in the IG. Thresholds, parameters and accountabilities need to be defined.

A sustainable health financing agenda will require a broad partnership with knowledge of the issues at hand. This is a complex agenda with long term aims and will require staying power in the partnership to ensure results. Is the Investors Group well positioned, through its membership and its operations, to reach and cultivate this broader partnership which should be largely country-based? In what way can the IG facilitate this broader understanding, advocacy and action?

APPROACH

The following principles will guide the approach:

- The governance will be fit-for-purpose, efficient, inclusive and transparent;
- The governance will focus on the added value of GFF involvement in any item under consideration and will not duplicate work undertaken by other entities;
- The governance will be cost-effective and focus on facilitating progress in-country.

The proposed process is as follows:

Q4 2016	Circulate consultation paper to constituencies for feedback. This paper outlines
	approaches to the issues, where possible giving options and pros and cons of the
	approaches.
January	Incorporate feedback and suggestions from IG into consultation paper
2017	Informal consultations with constituencies and collecting of best practice exemplars
February	Re-circulate consultation paper with proposed amendments and key questions
2017	Convene virtual consultation to get feedback and guidance
	Objectives of consultation:
	Create ownership and buy-in
	Develop agreement on main issues before it gets to IG
	Range of ideas and experience of members can inform proposals
March 2017	Paper with proposed amendments circulated to IG in advance of IG5 (April 2017). The
	paper to the IG will propose specific language to be added to the amended Governance
	Document.
April 2017	Review and adoption of revised Governance Document at IG5

ANNEX 1

Issues for Review

Issue 1:

Parameters for selection of a Chair including:

- a. Terms of office/rotation
- b. Nomination/selection process
- c. Need for a Vice Chair

Issue 2: Composition of the Investors Group Addition of seats to IG:

- a. New donors
- b. All countries with GFF financing
- c. Seats for 'thematic experts' (e.g. on financing)

Issue 3: Membership of the Trust Fund Committee

- a. Thresholds
- b. Parameters
- c. Accountabilities

Issue 4: Constituency management

a. Constituency processes and rotation of members

Issue 5: Operational Guidelines for the GFF IG

1. Meeting Protocols:

- a. Guidance needed on Observers
- b. Delegation size
- c. Frequency of meetings

2. Committees/ TTs/Working Groups:

- a. Establishing Mandates
- **b.** Terms of References
- **c.** Membership
- d. Chairing



www.globalfinancingfacility.org

COUNTRY-POWERED INVESTMENTS FOR EVERY WOMAN, EVERY CHILD.

Governance





The Governance consultation is intended to clarify outstanding issues of GFF Governance

 The IG is asked to consider these issues, participate in the consultations and provide guidance over the next few months to develop revisions as needed

Governance Consultation

Q4 2016	Circulate consultation paper (with options and pros and cons
	of approaches) to constituencies for feedback
January	Incorporate feedback and suggestions from IG into
2017	consultation paper
	Informal consultations with constituencies and collecting of
	best practice exemplars
Feb	Re-circulate consultation paper with proposed amendments
2017	and key questions
	Convene virtual consultation to get feedback and guidance
March	Paper with proposed amendments to governance document
2017	circulated to IG in advance of IG5 (April 2017).
April	Review and adoption of revised Governance Document at IG5
2017	



PRIVATE SECTOR ENGAGEMENT

OVERVIEW

This paper provides an update on private sector engagement in the context of the Global Financing Facility as a regular agenda item for the Investors Group, and requests feedback and discussion on the ongoing work. The paper should be reviewed in conjunction with paper GFF-IG4-9 on Resource Mobilization and paper GFF-IG4-2 Portfolio Update.

SUMMARY OF FINDINGS

After the GFF's Private Sector Strategy was approved in March 2016, the GFF Secretariat and partners have focused on implementation. This paper outlines the progress made to date on the three main GFF private sector pathways, including details of the engagements underway in the current private sector focus countries of Cameroon, Kenya, Senegal and Uganda.

On the innovative financing agenda, Vietnam and Guatemala have been identified as the first GFF countries in which GFF Trust Fund grants will be used to buy-down their IBRD loans (each US\$100 million) to concessional rates. A landscape analysis is underway to identify the barriers private investors in health face in GFF countries, and the potential instruments GFF partners can leverage to catalyze greater private capital flow into values-driven health investment. The Medical Credit Fund deal, the pilot for such GFF-supported private sector investment, is currently going through the internal approvals process for a US\$1 million GFF first loss grant.

The first GFF partnership between global private sector and countries is being developed around capacity building for governments on effective selection and procurement of health technologies for their needs. This will be done in coordination with the WHO and will leverage the expertise of private medical technology companies in a transparent and non-competitive manner to strengthen government capacity.

The GFF country experiences with the private sector have included private sector integration in large scale reforms in areas such as service delivery and supply chains, as well as in developing innovative solutions to address Investment Case priorities. Governments are demonstrating great leadership in engaging the private sector to develop joint solutions for health priorities in each country. GFF partners such as USAID and UNFPA are playing a key role in supporting private sector engagement.

There are also some early lessons learnt that are emerging from the experiences to date and these have been included here along with potential solutions. The GFF's approach to private sector will integrate these learnings into both its ongoing and future work.

ACTION REQUESTED

This paper is for information only.

BACKGROUND

The Global Financing Facility uses the flexibility of its trust fund and the expertise of its facility partners to draw in the financial resources and capacity of the private sector to help countries achieve RMNCAH target outcomes. The GFF's equity-driven approach to private sector engagement is built around facilitating and emphasizing the importance of policy and planning process that are inclusive of the private sector resources, and by supporting specific mechanisms at the global and country levels to best leverage private sector resources, capacity and innovation for RMNCAH.

The Investors Group approved the GFF's approach to private sector engagement at the second Investors Group meeting in March 2016. The main pathways for private sector engagement agreed upon were:

- 1. Developing **innovative financing mechanisms** to catalyze private sector capital for Investment Case financing;
- 2. Facilitating partnerships between global private sector and countries;
- 3. Leveraging private sector capabilities in countries to deliver on Investment Case objectives.

All three pathways will require involvement of various GFF partners (including UN agencies, bilateral donors like USAID, multilateral financiers such as Gavi and Global Fund, and World Bank Group institutions such as the IFC) based on the comparative advantage of each institution in working with the private sector.

It was also decided that the Investors Group will retain the Private Sector as a regular item on their agenda and the Secretariat will provide regular updates on the status of the strategic directions above.

PROGRESS ON GFF PRIVATE SECTOR PATHWAYS FOR 2016

Pathway 1: Innovative Financing

The GFF has a unique opportunity to leverage its catalytic grant funding and partner expertise to broker impactful financing structures and effective, market based solutions for investments into RMNCAH. With the right incentive structures in place, the GFF could raise additional financing for countries by supporting values-driven private investment in RMNCAH. Some of the key GFF initiatives underway are:

- 1. Innovative financing landscape analysis:
 - Analytical work is currently underway to identify the key barriers to increased private investment in RMNCAH, as well as potential catalytic instruments GFF trust fund and partners (including the World Bank Group's International Finance Corporation) can use to help "de-risk" greater participation from impact-oriented equity-focused private investors in GFF countries;
 - This study will also identify potential private investors who could form partnerships with the GFF at country/regional/global level for making values-driven health investments in GFF countries;
 - This analysis is expected to be completed in December, with 3-5 potential investment opportunities identified.

- 2. Medical Credit Fund (MCF) deal:
 - The GFF Trust Fund is providing US\$1 million as a first-loss grant to MCF to de-risk private forprofit investors and help raise affordable capital for MCF's expansion of financial services;
 - By leveraging additional private capital for every dollar of grant, this catalytic financing deal will significantly increase overall financing available for local banks to make loans to small and medium healthcare (SME) providers in Africa, in turn increasing access to quality RMNCAH services.
- 3. IBRD loan performance-based buy-downs:
 - IBRD raises funds from capital markets for loans that IBRD-eligible GFF countries can take out to finance investments in health systems;
 - As a function of meeting agreed upon country-specific performance metrics, borrowing countries receive "buy-down" payments from the GFF Trust Fund to bring the IBRD loan to concessional terms;
 - Discussions are underway with Vietnam and Guatemala on designing buy-downs for their IBRD loans (each of which are US\$100 million) using the GFF Trust Fund allocations;

Pathway 2: Global Partnerships

The GFF facilitates partnerships for innovation, global public goods and resource mobilization to match specific needs in country Investment Cases (e.g., technical assistance for supply chain improvement, medical technology procurement, innovative service delivery, etc.). This brings together the resources and expertise of GFF global partners, including private sector, for country needs.

The first such example is around building capacity in GFF countries for more efficient and cost-effective procurement for health technologies:

- Recognizing that GFF countries may require technical support in selecting, procuring/leasing, and introducing the optimal health technologies (both global and local) for their RMNCAH programs, the GFF is facilitating the provision of specialized technical assistance in the form of an initial workshop, combined with follow-up support at country level on priorities identified during the workshop; consultants have been identified to conduct an initial workshop for 2-3 GFF countries that will be selected in the coming weeks based on discussion with governments and priorities outlined in Investment Cases;
- This capacity building work will be done in coordination with WHO, and can leverage a Memorandum of Understanding signed between the World Bank and DITTA¹ for provision of technical expertise in a transparent manner from private sector medical technology companies.

Pathway 3: Leveraging private sector in country

The GFF recognizes that private provider presence in health varies across countries, income groups and types of care, and encourages countries to engage with those private sector actors who are most relevant for their health system, in service delivery and beyond.

¹ Global Diagnostic Imaging, Healthcare IT, and Radiation Therapy Trade Association

The GFF approach relies on country platforms based on the principles of inclusivity and transparency that is responsible for preparing an Investment Case that sets out priorities for RMNCAH, health systems and multi-sectoral programming. These Investment Cases provide an opportunity for government and private sector to design and implement solutions to achieve RMNCAH objectives that harnessing private sector resources, technical expertise, and innovation.

The current focus countries for GFF private sector work are Cameroon, Kenya, Senegal, and Uganda. Highlights of the GFF private sector work underway in each of these are as follows:

- 1. Cameroon
 - The private sector has been engaged throughout the Investment Case process and participated in the Country Platform through an existing private sector association;
 - Key private sector components in Investment Case include:
 - National scale up of Performance-Based Financing (PBF) for facilities providing maternal and child health services, with for-profit private facilities and faith-based organizations being included;
 - Kangaroo mother care (KMC) was identified in the Investment Case as a priority intervention to scale up, as neonatal mortality is high and KMC is not widely used. Grand Challenges Canada and Social Finance are partnering with the Kangaroo Foundation and the Cameroonian Ministry of Health to prepare a Development Impact Bond (DIB) for KMC that would use private capital to provide the initial financing for the scale-up, with investors being paid back at rates that will vary based on the country's performance in rolling out kangaroo mother care. The World Bank project financed by the GFF Trust Fund and IDA will provide US\$2 million as an outcome payer. The DIB is currently in structuring discussions, following which active private investor outreach will begin.
 - The Ministry of Health (MoH) in Cameroon has demonstrated great leadership and taken a very active role in GFF private sector outreach:
 - Minister of Health has sent a letter to major local private sector companies encouraging support to key GFF Investment Case priorities;
 - MoH has initiated early discussions with telecom companies around providing specific support to the Investment Case.
- 2. Kenya
 - The private sector was engaged in Investment Framework preparation through the Kenya Healthcare Federation (KHF), an umbrella body for private sector in health;
 - The Investment Framework highlights several areas for potential private sector participation to be followed up at county level due to Kenya's devolution context;
 - The Kenya World Bank project and GFF grant are providing financing for operationalizing a Joint Health Inspection Checklist (JHIC) developed by the Government of Kenya in collaboration with private sector and support from Health in Africa; the JHIC streamlines and standardizes routine inspections of health facilities across both public and private providers to improve overall quality of care;
 - The UNFPA-led Private Sector Health Partnership (PSHP) in 6 high-need counties has private sector companies such as Philips, Huawei, GlaxoSmithKline, MSD for Mothers and Safaricom using their expertise to support for health priorities:
 - Innovative private-sector designed solutions in the PSHP include Huawei and Safaricom's telemedicine linkages for dispensaries and health centers to connect with experts at county and

regional referral hospitals, Huawei's digital clinics initiative to strengthen the health information management systems of all public facilities in Lamu county, and Philips' Community Life Center for quality private primary health care.

- The Government of Kenya has expressed an interest in expanding their partnerships with the private sector, and have requested additional technical assistance support to increase capacity for private sector engagement; the specifics of this support are currently being discussed.
- 3. Senegal
 - The country is in the initial stages of the Investment Case process and the private sector is participating in the Country Platform through the Private Sector Alliance (a local private sector association); the government is taking a leadership role and actively engaging with private sector to jointly identify RMNCAH solutions with a clear private sector contribution.
 - Based on early discussions with the government, a potential priority for inclusion in the Investment Case is national scale up of the Informed Push Model for supply chains; the IPM pilot was funded by Gates Foundation and Merck for Mothers. The model uses private providers to distribute from the district level down to the health posts, demonstrating great success in reducing stock-outs. The Government of Senegal is now interested in exploring GFF support to institutionalize IPM by 2018.
 - Another area of interest in the Investment Case discussions is the contracting of private midwives to support public RMNCAH service delivery as a potential strategy to deal with HRH gaps.
- 4. Uganda
 - GFF-USAID funded Private Sector Assessment has been completed and delivered to Ministry of Health to support further policy making around leveraging private sector in key areas of RMNCAH and health systems;
 - Key private sector components in Investment Case:
 - Scaling up of results-based financing for both public and private facilities for provision of RMNCAH services;
 - Scaling up of Uganda's maternal health voucher program, using qualified public and private providers to offer services for vouchers;
 - Merck for Mothers is supporting the exploration of possible solutions using private providers to decongest Kampala's over-burdened public facilities; a key stakeholder workshop is being planned for mid-November.

EARLY LESSONS LEARNT FROM GFF COUNTRIES ON PRIVATE SECTOR ENGAGEMENT

Recognizing the GFF is a new mechanism and the complexities of integrating private sector engagement at scale in countries, there has been a deliberate emphasis on "learning by doing" and adapting the GFF private sector pathways for various country contexts and priorities as needed.

From the private sector work underway in current GFF countries, certain key issues and possible solutions for more effective public-private engagement have been identified and are summarized in the following table:

No.	Issues	Potential Solutions		
1	Lack of sufficient clarity on various private sector entry points in the stages of the Investment Case process	GFF Secretariat to revise Investment Case (IC) guidance with details on the integration of private sector components into all relevant stages of the IC process		
2	Limited data is often available on the role of the private sector in health systems; this may not be sufficient for decision-making in Investment Cases	Data gaps regarding private sector can be identified and addressed in early stages of GFF Investment Case (i.e., during the situational analysis) by commissioning additional research and analysis (e.g., assessing role, composition and extent of private sector in service delivery, supply chains)		
3	Governments may not be aware of successful existing private sector solutions; newer innovative private sector proposals may not be backed by data on cost effectiveness, expected impact, etc.	GFF Secretariat will include in the revised IC guidance successful models of leveraging private sector in health systems based on existing evidence and GFF partner initiatives; When private sector stakeholders propose innovative solutions at country level, they are being asked to support this with analysis of comparative cost estimates, expected impact, sustainability, fit with national health policy and regulation, etc. to better support stakeholder decision making around the proposals		
4	Private sector in health is often heterogeneous and fragmented; can be difficult to engage effectively through GFF country platforms	The Country Platform guidance is being revised with detail on developing a mechanism for effective private sector participation at country level, by drawing on best practice from developing and OECD country experiences. This includes suggestions such as using umbrella associations to participate in Country Platforms and manage the GFF private sector constituency for the MoH, thus reducing fragmentation of private sector		
5	Lack of sufficient trust and public- private dialogue between stakeholders at country level	The GFF partners can continue to support governments to establish or strengthen public-private dialogue to create an enabling environment for effective discussion around GFF priorities; this will build on existing partner initiatives such as World Bank's Health in Africa, USAID SHOPS and UNFPA's Kenya private sector initiative.		
6	Limited capacity within governments to manage private sector effectively	The GFF Trust Fund is providing flexible resources to governments for private sector-focused technical assistance alongside capacity building support (training workshops, etc.) to enable greater private sector engagement; this work will also draw on GFF partners with relevant private sector expertise		
Bill#N G/	MELINDA XTES foundation Canadă Canadă Contraction Contraction <td>Main Image: State of the state of the</td>	Main Image: State of the		

www.globalfinancingfacility.org

COUNTRY-POWERED INVESTMENTS FOR EVERY WOMAN, EVERY CHILD.

Private Sector Update





4 November 2016, Dar es Salaam

FOURTH INVESTORS GROUP MEETING

Overarching objective:

GFF to use the flexibility of its trust fund and the expertise of its facility partners to draw in the **financial resources and capacity of the private sector** to help countries achieve RMNCAH outcomes

Three pathways:

- 1. Developing **innovative financing mechanisms** to catalyze private sector capital for Investment Case financing
- 2. Facilitating partnerships between global private sector and countries
- 3. Leveraging private sector capabilities in countries to deliver on Investment Case objectives

All pathways require involvement of various GFF partners (e.g., UN agencies, bilateral donors like USAID, World Bank Group institutions such as IFC, etc.), based on the comparative advantage of each institution in working with the private sector

Pathway 1: Innovative financing

Comprehensive landscape analysis underway

- Aim: to identify barriers to increased private investment in RMNCAH, as well as potential catalytic instruments GFF trust fund and partners can use to help "derisk" impact-oriented equity-focused private investors in GFF countries
- Study expected to be completed in December

Blended financing for RMNCAH investments

- Objective: To draw in private capital to invest in equity focused RMNCAH country priorities
- GFF grant can reduce risk for private investors through various financial instruments (grants, guarantees, concessional finance)
- Medical Credit Fund example

IBRD performance based buy-downs

- Sustainable Development Bond raises private sector financing (IBRD)
- GFF grant buys down interest rate upon achievement of performance targets
- Vietnam and Guatemala IBRD buy down under design

Pathway 2: Partnerships

- Medical technology capacity building
 - GFF countries request technical support in selecting, procuring/leasing, and introducing the optimal health technologies for their programs
 - Workshop and technical assistance for 2-3 GFF countries
 - Countries will be selected based on discussion with governments and priorities outlined in Investment Cases
 - WHO and DITTA* key partners (leveraging technical expertise from private sector)

*Global Diagnostic Imaging, Healthcare IT, and Radiation Therapy Trade Association

Pathway 3: Leveraging private sector in country

Current focus countries: Cameroon, Kenya, Senegal, Uganda Cameroon

- Private sector engaged throughout Investment Case process; participated through existing private sector association
- Key private sector components in Investment Case:
 - Contracting of comprehensive package of maternal and child health services with private providers and faith-based organizations.
 - Development Impact Bond for kangaroo mother Care; GFF TF is outcome payer
- Govt. has taken a very active role in GFF private sector outreach:
 - Letter from Minister of Health to major local private sector companies encouraging support to key Investment Case priorities

Pathway 3: Leveraging private sector in country

Kenya

- Private sector engaged in Investment Framework through Kenya Healthcare Federation (KHF)
- UNFPA-led Private Sector Health Partnership (PSHP) in 6 high-need counties with Philips, Huawei, GSK, MSD for Mothers and Safaricom using their expertise to create solutions for health priorities
- Investment case financing supports various aspects of private sector engagement:
 - Joint Health Inspection Checklist (JHIC) developed by GoK in collaboration with private sector and Health in Africa support
 - Recently launched Maternity Insurance provides comprehensive cover for mothers and children up to the age of one year with choice between public or private providers accredited by NHIF
 - Private sector providers accredited by NHIF are delivering services under Health Insurance Subsidies for the Poor scale up

Senegal

- Private sector engaged in GFF country platform through Private Sector Alliance; strong govt. support to engage
- National scale-up of Informed Push Model (IPM) for supply chains using private providers has been identified as a potential priority for the IC
 - IPM pilot funded by Gates and Merck for Mothers, demonstrated success in reducing stock-outs
 - Government interested in exploring GFF support to institutionalize IPM by 2018
- Contracting/hiring of private midwives to support public RMNCAH service delivery being explored as a potential strategy to deal with HRH gaps

Uganda

- GFF-USAID funded Private Sector Assessment completed
- Key private sector components in Investment Case:
 - Scaling up results-based financing for public and private facilities for provision of RMNCAH services
 - Scaling up of maternal health voucher program; qualified public and private providers will offer services for vouchers
 - Merck for Mothers-supported work underway to explore possible solutions using private providers to decongest Kampala's over-burdened public facilities; key stakeholder workshop being planned for mid-November

Challenges

- Private sector in health often heterogeneous and fragmented; difficult to engage effectively through GFF country platforms
- Lack of data available in initial phase of GFF process
- Limited in country capacity to manage PS effectively

Going forward

- Revise country platform guidelines to support more systematic engagement of private sector
- Include private sector analysis in early stages of GFF Investment Case development
- Support a more systematic approach to private sector engagement in GFF countries through DFID supported course
- Use GFF TF resources for TA





www.globalfinancingfacility.org

GFF@worldbank.org









RESOURCE MOBILIZATION ANNUAL UPDATE

OVERVIEW

A decision was taken at the third Investors Group meeting in Geneva to retain Resource Mobilization (RM) as a regular item on the agenda and for the Secretariat to provide annual updates at the last Investors Group meeting of every year.

This paper provides an update on Resource Mobilization activities and outlines strategic objectives for the next two years based on consultations with the GFF Trust Fund Committee members.

This paper needs to be reviewed in conjunction with papers GFF/IG4/4 Health Financing: Domestic Resource Mobilization and GFF/IG4/8 Private Sector Progress Update.

ACTION REQUESTED

The Investors Group is asked to endorse the GFF resource mobilization priorities for 2017-18 and discuss areas where they can best contribute to the process.

INTRODUCTION

Financing the SDGs will require new ways of approaching development finance that go beyond the traditional emphasis on official development assistance (ODA), given that ODA represents a diminishing share of external financing flows to developing countries: the volume of remittances is now four times that of ODA, and foreign direct investment six times ODA. Taking this broader perspective is critical for RMNCAH, given that the <u>additional</u> annual financing needs for RMNCAH is roughly equivalent to the <u>total</u> volume of all development assistance for health (DAH) for all diseases and conditions.

The GFF acts as a pathfinder in a new era of financing for development by pioneering a model that shifts away from a focus solely on official development assistance to an approach that combines domestic financing, external support, and innovative sources for resource mobilization and delivery (including the private sector) in a synergistic way.

Incremental RMNCAH resource needs are estimated to be approximately US\$33.3 billion a year in 2015. The gap closes to US \$7.4 billion by 2030 as a result of economic growth and the effects that the GFF has by reducing financing needs by generating efficiencies through smarter financing, by crowding in additional domestic resources, and by mobilizing DAH and improving coordination of this assistance, as shown in Figure 1.

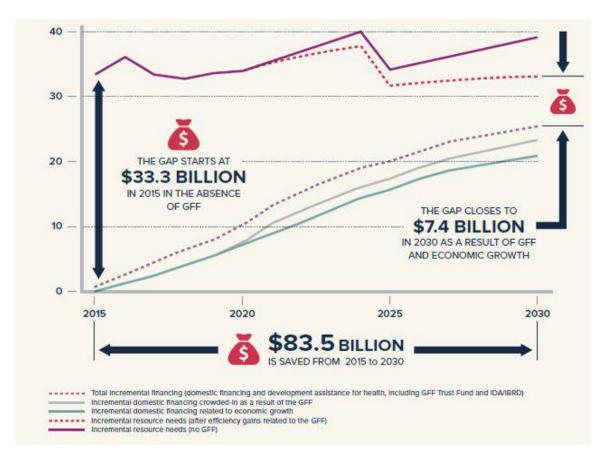


Figure 1: Bridging the financing gap for RMNCAH

The GFF has a four-pronged approach to mobilizing additional domestic and external resources:

- 1. Domestic resource mobilization;
- 2. Complementary financing (DAH and private capital);
- 3. Concessional finance (IDA/IBRD);
- 4. The GFF Trust Fund.

GFF resource mobilization priorities for 2017-18 will focus on:

- support to Governments for increased domestic resource mobilization and public financing for health and that RMNCAH receives adequate resources and that access and equity issues are addressed;
- increasing partner engagement in the development and implementation of country Investment Cases and Health Financing Strategies to further align investments, increase efficiencies and provide GFF countries with increased opportunities for complementary financing;
- defining pathways for effective partnerships with private sector partners to draw in additional resources and expertise;
- mobilizing international private capital through innovative financing mechanisms that increase investments in RMNCAH;
- identifying opportunities for increased levels of concessional financing and additionality in RMNCAH financing;
- broadening the donor base of the GFF Trust Fund to respond to increasing country interest and demand in 2017-18;
- building momentum towards the first GFF Trust Fund Replenishment meeting to take place in 2018 covering resource needs for 2019-21.

DOMESTIC RESOURCE MOBILIZATION

Figure 1 highlights the fact that by far the largest share of financing for RMNCAH will come from domestic resources. If economies continue to grow at historical rates, the resulting increased expenditure on health will close roughly half of the financing gap for RMNCAH by 2030.¹

However, there is considerable scope to do more. The paper GFF/IG4-4 "Health Financing: Domestic Resource Mobilization" examines two key pathways for increasing domestic resource mobilization:

- Increasing general government revenue, particularly in those countries where the ratio of general government expenditure to GDP is below the median for low and lower-middle income countries (holding the share going to health constant); and
- Increasing the share of government expenditure going to health, particularly in those countries that allocate below the median for low and lower-middle income countries.

¹ See Annex 2 of the GFF Business Plan for more details about this modeling.

The domestic resource mobilization potential in the 16 GFF countries from these two approaches is enormous: more than US\$23 billion in additional resources can be generated annually for health in the GFF countries through the combination of increasing general government expenditure as a share of GDP to median levels and modestly increasing the prioritization of health within government spending. There is significant heterogeneity among the GFF countries as to how much can be mobilized through these approaches, but half of the GFF countries can double per capita government health expenditure, which would have a dramatic effect on closing the financing gap for RMNCAH. This is an optimistic scenario and would require challenging reforms at country level that are inherently political and will not occur overnight, but it does give a sense of the magnitude of gains that are possible.

There are also opportunities to generate more private revenue for health from domestic sources, although the origin of these resources is critical: out-of-pocked expenditure (OOPs) is already a significant share of total health expenditure in almost all GFF countries, which is problematic as out-of-pocket payments for health both deters women, adolescents, and children from accessing health services and can result in financial catastrophe and impoverishment. Thus the expansion of repayment schemes that pool resources and protect against catastrophic health expenditures is the main agenda. In addition, there are discussions underway in a number of GFF countries about in-kind or technical resources that can be provided by the private sector, such as by utilizing the expertise of five private companies to support six high-need counties in Kenya (e.g., through telemedicine an digital clinic solutions approaches) or by tapping the communications experience and networks of telecommunications companies in Cameroon.

Complementing the efforts on domestic resource mobilization is an emphasis on improving efficiency. The World Health Organization has estimated that 20-40% of health spending is wasted, so the scope for improvement is considerable, both from addressing allocative efficiency ("doing the right things") and technical efficiency ("doing things the right way"). In most GFF countries, a complementary quick win is to focus on ensuring that the ministry of health fully executes the budget that it is provided (including by addressing any problems in public financial management that make this difficult).

The GFF supports countries to generate additional domestic financing in a number of ways:

- 1. **Assess** the best options for addressing the domestic resource mobilization agenda; for example, by conducting fiscal space analysis or estimating the revenue generation potential of different options for raising additional resources (such as through "sin" taxes);
- 2. **Develop strategies** for increasing domestic resources for health through the support of the preparation of health financing strategies; and
- 3. **Provide implementation support** of key domestic resource strategies (e.g., translation of high-level strategic directions into implementation plans with actionable steps, support to the implementation of the chosen policies through a combination of technical assistance, financing, capacity building and institutional strengthening).

In all of these areas, engagement with ministries of finance in addition to ministries of health is critical to ensure buy-in for key reforms, so he GFF health financing work helps to facilitate this.

Details on the approaches and progress to date applying them in the initial GFF countries can be found in GFF/IG4/4 Health Financing: Domestic Resource Mobilization.

COMPLEMENTARY FINANCING

While the bulk of additional resources for RMNCAH will come from domestic sources, external support is still important in a number of GFF countries. Development assistance for health exceeds US\$35 billion annually, having grown quite rapidly over the past fifteen years (although it has plateaued over the past several years).

The partnership model of the GFF is explicitly geared toward improving the efficiency and coordination of this financing. In particular, through the Investment Case process financiers are engaged in identifying priorities and then aligning their financing to them. This simultaneously strengthens the focus on evidence-based interventions, and reduces duplication between financiers and gaps in financing for critical priorities.

In practice, several different models for the provision of complementary financing have emerged:

- Directing bilateral/multilateral financing to the priorities in Investment Cases using each donor's normal modalities for providing support;
- Establishing trust funds at the World Bank to support implementation;
- Providing dedicated resources to finance technical assistance.

The most common approach is the first of these, orienting bilateral/multilateral financing to address the priorities identified in an Investment Case. In this model, a development partner uses its normal procedures (which could involve directly financing the government or working through civil society, the private sector, the United Nations, or other actors) to channel resources that finance key areas of the Investment Case. This is for example the case with JICA financing in several GFF countries.

For example, in Cameroon the Investment Case specifically focuses on four regions with the worst RMNCAH indicators, so the discussions around complementary financing have been oriented to how development partners can direct their financing to these regions. The World Bank will support the government's expansion of a package of maternal and child health services through results-based financing and the French cooperation will scale up a voucher program. In Uganda, the emphasis was on delivering a comprehensive package in a more synergistic way than is currently the case, such that, for example, demand-side approaches being scaled up by USAID complement the financing provided by the World Bank to strengthen the delivery of services.

The second modality is the establishment of a local trust fund at the World Bank to contribute directly to implementing the Investment Case. For example, this is the approach adopted by USAID in Tanzania, where a US\$46 million single-donor trust fund has been created to support RMNCAH results.

The third approach is to set up dedicated mechanisms to finance technical assistance. In light of a context of increased decentralization, Kenya developed an "Investment Framework" that set the overarching policy direction for the country but then encouraged each county to develop its own investment case. This is a challenging

exercise given capacity constraints at the decentralized level, so DFID and USAID have agreed to support this and are in the process of setting up mechanisms to finance technical assistance to the counties.

The process of securing complementary financing in this manner is occurring to varying extents in every GFF country. A number of lessons have been learned to date about how to do this:

- Early engagement of key financiers is critical: potential financiers are more likely to support the priorities in the Investment Case if they feel that they have been part of the process that develops them and so feel some measure of ownership toward the priorities;
- Strong government leadership is key: in countries where the government has proactively engaged with
 potential financiers and strongly argued to direct financing toward the priorities in the Investment Case,
 more progress has been made in reducing duplications and eliminating gaps in financing;
- Timing matters: it is easier for donors to align their financing if the priorities of the Investment Case are identified in time to inform the development of a new donor program/project, rather than expecting that a donor will restructure its existing investments in light of the development of the Investment Case; inevitably there are multiple donor cycles in one given country so it is never possible to ensure that the Investment Case is done at a time that can optimally shape every donors new financing, but it is important to be attentive to these cycles so as not to miss opportunities;
- Support from headquarters is important: several of the major financiers that are core supporters of the GFF (e.g., JICA, USAID) have been proactive about ensuring that their country offices are well-informed about the GFF process and encouraged to participate in it, which has contributed to greater engagement at national level; to facilitate this, structured conversations at the global level have recently been initiated;
- In-country engagement can bring in new partners: the GFF Investors Group includes many of the major financiers of RMNCAH globally, but in-country processes have facilitated the engagement of new development partners that have not participated in the Investors Group, including the governments/aid agencies of Belgium, France, Germany, Korea, Sweden, and the European Commission.

Several ongoing issues have made the process of securing complementary financing more challenging. First, resource mapping is intended to be a core part of the Investment Case process so as to ensure that the document is based on a realistic sense of the resources available. However, in many of the GFF countries it has proven difficult to get estimates of planned financing from major bilateral and multilateral financiers. This is an area in which further support from Investors Group members will be important.

Second, some governments have not fully assumed their leadership roles with regard to working with external financiers to align their support to nationally-agreed priorities. In some cases this is as a result of unequal power relationships between donors and national governments, whereas in other situations capacity constraints are ongoing challenges, but the effect is that the efficiency gains that can be achieved through better coordination are not being fully realized in some countries.

The discussion above focuses on complementary financing from public sources, which constitute the majority of planned financing of Investment Cases. However, private resources can also make important contributions to complementary financing. National-level efforts were already mentioned above in the section on domestic

resource mobilization, but there are also several global-level efforts are underway to generate private resources to complement this.

A collaboration with Merck for Mothers is being developed to bring expertise and grant financing to support the government to institutionalize innovative supply chain solutions in Senegal (in partnership with the Bill and Melinda Gates Foundation) and to exploring how private providers could be used to decongest overcrowded public facilities in Kampala, Uganda. In Cameroon, a development impact bond is being set up that would use private capital to provide the initial financing to scale up kangaroo mother care (a priority intervention in the Investment Case), with investors being paid back at rates that will vary depending on the country's performance in rolling out kangaroo mother care.

The GFF Trust Fund is also using its resources to de-risk the expansion of the Medical Credit Fund (MCF), a nonprofit health investment fund that is partnering with local banks to provide financing for small and medium enterprises in four African countries (with more to be added after the current financing round). Every dollar of the GFF grant will leverage several dollars of private investment into MCF, expanding greatly the pool of capital available at country level to make loans to SMEs. Exploratory work is also underway to determine which innovative financing approaches offer the best opportunities for the GFF Trust Fund.

CONCESSIONAL FINANCING (IDA/IBRD)

The GFF Trust Fund provides catalytic funding to close the financing gap by linking to IDA and IBRD financing. This improves the quality of IDA/IBRD financing by strengthening the process of identifying national priorities and creates a multiplier effect focused on evidence-based results. The availability of GFF Trust Fund financing has encouraged countries to allocate additional IDA or IBRD financing to health, as was the case in the DRC, Ethiopia, and Vietnam.

In an example of how GFF Trust Fund resources can be used flexibly to encourage additional investments in the health of women, children, and adolescents, two "buy-downs" are being prepared, in Guatemala and Vietnam. In these, grant resources are used to improve the lending terms for countries that access IBRD financing.

To date six projects with GFF Trust Fund financing linked to IDA resources have been approved by the World Bank Executive Directors. As shown in the table below, the overall ratio of GFF Trust Fund grants to IDA is 1:4.3 in these countries. In addition to this, indicative GFF Trust Fund allocations have been made to 12 countries (the ten GFF countries not listed below and second allocations to the DRC and Nigeria). The final trust fund allocations and IDA/IBRD financing are not considered finalized until approval by the Executive Directors, but the current indication is that this ratio will improve as a result of these additional projects.

Country	Board Date	GFF Trust Fund (US\$ millions)	IDA (US\$ millions)	IBRD (US\$ millions)
Tanzania	5/28/2015	\$40	\$200	
DRC (CRVS)	3/29/2016	\$10	\$30	
Cameroon	5/3/2016	\$27	\$100	
Nigeria (emergency project focused on the northeast)	6/7/2016	\$20	\$125	
Kenya	6/15/2016	\$40	\$150	
Uganda	8/4/2016	\$30	\$110	
Board Approved		\$167	\$715	
Projects under preparation	(indicative figures)	\$251	\$1,296	\$100
Total Commitments (indica	ative figures)	\$418	\$2,011	\$100

THE GFF TRUST FUND

The GFF Trust Fund provides catalytic funding to countries in three ways:

- By providing financial and technical assistance to support the development of country Investment Case and Health Financing Strategies mobilizing and improving the efficiency of domestic and external financing for RMNCAH;
- By linking GFF Trust Fund grants with IDA and IBRD financing, which improves the quality of IDA/IBRD financing by strengthening the process of identifying and implementing national priorities;
- By crowding-in private financing, including through de-risking private investments and social impact bonds.

Resources from the GFF Trust Fund have been allocated to a total of 16 countries to date. These countries represent a *Learning Phase* for the GFF in terms of differentiation in approaches in low and lower-middle income countries, commitment to raise domestic resources, opportunities for joint finance with partners and geographic balance. This initial set of countries include:

- Frontrunner countries: DRC, Ethiopia, Kenya and Tanzania;
- Second wave countries: Bangladesh, Cameroon, Vietnam, Liberia, Mozambique, Nigeria, Senegal and Uganda;
- Four countries announced at UNGA: Guatemala, Guinea, Myanmar and Sierra Leone.

Additional pledges to the Trust Fund are required to enable GFF to respond to interest expressed beyond this initial set of 16 GFF eligible countries. The cost of reaching all 62 GFF-eligible countries with one grant (based on the resource allocation formula contained in the GFF Business Plan) was estimated at US\$2.56 billion. To date the signed commitments to the GFF Trust Fund are US\$ 510 million equivalent current value, leaving a sizeable funding gap.

GFF TRUST FUND	
Initial estimates	US\$ 2.56 billion
Signed contributions current value	US\$ 510 million
Funding gap	US\$ 2.05 billion

The majority of Trust Fund commitments of US\$ 508.2 million is allocated directly to GFF countries (91%, including \$418m for country grants and \$45m for country support activities), with the following costs making up the balance: Secretariat costs (5%), Knowledge, Learning and Communications (1%), Trust Fund Administrative fee (0.8%) and Contingency funding (2%).

New pledges to the GFF Trust Fund are now urgently needed to reach additional countries in 2017. The resource mobilization objectives for the next two years are to expand the GFF Trust Fund donor base in 2017 while building momentum for a GFF pledging event to take place in 2018.

Factors taken into consideration regarding the timing of the GFF Trust Fund replenishment included:

- Respecting IDA and GFATM fundraising processes restricting GFF donor outreach until 2017;
- Political shifts and elections taking place in 2016-17 (e.g. EU, France, Germany, Netherlands, UK, US);
- 2017 ODA budget decisions have largely already been taken;
- Current focus on the migrant crisis & climate change;
- Time needed to finalize more country Investment Cases and Health Financing Strategies, collect data and stories to build a solid evidence base and proof of concept for the GFF model.

The best window for a GFF replenishment event is found to be 2018 to cover resource requirements for 2019-2021. This timing aligns well with the replenishment cycles of GFF partners (Gavi 2016-2020, IDA & GFATM both 2017-19).

Work is currently underway to put in place the necessary preconditions for an effective RM strategy. This includes the development of a crisper value proposition for both the GFF *Facility* and GFF *Trust Fund* and defining precise resource requirements for the replenishment period and outcomes to be achieved as a result. Resource mobilization efforts will draw on critical learning from the initial GFF countries, initial results, and extensive consultations with GFF Trust Fund partners and interested new donor partners in 2016-17.

Once the IDA replenishment is completed in December 2016, the GFF leadership and partners, along with World Bank Group leadership, will be proactively reaching out to donors to expand the GFF Trust Fund donor base.

Priorities for 2017-18 include:

- consultation with interested partners and potential new donors, including technical meetings and visits to both public and private sector partners;
- strengthened engagement with CSO and Parliamentary constituencies;

- inviting interested partners and prospective donors to attend Investors Group meetings as observers;
- increased engagement of partners at country level;
- leveraging of high level global events, panels, round tables (e.g. WEF, World Bank Spring and Annual Meetings, UNGA, expert panels, think tanks, academia, etc.);
- cultivation of GFF champions and ambassadors from among the GFF Investors Group and broader partnership;
- developing and launching a global communications, advocacy and social media strategy in support of RM.

A timeline for high level events to be organized and/or leveraged to increase awareness of and commitment to the GFF Trust Fund is outlined in Annex 1. Together these efforts will also set the groundwork for the first GFF Trust Fund pledging event in 2018.

The active engagement of Investor Group members is needed to help build high level support for the GFF mission, principles & activities of GFF and promote active engagement of wide range partners supporting GFF Global Strategy, as outlined in Governance Document GFF/IG1/3, Sept 2015. The GFF Secretariat will facilitate timely engagement of Investor Group members to strengthen complimentary financing of GFF investment cases at country level as well as for global advocacy for resource mobilization for the RMNCAH agenda.

ANNEX 1: ADVOCACY EVENT TIMELINE

2017					
Date	Event	Activity			
January 17-20	World Economic Forum, Davos	GFF presence and advocacy			
March	Launch GFF Annual Report	Advocacy and outreach			
April 21-23	WB Spring Meetings	GFF Event			
April 24	GFF 5 th Investors Group Meeting	Discussion on resource mobilization			
May 22-26	World Health Assembly	GFF Event			
May 26-27	• G7 Summit, Taormina, Sicily, Italy	Advocacy and outreach			
September 12-19	United Nations General Assembly	GFF Event			
October 13-15	WB Annual Meetings	GFF Event			
November	Sixth Investors Group Meeting	Resource Mobilization Annual Update			



www.globalfinancingfacility.org

COUNTRY-POWERED INVESTMENTS FOR EVERY WOMAN, EVERY CHILD.

RESOURCE MOBILIZATION





FOURTH INVESTORS GROUP MEETING

4 November, Dar es Salaam

Objectives and approach

- Strategic objectives 2017-18:
 - To support countries' resource mobilization and public & private financing for RMNCAH
 - To broaden the donor base of the GFF Trust Fund
- Four-pronged approach for delivering the objectives:
 - 1. Domestic resource mobilization
 - 2. Complementary financing (DAH & private capital)
 - 3. Concessional finance (IDA/IBRD)
 - 4. GFF Trust Fund

1. Domestic resource mobilization

- Large potential, via three distinct routes:
 - Increasing general government revenue as a share of
 GDP → increasing to median level for low/lower-middle
 income countries: additional US\$14+ billion per year
 - Increasing prioritization of health in government budgets
 → increasing to median level for low/lower-middle income countries: additional US\$3.3+ billion per year
 - Improving efficiency (e.g., increase budget execution rates)

2. Complementary financing

Model: Investment Cases provide clear set of priorities that financiers align behind

<u>Approach</u>

- Basing new bi-/multilateral programs on Investment Case priorities (or realigning existing programs)
- Establishing trust funds at the World Bank to support priorities
- Providing dedicated resources for technical assistance
- Private sector financing

Experience to date

- Most significant focus: varying stages in all GFF countries but typically at least three financiers (including some non-Investors Group members)
- USAID in Tanzania

- DFID/USAID support in Kenya, BMGF in Ethiopia
- Multiple examples, at both country and global levels

3. Concessional finance

- IDA:
 - Linking to IDA exceeded expectations: ratio of \$1 GFF Trust Fund to \$4.3 IDA/IBRD
 - Trust fund financing mobilizes additional IDA (e.g., DRC, Ethiopia)
- IBRD:
 - Two buy-downs under preparation: Guatemala and Vietnam
 - Trust fund resources used to improve lending terms for countries that have graduated from IDA → expanding the pool of concessional resources for RMNCAH with a particular focus on underserved populations

4. GFF Trust Fund: catalytic funding

- Supporting Investment Case and health financing strategy development with financing and technical assistance
 mobilizing and improving efficiency of domestic and external financing
- Linking to IDA and IBRD financing → increases available additional for RMNCAH and improves quality of IDA/IBRD financing by strengthening analytical and design process with clear focus on national priorities
- Crowding-in private financing, including pay-forperformance schemes and de-risking private investments

Looking forward

Key focus of RM approach

 Strong country ownership and high quality technical programs

Major areas of work:

- Proactive donor outreach
- Increased communications
- Advocacy
- Knowledge and learning

What can the GFF Secretariat and the GFF IG members do more:

- To support countries' resource mobilization and public & private financing for RMNCAH
- To broaden the donor base of the GFF Trust Fund





www.globalfinancingfacility.org

GFF@worldbank.org









GFF SUPPORT FOR STRENGTHENING CIVIL REGISTRATION AND VITAL STATISTICS

OVERVIEW

This paper focuses on one key element of how the GFF contributes to improving results measurement, through the strengthening of civil registration and vital statistics (CRVS) systems in low- and lower-middle income countries. It highlights the importance of CRVS and the current status of CRVS systems in GFF-supported countries. Additionally, the paper provides information on partnership engagements between the GFF and other CRVS stakeholders at national and global levels in supporting country-led CRVS priorities. It concludes by summarizing the general contribution of the GFF in supporting improvements in CRVS systems.

SUMMARY OF FINDINGS

The GFF has prioritized strengthening CRVS systems as a basic human right and as an important data source for tracking and ultimately improving the health and well-being of women, children, and adolescents. In many GFF-supported countries, CRVS systems are weak, with low coverage of birth registration; almost non-existent information on death registration and causes of death; and no production of statistics from the civil registration system.

Many low- and lower-middle income countries face substantial financing gap for strengthening CRVS, with most GFF-supported countries requiring high or moderate investments to have well-functioning CRVS systems. The GFF processes have supported growing momentum towards strengthening CRVS systems at country level and facilitated coordinated partnerships between governments and development partners to support country-led priorities and plans. Support has been provided to specific countries to have strong components of CRVS in Investment Cases and to reinforce dialogue between the ministry of health and ministries or agencies responsible for CRVS. Significant investments have been made in CRVS as a result of GFF processes, particularly through a significant expansion of the number of countries choosing to use financing from the International Development Association (IDA), as well as contributions from the GFF Trust Fund.

ACTION REQUESTED

This paper is for information only.

RESULTS MEASUREMENT FOR THE GFF

The GFF mobilizes smart, scaled and sustainable financing to end preventable maternal, newborn, child and adolescent deaths and improve the health and quality of life of women, children, and adolescents thereby preventing up to 3.8 million maternal deaths, 101 million child deaths, and 21 million stillbirths in high-burden countries by 2030¹. Currently, the GFF focuses on 16 countries: Bangladesh, Cameroon, Democratic Republic of Congo (DRC), Ethiopia, Guatemala, Guinea, Kenya, Liberia, Mozambique, Myanmar, Nigeria, Senegal, Sierra Leone, Tanzania, Uganda, and Vietnam.

Results are at the heart of the GFF's approach. In order to track progress made in ending preventable maternal, newborn, child and adolescent deaths on a regular basis, the GFF has established indicators to be included in each country's Investment Case. These indicators are classified into two broad categories: **core indicators** (core impact level and core health financing) and **additional indicators** (programmatic, health financing, health system strengthening, and monitoring and evaluation system)². This approach is embedded within the monitoring framework of the "Global Strategy for Women's, Children's and Adolescents' Health (2016-2030)" in an effort to ensure close correspondence with the overall reporting process for the Sustainable Development Goals (SDGs). The measurement of these indicators requires appropriate monitoring and evaluation tools. These can include the following:

- Routine administrative data sources (e.g., district health information systems and civil registration and vital statistics [CRVS] systems);
- Facility surveys (e.g., Service Availability and Readiness Assessment [SARA], Service Provision Assessment [SPA], and Service Delivery Indicators [SDA] survey);
- Population-based surveys (e.g., Demographic and Health Surveys [DHS] and Multiple Indicator Cluster Surveys MICS); and
- Demographic and health surveillance systems.

Many GFF-supported countries have inadequate systems to track progress and the GFF has prioritized the strengthening of national data systems. Compared to other data sources, CRVS systems have the potential to provide much better measurement of mortality, including comprehensive data on the causes of death in children, women and adolescents. It is the only data system that can provide continuous data disaggregated at the lowest level of geography in real time.

According to the GFF results measurement framework, there are six **core impact level indicators** to be included in each Investment Case results framework: maternal mortality ratio, under-5 mortality rate, neonatal mortality rate, adolescent birth rate, percentage of women of reproductive age who have their need for family planning satisfied with modern methods and prevalence of stunting among children aged below five years.

Four of these indicators can be derived directly from a well-functioning CRVS system in real time and at the lowest level of geography. In addition, data from the registration of births can provide denominators for **additional programmatic indicators** such as percentage of children fully immunized and proportion of infants who were breastfed within the first hour of birth. In light of these important contributions, the GFF has prioritized the strengthening of CRVS systems as a historically under-funded data source to improve decision-making for RMNCAH programming.

¹ Global Financing Facility 2015. Business plan. Available on <u>www.globalfinancingfacility.org</u>.

² GFF-IG3-5 Results Measurement Available on www.globalfinancingfacility.org

BACKGROUND ON CRVS

Civil registration is defined as "the continuous, permanent, compulsory and universal recording of the occurrence and characteristics of **vital events** pertaining to the population, as provided through decree or regulation in accordance with the legal requirements in each country"³. **Vital events** include births, deaths (and their causes), fetal deaths, marriages, judicial separations, divorces, annulment of marriages, adoptions, legitimations and recognitions. The registration of vital events has two main purposes: (i) to provide legal documentation of identity and civil status as determined by the laws in each country; and (ii) to derive data for the production of vital statistics on a regular basis.

Legal documents derived from civil registration are the foundation of human and civil rights of individuals. They prove identity, citizenship and rights over property and thereby provide access to services or other entitlements⁴ such as education, health, cash transfers and inheritance. Through the registration of births, legal documentation of identity and civil status are provided; death registration provides legal evidence of the fact and circumstances of death which can be used for purposes of inheritance, insurance claims and other death benefits; and marriage and divorce records provide documentation for the establishment of the civil status of individuals for claims for tax benefits, provision and allocation of housing and changing nationality on the basis of marriage⁵. Registration of both births and marriages can also be used to determine eligibility for marriages based on age, thereby providing evidence against early marriage to protect the rights of young girls in particular.

Vital statistics derived from a well-functioning civil registration system is the ideal source from which to derive accurate, complete, timely and continuous information on vital events⁶. Examples of vital statistics that can be derived from civil registration include absolute numbers of births, deaths, marriages and other vital events; age specific and total fertility rates; crude birth and death rates; infant and under-five mortality rates; maternal mortality ratio; and life expectancy at birth. Linked to death registration, information on causes of death can also be derived, including deaths due to communicable and non-communicable diseases and injuries; and from specific causes such as tuberculosis, HIV disease, diarrhea, malaria, cancer and diabetes mellitus.

At the local and national levels, vital statistics have public health importance as well as social, political, and economic benefits⁷ which include estimating the size and growth of a population; implementing and evaluating public, maternal and child health and other programs; understanding the economic and social dimensions of a population; and producing development indicators⁸. Vital statistics can therefore be used by governments to plan

³ United Nations. 2014. Principles and Recommendations for a Vital Statistics System. Department of Economic and Social Affairs, Statistics Division Statistical Papers, Series M, No. 19, Rev.3, p. 65. Available from

http://unstats.un.org/unsd/demographic/standmeth/principles/M19Rev3en.pdf [Accessed 08/10/2016].

⁴ Setel PW, Macfarlane SB, Szreter S, Mikkelsen L, Jha P, Stout, S & AbouZahr C. 2007. A scandal of invisibility: making everyone count by counting everyone. *The Lancet*, Who Counts? 1, DOI:10.1016/S0140-6736(07)61307-5. Available from

http://www.who.int/healthinfo/statistics/WhoCounts1.pdf [Accessed 10/19/2016].

⁵ United Nations. 2001. Principles and Recommendations for a Vital Statistics System. Department of Economic and Social Affairs, Statistics Division Statistical Papers, Series M, No. 19, Rev.2. Available from

http://unstats.un.org/unsd/publication/SeriesM/SeriesM 19rev2e.pdf [Accessed 10/19/2016].

⁶ United Nations. 2014. op cit.

⁷ Mahapatra P, Shibuya K, Lopez AD, Coullare F, Notzon FC, Rao C & Szreter S. 2007. Civil registration systems and vital statistics: successes and missed opportunities. *The Lancet*, Who Counts? 2, DOI:10.1016/S0140- 6736(07)61308-7. Available from http://www.whoCounts2.pdf [Accessed 10/19/2016].

⁸ United Nations. 2014. op cit.

adequately for the current and future needs of the population through developing and implementing evidencebased policies and programs⁹.

With a specific focus on the health sector, a well-functioning CRVS system (registering all births and deaths; issuing birth and death certificates; and compiling and disseminating vital statistics, including cause-of-death information) provide the "gold standard" for the measurement of child, adolescent and adult mortality, including comprehensive data on the causes of death¹⁰. It provides data that can be used for planning, monitoring and evaluation of health programs; and for tracking health indicators at national and sub-national levels. At the global level, the importance of CRVS is recognized in a number of sustainable development goals (SDGs), in particular Goal 3 for monitoring health-related indicators; Goal 16 on birth registration and measurement of violent deaths; and Goal 17 for availability of high-quality, timely and reliable data¹¹.

STATUS OF CRVS IN GFF-SUPPORTED COUNTRIES

It is estimated that globally, almost half of all children and two-thirds of annual deaths are not registered with civil registration authorities¹². Consequently, many low- and lower-middle income countries do not have adequate CRVS systems in place, with progress much slower with the registration of deaths and their causes. Figure 1 summarizes the current status of birth and death registration and cause-of-death statistics¹³. In many of the GFF-supported countries, birth registration coverage is classified as either very low or low. For most of these countries, like other low- and lower-middle income countries, there are generally no data on death registration and correspondingly no data on causes of death. Consequently, most countries have not published any vital statistics from the civil registration system.

With the current status of death registration and causes of death, data to track progress made in ending preventable deaths for many of the GFF countries cannot as yet be derived from the CRVS system. Alternative data sources such as population census and household-based surveys are often used to provide vital statistics, but these sources cannot provide complete and detailed data on a continuous basis. In addition, these sources cannot be used to provide legal identity of individuals to enable them to realize their legal and human rights.

documents/Statistics/CRMC3/making everyone visible en.pdf [Accessed 10/19/2016].

⁹ United Nations Economic Commission for Africa. Not dated. Making everyone visible: Why improving civil registration and vital statistics in Africa is important. Available from http://www.uneca.org/sites/default/files/uploaded-

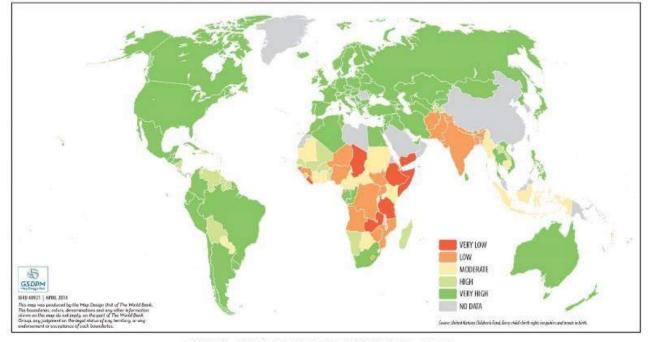
¹⁰ Every Woman Every Child. 2016. Indicator and monitoring framework for the global strategy for women's, children's and adolescents' health (2016-2030). Available from <u>http://www.who.int/life-course/publications/gs-Indicator-and-monitoring-framework.pdf</u> [Accessed 10/19/2016].

¹¹ Pacific Community. 2016. Civil Registration and Vital Statistics (CRVS) and the Sustainable Development Goals (SDGs). Available from <u>http://www.pacific-crvs.org/82-news-and-updates/167-civil-registration-and-vital-statistics-crvs-and-the-sustainable-development-goals-sdgs</u> [Accessed 9/13/2016].

¹² WHO. 2014 Civil registration: why counting births and deaths is important. Available from <u>http://www.who.int/mediacentre/factsheets/fs324/en/</u> [Accessed 10/19/2016].

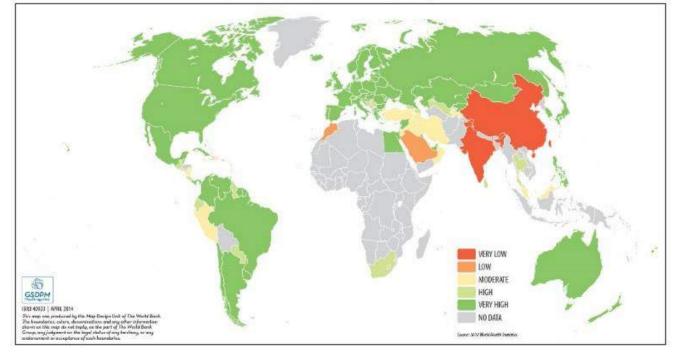
¹³ World Bank and World Health Organization. 2014. Global Civil Registration and Vital Statistics Scaling up Investment Plan 2015–2024. Available from <u>http://www.worldbank.org/content/dam/Worldbank/document/HDN/Health/CRVS%20Scaling-up%20plan%20final%205-</u> <u>28-14web.pdf</u> [Accessed 9/13/2016]

FIGURE 1: STATUS OF BIRTH AND DEATH REGISTRATION

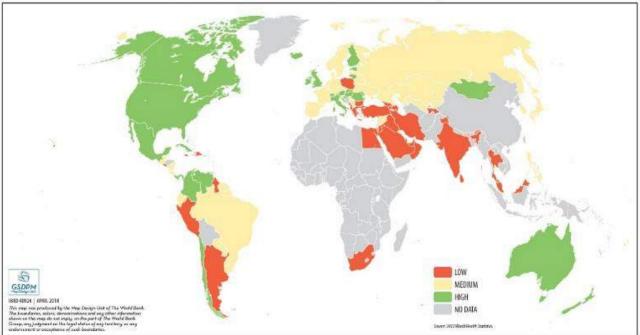


BIRTH REGISTRATION COVERAGE, DECEMBER 2013

DEATH REGISTRATION COVERAGE, 2013



QUALITY OF CAUSE-OF-DEATH STATISTICS, 2012



REQUIREMENTS FOR STRENGTHENING CRVS IN GFF-SUPPORTED COUNTRIES

There is a good cause to prioritize the strengthening of CRVS given the importance of accurate and timely data for informed decision-making, which is necessary for health planning, monitoring and evaluation. For GFF-supported countries, this is particularly important for measuring results in RMNCAH programs, and as a contribution towards providing legal identity for all, including universal birth registration by 2030.

There is also evidence that CRVS has had some positive health outcomes in other settings. For instance, children registered at birth were more likely to be immunized in Dominican Republic, which indicates the effect of the lack of legal identity on access to health services such as immunization¹⁴. Additionally, registered deaths and their causes can provide information to measure the functioning of health systems. For example, monitoring of amenable and preventable deaths can be used to "provide a warning signal of potential shortcomings in health systems"¹⁵.

The importance of CRVS systems in addressing basic human rights and provision of data for evidence-based decision making is growing in many countries, particularly in low- and lower-middle income countries where these systems are mostly weak. There have been calls for concerted efforts at national, regional and global levels to build functional, integrated and sustainable CRVS systems, and individual countries are making efforts to strengthen CRVS systems to achieve universal registration by 2030. At the political level, Ministers responsible for civil registration in Africa and Asia and the Pacific have acknowledged the importance of CRVS and declared 2015–2024 as "the Decade of Civil Registration" with the goal of registering all vital events during this period^{16, 17}. The Ministers in the Americas held their first meeting in September 2016 and committed to universal civil registration of births and deaths. The commitment of strengthening CRVS systems at this high political level and country leadership are important for ensuring that CRVS systems at country level are sustainable.

Many countries have now completed comprehensive or rapid assessments of their CRVS systems and prepared national CRVS strategic plans with the aim of achieving universal registration of births, deaths and causes of death, marriages and divorces as key priority vital events. Other countries have also included fetal deaths, adoptions and other vital events. However, given the current state of many CRVS systems in low- and lower-middle countries in particular, investments required for strengthening these systems are substantial.

The World Bank and the World Health Organization, in consultation with other organizations, prepared an investment plan for global CRVS for 2015–2024 with the goal of estimating additional financial resources required to reach targets aimed at reaching universal civil registration of births, deaths and other vital events, and accessing legal proof of registration for all individuals by 2030¹⁸.

¹⁴ Corbacho A, Brito S & Osorio R. 2013. Does birth under-registration reduce childhood immunization? Evidence from the Dominican Republic. Available from <u>https://publications.iadb.org/bitstream/handle/11319/4660/IFD%20WP%20Does%20Birth%20Under-registration%20Reduce%20Childhood%20Immunization.pdf;jsessionid=69E0BA75D9A015011D7E88089405D799?sequence=1</u> [Accessed 10/20/2016].

¹⁵ Eurostat. 2017. Amenable and preventable deaths statistics. Available from <u>http://ec.europa.eu/eurostat/statistics-</u>

explained/index.php/Amenable_and_preventable_deaths_statistics#Data_sources_and_availability [Accessed 10/20/2016].

¹⁶ United Nations Economic and Social Commission for Asia and the Pacific. 2014. State of civil registration and vital statistics in Asia and the Pacific and overview of supporting initiatives. Available from

http://www.getinthepicture.org/sites/default/files/resources/State%20of%20CRVS%20in%20AP%20and%20overview%20of%20supporting%20initiatives.pdf [Accessed 10/19/2016].

¹⁷ United Nations Economic Commission for Africa. 2015. Ministers propose 2015-2024 as decade on civil registration. Available from http://www.uneca.org/stories/ministers-propose-2015-2024-decade-civil-registration [Accessed 10/19/2016].

¹⁸ World Bank and World Health Organization. 2014. op cit.

Table 1 shows the estimated financing required for 2015–2024 to establish functional CRVS systems in 73 countries of the Commission on Information and Accountability for Maternal and Child Health (COIA). In total, US\$3.8 billion is required, with a financing gap of about US\$2 billion over the ten-year period. The financing gap is mostly required for the development of systems (80% of the financing gap), with the remainder required for recurrent costs; technical support and capacity building; and monitoring and evaluation.

COIA countries were also classified according to their level of need for financing required for strengthening CRVS systems based on birth registration coverage (see Annex 1). Accordingly, the CRVS investment needs of GFF-supported countries fell into the following categories:

- High: Bangladesh, DRC, Ethiopia, Liberia, Nigeria, Tanzania and Uganda (+ 13 other countries);
- Moderate: Cameroon, Kenya, Mozambique, Senegal, Guinea, Myanmar and Sierra Leone (+ 27 other countries); and
- **Low:** Vietnam and Guatemala (+17 other countries).

TABLE 1: ESTIMATED FINANCING GAP FOR 2015–2024 SCALING UP INVESTMENT PLAN (US\$ MILLION)

Costs	Required resources	Available resources	Financing gap
Development costs	2,281	677	1,604
Recurrent costs	1,201	1,152	49
International support to CRVS, including knowledge sharing and strengthening the evidence base	228	0	228
Monitoring and evaluation	114	0	114
Total	3,824	1,829	1,995

PARTNERSHIPS TO SUPPORT THE STRENGTHENING OF CRVS SYSTEMS

Partnerships are at the heart of the overall GFF approach, and that is equally true in the context of CRVS. Financing for CRVS comes first and foremost from national governments. The establishment of the GFF has increased international support for this agenda, including as a result of dedicated financing being available from the GFF Trust Fund. To complement this, the GFF leverages additional resources from the International Development Association (IDA) and International Bank of Reconstruction and Development (IBRD), from other external sources, and from the private sector. Countries qualify for additional resources of up to US\$10 million from the GFF Trust Fund when matched with IDA/IBRD financing, if they explicitly include CRVS in their Investment Case. The final amount is based on the resource gap and the amount of IDA/IBRD allocated to CRVS.

Support for CRVS at country level is also provided by development partners and donors, including United Nations children Fund (UNICEF); World Health Organization (WHO); United Nations Population Fund (UNFPA); Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund); Global Alliance for Vaccines and Immunization (Gavi); Global

Affairs Canada (GAC); United States Centers for Disease Control and Prevention (CDC); United States Agency for International Development (USAID); World Bank Group; PLAN International and PLAN at country level; MEASURE Evaluation; PATH; and others.

The participation and level of support provided by development partners and donors differ per country. UNICEF in particular has provided substantial financial and technical support in many countries to promote birth registration while WHO has mainly provided technical support in death registration and causes of death. Box 1 gives an example of how stakeholders are working together to support CRVS in Mozambique.

With regard to the private sector, countries have received support from mobile phone companies which facilitates mobile notification or registration of events through providing an electronic platform for CRVS. For example, in Tanzania, TIGO has partnered with the government to upload records of all birth registrations to a centralized system through SMSs sent on mobile phones.

At global level, the support provided to countries to improve CRVS systems include the establishment and updating of international standards and tools; undertaking implementation research; and creating a platform for sharing lessons learnt and best practices¹⁹. For example, the GFF is supported by the Centre of Excellence for strengthening CRVS (see Box 2).

¹⁹ World Health Organization. 2014. Civil registration and vital statistics investment planning: Report of a technical consultation. Available from http://www.who.int/healthinfo/civil_registration/crvs_meetingreport_april2014.pdf [Accessed 10/20/2016].

BOX 1: CRVS PARTNERSHIPS IN MOZAMBIQUE

Mozambique is one of the first countries in Africa that took a heed of the recommendations of African Ministers responsible for civil registration to undertake comprehensive CRVS assessments and prepare costed national CRVS strategic plans. The assessment was undertaken in 2013 and the investment plan finalized in 2014. The total budget required to strengthen CRVS was estimated at around US\$ 31 million in 2014. Birth registration for children aged below five years is 48% (28% with birth certificates) and death registration 12%. Cause-of-death statistics is derived only from hospital deaths (9% of all deaths). Three key priority areas for CRVS are:

- 1) Increasing coverage of birth and death registration;
- 2) Generating vital statistics from the civil registration systems; and
- 3) Developing legislation and increasing awareness of CRVS

CRVS activities are undertaken mainly by three ministries: Ministry of Health (MISAU) to provide notification of births and deaths and medical certificate of causes of death for events that occur in health facilities; Ministry of Justice (MINJUST) for the registration of vital events; and National Statistical Institute (INE) for the production of vital statistics. The country is currently piloting the eCRVS system for electronic registration of vital events and awaiting finalization of the legal framework to facility this process.

CRVS activities in the country are facilitated by an Inter-Ministerial Working Group (GITEV) led by MINJUST and includes officials from MISAU, INE, Ministry of Interior and Ministry of Public Administration. Plans are underway to also include the Ministry of Science, Ministry of Foreign Affairs and the University of Eduardo Mondlane.

The United Nations (UN) organization are also coordinated to provide the necessary support for CRVS in Mozambique and formed the UN Task Team on CRVS. The Task Team is chaired by UNICEF and includes officials from UNHCR, WHO, UNFPA and UNDP. Some of the activities of the team include technical support on the CRVS assessment, investment plan and operational plan; coordination of support for CRVS and a harmonized advocacy agenda among UN agencies; and ensuring integration of CRVS into UN planning exercises.

WHO and UNICEF have recently coordinated the development and submission of a CRVS proposal to Global Affairs Canada, with the objectives of supporting the strengthening of the legislation and increasing awareness of the importance of CRVS; and increasing registration of births and deaths. The project has been approved with a total funding of C\$19 million over a period of five years. The project is implemented by UNICEF and WHO.

As part of GFF processes in Mozambique, CRVS has been identified as a priority area for strengthening monitoring and evaluation systems in the country. Immediate plans in this regards include a discussion to outline priorities and activities to be included in the RMNCAH Investment Case and revise the operation plan and to establish a working group to prepare a write-up of costed CRVS activities and priorities for the Investment Case.

BOX 2: THE CENTRE OF EXCELLENCE FOR CRVS SYSTEMS

The Centre of Excellence for CRVS was established by Global Affairs Canada at the International Development Research Centre (IDRC) in December 2015 to serve as a global resource hub that actively supports national efforts to develop, strengthen, and scale-up CRVS systems. It works in close collaboration with the GFF to strengthen CRVS in selected low- and lower-middle income countries.

At the global and regional level, the Centre of Excellence partners with existing stakeholders to cultivate a community of practice to find sustainable solutions to CRVS challenges. It advocates the importance of CRVS systems for improved RMNCAH results; facilitates access to information by curating tools and standards, documenting good practices, and making resources easily accessible through an online platform; and encourages and supports peer learning and exchange opportunities.

At the country level, the key role of the Centre of Excellence is to support the development and implementation of CRVS components in the Investment Cases. The Centre has commissioned a study to unpack the decision-making process that was pursued in Kenya in the preparation of the CRVS component of the Investment Case, to distill key challenges, opportunities and lessons learned. It has also convened international and key national stakeholders in Cameroon to undertake a Business Process Mapping and Analysis exercise. The Centre of Excellence has also engagement with Uganda to identify and connect with key government stakeholders, including the National Identification and Registration Authority (NIRA), National Planning Authority, and Ministry of Health, as well as with other CRVS development partners already active in Uganda such as UNICEF, WHO and Plan International.

GFF SUPPORT FOR STRENGTHENING CRVS SYSTEMS

While countries have their individual CRVS investment plans with specific goals and targets, the global CRVS investment plan focused investments the registration of births, deaths (focusing on maternal and newborn deaths) and causes of death (for deaths occurring in health facilities and in communities). Essentially, the plan proposes that countries should aim to reach universal birth registration by 2030, in line with SDG 16.9; and to have all maternal and newborn deaths reported, registered and investigated as well as all hospital deaths officially certified. Issuance of birth certificates is also prioritized.

The GFF is one of the opportunities through which birth and deaths registration as well as collection of information on causes of death can be strengthened. GFF supports the strengthening of CRVS systems by ensuring that CRVS components are included in countries' Investment Cases for provision of timely and accurate health-related. The GFF plays an advocacy role at country level to highlight the importance of CRVS in monitoring health indicators and in supporting the realization of basic human rights. Priority areas for the GFF in support of RMNCAH programs are birth and death registration including cause of death, as well as registration of marriages with the aim of improving adolescent health through ending child marriages. In collaboration with other partners, the GFF provides technical support to countries to have strong CRVS components in the Investment Case through analysis of the CRVS system and identification of gaps and key interventions required to strengthen CRVS. The Investment Case broadly identifies investments that will make the most difference in the health of women, adolescents and children. The preparation of the Investment Case is a consultative process that involves key RMNCAH stakeholders as well as technical subgroups working on specific components of the Investment Case (e.g., CRVS and health financing). The strengthening of CRVS systems is included as an integral part of Investment Case is informed by priorities set in national health and development strategies and plans, including those in national CRVS strategic plans; and aligned to RMNCAH priorities. An example of the process of integrating CRVS in the Investment Case for Liberia is provided in Box 3.

BOX 3: INTEGRATING CRVS IN THE INVESTMENT CASE IN LIBERIA

Through a consultative process of conducting a comprehensive bottleneck analysis of RMNCAH in Liberia facilitated by the Ministry of Health, it was agreed that there was a need to consolidate RMNCAH efforts if the high maternal and neonatal mortality trends were to be reversed. Further consultations and deliberations concluded that having a functional CRVS system as a key area of investment would be crucial for continuous monitoring of progress towards reducing mortality. Therefore, strengthening the CRVS system was identified as one of the five priority investments for RMNCAH. CRVS was prioritized as a basic social service to its citizens; and for the monitoring and evaluation of health outcomes including maternal mortality ratio, infant and child mortality rates, adolescent birth rates and immunization rates.

Both birth and death registration rates are low in the country, with limited information on causes of death collected. As a results, vital statistics has not been derived from the civil registration system. However, there have been improvements in birth registration in the recent past, with coverage increasing from 4% in 2007 to 25% in 2013. Death registration is estimated at less than 5%.

Priority areas for CRVs included in the Investment Case were identified primarily from the national CRVS investment case completed in December 2015. They include supporting the strengthening of the registration of births and deaths, including causes of death, covering events that occur in health facilities as well as those that occur in the community. Registration of marriages will also be prioritized in light of avoiding early marriages that are directly related to early childbearing and poor adolescent health outcomes. Other priority areas include improving civil registration information systems; strengthening legislation and raising awareness and advocacy; and coordinating national efforts and project management.

The CRVS priority areas were alighted to RMNCAH programs and incorporated in the Investment Case. The consolidated Investment Case was endorsed by Senior Management Team in the Ministry of Health and subsequently endorsed at the Validation Meeting attended by stakeholders, county health teams and administrators from six focus counties. From the Investment Case, CRVS had the largest financing gap of US\$ 1,760,286. The total financing gap for the national CRVS investment for 2016–2020 was estimated at US\$ 3,021,615.

The GFF process at country level has reinforced dialogue between the ministries of health and ministries and agencies responsible for CRVS. In most GFF-supported countries, as in many parts of the world, CRVS falls outside the ministry of health, with limited collaboration on CRVS-related issues across ministries. Thus, the Third

Conference of African Ministers Responsible for Civil Registration highlighted the importance of the health sector in delivering civil registration services and called for the establishment of strong working arrangements with the health sector to improve the delivery of civil registration services²⁰. This third conference was the first to be attended by Ministers of health, following a resolution taken at the Second Conference to invite their counterparts from the health sector.

The strengthening of CRVS, which with the GFF process requires alignment to RMNCAH programs will assist in improving efficiency in the delivery of registration services. Based on Investment Cases that have been finalized or are at the final stages of preparation, there is focus on increasing birth and death registration and collection of information on causes of death. For example, the Uganda Investment Case includes the training of clinical staff and Maternal and Perinatal Death Audit Committees on cause-of-death reporting according to International Classification of Diseases (ICD) guidelines. This is aligned to prioritization of reducing maternal and child deaths in the country, and will consequently improve death registration and, in particular, cause-of-death statistics. In addition, birth registration will also be improved through developing and implementing a plan for using immunization processes as well as community maternal and child health outreach services for community births in Liberia. Investment Cases also focus on linking health information systems to CRVS systems to strengthen data systems in the country and improve the notification and registration of births and deaths.

Furthermore, the GFF has facilitated the process of reprioritizing CRVS activities within broader national CRVS plans/investment cases, which usually have substantial financing gaps. Through this process, countries are able to increase significantly financing for CRVS through leveraging on financing from the GFF Trust Fund and lending facilities from IDA/IBRD. Consequently, countries are able to make some progress in strengthening CRVS as many of them have prioritized CRVS for RMNCAH results monitoring. Even when countries had plans to improve their CRVS systems, they have been unable to make any progress due to lack of additional resources required. For example, DRC has managed to secure a total of US\$20 million (US\$10 million of which was from the GFF Trust Fund) for CRVS to be used for activities to increase the coverage of birth registration through the education sector and for supporting a process of reform leading to a costed revised national strategy and implementation plan.

The GFF process has also facilitated collaboration between development partners and donors in support of CRVS activities at country level. Through the process of preparing the Investment Case, domestic and other resources available for CRVS (financial and technical) in the country are established, as well as the identification of other partners involved in CRVS. In addition, the prioritization of CRVS activities for the Investment Case involves multiple stakeholders as CRVS cuts across many sectors. These activities assist in bringing together key CRVS stakeholders and facilitate the integration and coordination of activities aimed at improving CRVS systems in countries.

Notwithstanding the positive issues highlighted above, it is challenging for the GFF process to meet the high expectations at country level for substantial financial support required for strengthening CRVS systems. The main risk for CRVS in the GFF process is insufficient financing, given other priorities in the RMNCAH program. Furthermore, while some progress will be made in improving CRVS through the GFF, with the current level of birth and death registration, it may take some years for the CRVS system to be fully functional to provide the core impact level indicators for RMNCAH results monitoring. These challenges require that the CRVS agenda within the GFF context be highly focused and well prioritized, rather than trying to address of the myriad needs.

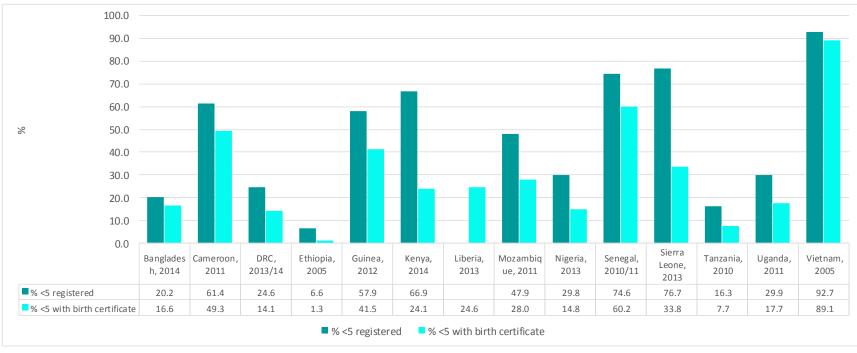
²⁰ United Nations Economic Commission for Africa. 2015. The third conference of African Ministers responsible for civil registration: Yamoussoukro declaration. Available from <u>http://www.uneca.org/sites/default/files/uploaded-documents/Statistics/CRMC3/crmc3-final_resolution_third_ministerial_conference_on_crvs_en.pdf</u> [Accessed 10/20/2016].

CONCLUSION

GFF/IG4/10

Through the engagements of the GFF at country level, there is growing momentum towards strengthening CRVS systems and building coordinated partnerships among development partners and donors to support country-led priorities and plans. The GFF process has resulted in significant investments in CRVS, including through IDA financing and GFF Trust Fund resources, to improve CRVS system. Countries are also focusing on strengthening connections between CRVS systems and the health sector, which has been a missing link for many countries. However, more efforts are still required as significant challenges remain in CRVS, especially for death registration and causes of death.





ANNEX 1: PERCENTAGE OF CHILDREN AGED BELOW FIVE YEARS WITH BIRTHS REGISTERED WITH THE CIVIL REGISTRATION AUTHORITY AND ISSUED BIRTH CERTIFICATES*

* No comparable information available for Guatemala and Myanmar Source: Demographic and Health Surveys

15

COUNTRY-POWERED INVESTMENTS FOR EVERY WOMAN, EVERY CHILD.

Support for strengthening civil registration and vital statistics





4 November, Dar es Salaam

FOURTH INVESTORS GROUP MEETING

Introduction

- Results measurement approach agreed at third Investors Group meeting (Geneva, June 2016)
 - Agreement on core and additional indicators to be included in each country's Investment Case (*aligned with EWEC, SDG processes*)
 - Programmatic, health financing, health systems strengthening, M&E capacity
 - Core programmatic indicators:
 - Maternal mortality ratio
 - Under-5 mortality rate
 - Neonatal mortality rate
 - Adolescent birth rate
 - Percentage of women of reproductive age who have their need for family planning satisfied with modern methods
 - Prevalence of stunting among children aged under-5 years

Results measurement for the GFF

- Many GFF-supported countries have inadequate monitoring and evaluation systems
- GFF prioritizes strengthening of national systems
 - CRVS systems have the potential to provide much better measurement of mortality, including comprehensive data on causes of death
 - CRVS prioritized as a previously under-funded data source

Background on CRVS

- Civil registration (CR) the continuous, permanent, compulsory and universal recording of the occurrence and characteristics of vital events pertaining to the population
- Vital statistics (VS) the collection of statistics on vital events (e.g., births, deaths [and causes of death], marriages, divorces) in a lifetime of a person as well as relevant characteristics of the events themselves
- A well-functioning CRVS system registers all births and deaths, issues birth and death certificates and compiles and disseminates birth and death statistics, including cause-of-death information

Legal documents

- Prove identity, citizenship and rights over property
- Realization and protection of human and civil rights

Real-time data

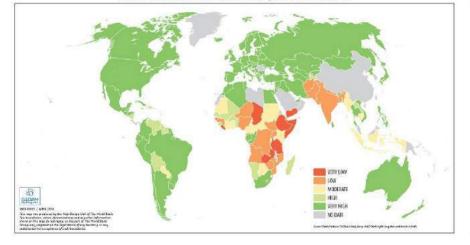
- Estimating population size and growth
- Implementing and evaluating public, maternal and child health programs
- Understanding economic and social dimensions of population
- Producing development indicators

Source: UN, 2014

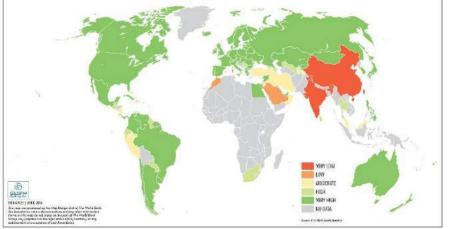
Importance of CRVS for the health sector

- Gold standard for measurement of fertility; and child, adolescent and adult mortality
 - E.g., infant and child mortality rates, maternal mortality ratio, communicable and non-communicable diseases, TB, HIV, adolescent birth rate
- Planning, monitoring and evaluation of health programs
- Data available at lower levels of geography for adequate planning of current and future needs
- Other uses:
 - Evidence that CRVS can have positive health outcomes (birth registration and immunization)
 - Data from CRVS may also be used to provide signal of potential shortcomings in the health system

Status of CRVS and cause-of-death statistics

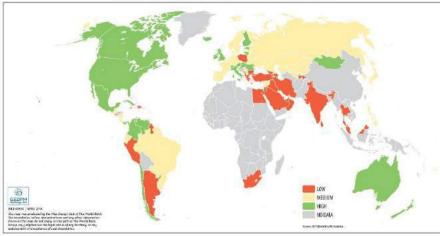


BIRTH REGISTRATION COVERAGE, DECEMBER 2013



DEATH REGISTRATION COVERAGE, 2013

QUALITY OF CAUSE-OF-DEATH STATISTICS, 2012



- Calls for efforts to build functional, integrated and sustainable CRVS systems
- 2015–2024 declared "Decade of Civil Registration" in Africa, Asia and the Pacific by CR Ministers, with the goal of registering all vital events
- Many countries have completed assessments of CRVS systems and costed national CRVS strategic plans
- Substantial financing gap: "Global CRVS scaling-up investment plan: 2015–2024" estimates gap at ~US\$2 billion
 - GFF countries largely "high" or "moderate" need

- National governments
- GFF Trust Fund + IDA/IBRD: Countries qualify for up to US\$10 million from GFF Trust Fund when matched with IDA/IBRD financing
- Development partners and donors at country level
 - UNICEF Gavi
 - WHO GAC
 - UNFPA CDC
 - Global Fund USAID

- World Bank Group
- Plan International
- MEASURE Evaluation
- PATH

Private sector

Partnerships: the case of Mozambique

- Registration indicators: birth registration = 48%; death = 12%; cause-of-death = 9% based on hospital deaths
- Key priorities: increase birth and death registration; generate vital statistics; revise legislation and increase awareness
- CRVS financing gap in 2014: US\$31 million
- Government partnerships
 - Inter-Ministerial Working Group on CRVS
 - Key CRVS Ministries: MISAU, MINJUST, INE
 - Others: Interior, Public Admin; to include Science, Foreign Affairs, University of Eduardo Mondlane

Partnerships: the case of Mozambique

- UN Task Team on CRVS
 - UNICEF, WHO, UNFPA, UNHCR, UNDP
 - Technical support and financial support
 - Coordination of CRVS support and harmonized advocacy agenda among UN agencies
 - Ensure integration of CRVS into UN planning exercise
- WHO and UNICEF facilitated Global Affairs CRVS project worth C\$19 million over 5 years
- GFF processes
 - CRVS prioritized for monitoring and evaluation of RMNCAH programs
 - Plans underway to include CRVS in the Investment Case

GFF support for CRVS

- Investment Case
 - Ensures CRVS is included in countries' Investment Cases
 - Advocacy for CRVS: births, deaths and causes of death, marriages
 - Results monitoring and realization of human rights
 - Provides technical support for strong CRVS components in the Investment Case (in collaboration with other partners)
 - Priorities informed by nation health and development strategies and plans, including CRVS
 - Aligned to RMNCAH priorities

GFF support for CRVS

- Reinforced dialogue between ministries of health and CRVS ministries/agencies
 - Many ministries of health have not been participating adequately in CRVS activities
- Improving efficiency in delivery of health and registration services
 - Use of health facilities to facilitate notification/registration of vital events
 - Training of medical staff in ICD guidelines (e.g., maternal and perinatal death audit committees, certifiers)
 - Using other established health structures to improve registration (e.g., immunization, community health workers)
 - Linking health and registration systems

GFF support for CRVS

- Facilitate re-prioritization of CRVS activities within national CRVS investment cases
 - Increased financing for CRVS: GFF Trust Fund + IDA/IBRD
 - Countries able to make progress in strengthening CRVS
- Facilitate collaboration between development partners and donors
 - Through the process of preparing Investment cases
 - Identification of partners; resource mapping
 - Multiple stakeholders coordination and integration of activities
- Close collaboration with the Centre of Excellence for CRVS Systems

Centre of Excellence for CRVS Systems

- GFF investment in "global public goods that support RMNCAH results at the country level"
- \$16 million in seed funding from the Government of Canada, and housed at the International Development Research Centre
- Mandate:
 - CRVS in Investment Cases: support countries to develop and implement CRVS systems strengthening plans in RMNCAH Investment Cases
 - **Global resource hub:** broker access to technical assistance, global standards and tools, and good practice
- Value-added approach:
 - Coordinate with CRVS development partners to complement and contribute to new and existing initiatives and capacity building
 - Convene stakeholders to support exchange of knowledge and expertise

Centre of Excellence for CRVS Systems

Approach		Role at Country Level
 Convening, coordinating, complementing in practice: Collaborate to design a digital platform that makes CRVS resources easily accessible Coordinate the development of a CRVS Systems 	Developing Investment Cases	 Information and resources: share tools and standards and document good practice Peer learning and exchange: support exchange of lessons learned and good practice across countries Technical assistance: facilitate access to expertise and capacity building
taxonomyContribute to and complement CRVS capacity		Investment Case Approved/ GFF Financing Secured for CRVS
 building efforts Convene CRVS stakeholders to support Investment Case development and implementation Explore mechanisms for leveraging expertise and facilitating access to technical assistance 	Implementing Investment Cases	 Implementation research: generate evidence to address bottlenecks or other implementation challenges Training: facilitate access to/support training and capacity building Technical assistance: broker access to technical expertise to support sustainable implementation Peer learning and exchange: support peer learning and exchange within and across countries

Key issues for CRVS

- Current status of CRVS systems require substantial investments in many countries
 - Limited domestic resources available for CRVS
 - GFF unable to meet high expectations for financial support required
 - Competing priorities between RMNCAH programs and strengthening of CRVS systems

Concluding remarks

- GFF process at country level:
 - Growing momentum towards strengthening CRVS systems
 - Building coordinated partnerships among development partners and donors to support country-led priorities
 - Significant investments in CRVS
 - Focus on strengthening links between CRVS systems and the health sector
- More efforts required as there remain significant challenges in CRVS
 - Especially for death registration and causes of death
 - Accessing and developing CRVS expertise





www.globalfinancingfacility.org

GFF@worldbank.org







Scaling up Support for the Demographic Dividend in Sub-Saharan Africa

The importance of SRHR under the GFF for poverty reduction

Dar es Salaam – November 3, 2016

Health, Nutrition and Population Global Practice The World Bank Group

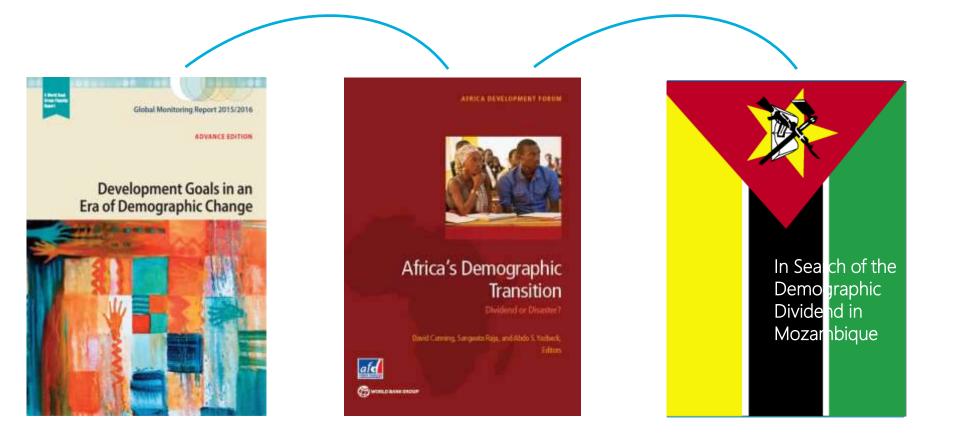




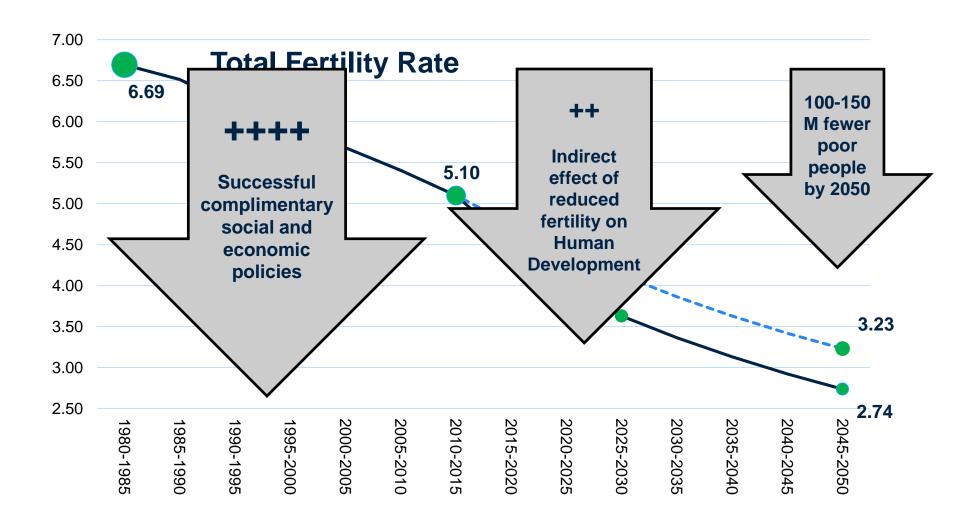
- The African Union has declared 2017 the year of "Harnessing Demographic Dividend through Investments in the Youth".
- Presidents, Prime Ministers and Sector Ministers from more than 20 countries gathered at UNGA to reinforce their political commitment to create the conditions for a Demographic Dividend in Sub-Saharan Africa

Population is central to development

From global and regional knowledge to country action



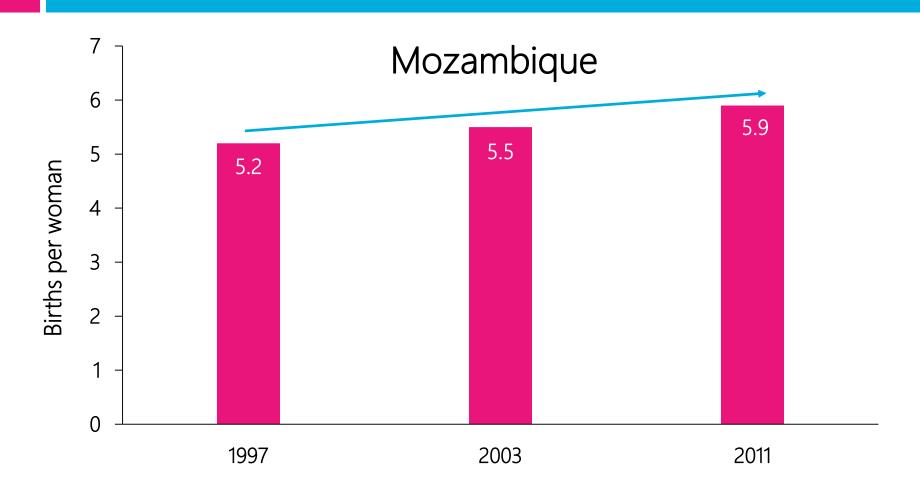
The Opportunity: harnessing demographic change as a driver of poverty reduction in Sub-Saharan Africa



Index

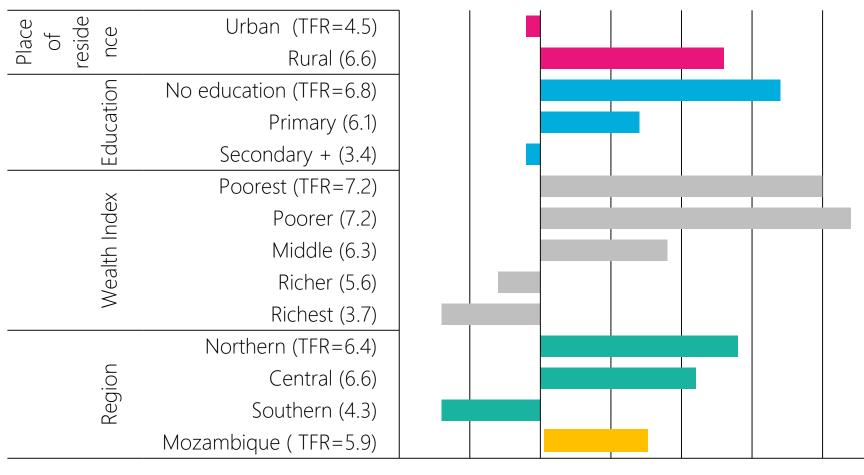
- The "mirage" of a demographic dividend in high fertility countries
 - 2. Policies to accelerate the fertility transition: *Empower* families and the role of the GFF
 - 3. The time for action at scale is now

Is Sub-Saharan Africa TFR is High



Inequity in Fertility is Increasing

Mozambique



Source: DHS

-1.0 -0.5 0.0 0.5 1.0 1.5 2.0 2.5

Absolute change in TFR, 1997-2011

Few adults to sustain many dependents

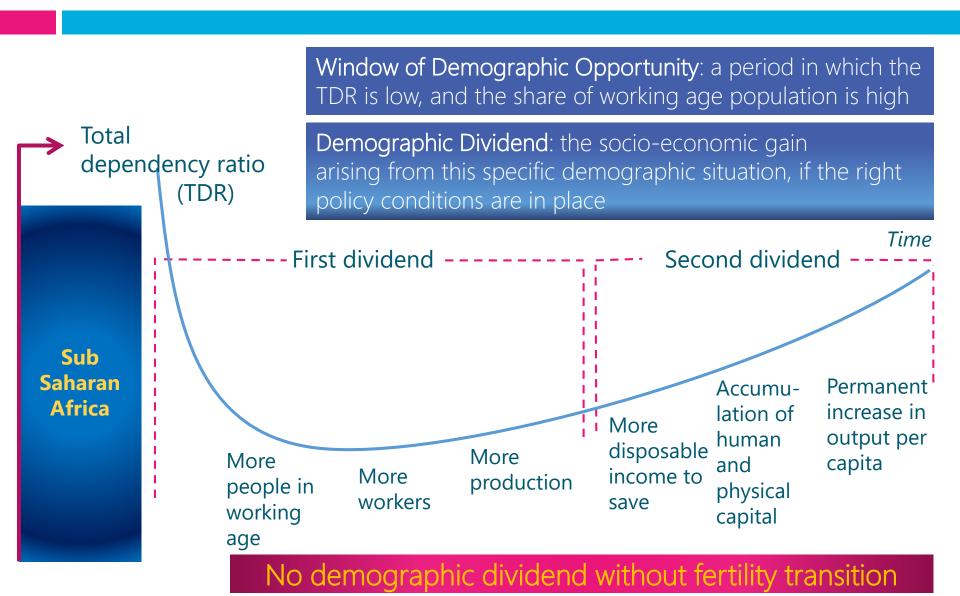
Working-age population / Working-age population / Dependents Dependents 90-94 80+ 80-84 70-74 70-74 60-64 60-64 Age group 50-54 50-54 40-44 40-44 2.6 30-34 30-34 1.2 20-24 20-24 10-14 10-14 0-4 0-4 10080 60 40 20 0 20 40 60 80 100 10 5 0 5 **Population in millions** ■ male ■ female

East Asia

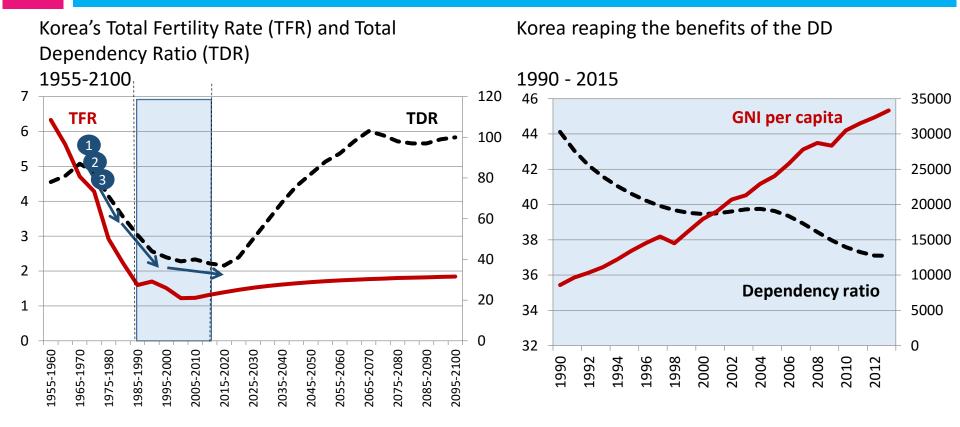
Sub-Saharan Africa

10

What is the Demographic Dividend ?



Korea: 1/3 of economic growth over 40 years (6.7%) attributable to Demographic Dividend



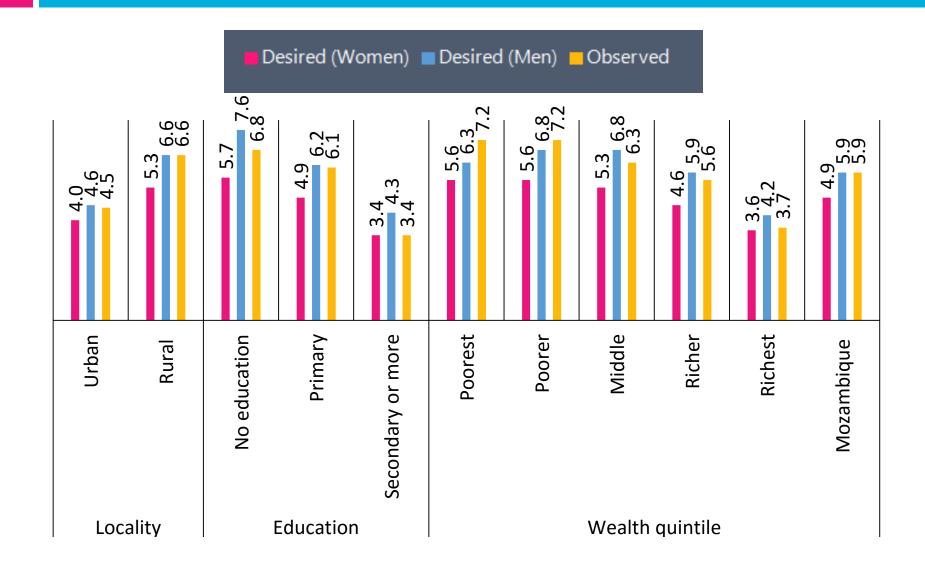
POLICY MEASURES

- 1) Explicit population policy
- 2) Shifting the education and skills development strategy
- 3) Comprehensive economic plans

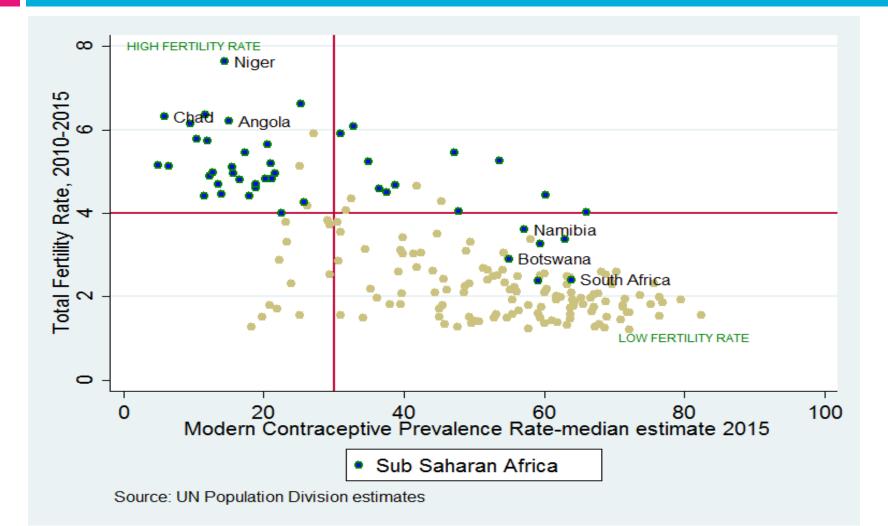
Index

- 1. The "mirage" of a demographic dividend in high fertility countries
- 2. Policies to accelerate the fertility transition: Empower families and the role of the GFF
 - 3. The time for action at scale is now

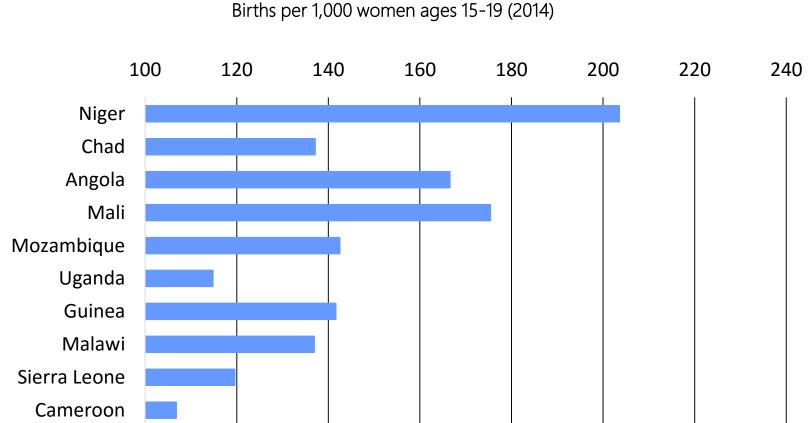
Observed fertility is generally higher than women's desired fertility (Mozambique)



Use of contraception in SSA is low, especially among the poorest



Early Marriage and Childbearing result in high adolescent pregnancy rates



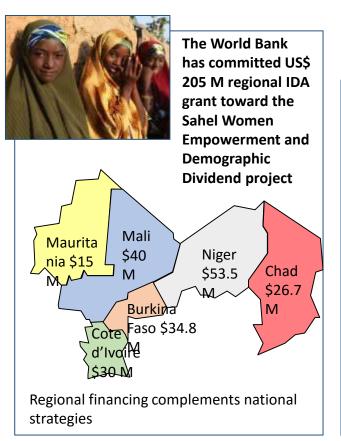
The required policy actions for pre-dividend countries resonate with the ambition of the GFF

Phase	Objective	Policies
Pre- Demographic Dividend Countries	Accelerate the fertility decline	 Reduce child mortality and malnutrition Increase female education and gender equity Empower equity Empower expression of the second se

Index

- 1. The "mirage" of a demographic dividend in high fertility countries
- 2. Policies to accelerate the fertility transition: *Empower* familiesand the role of the GFF
- **3.** The time for action at scale is now

As partners we need now to leverage platforms to support coordinated action





Cameroon Health Sector Support Investment Project (\$100M IDA & \$27M GFF TF)

 Progressive national scale-up of the Performance Based Financing (PBF)

• Women, adolescents and

children under 5, as well as displaced and refugee populations affected by insecurity in the region, will benefit from the interventions

AS OF JULY 2016. AT THE MIDPOINT OF FP2020

MORE THAN **300** MILLION WOMEN & GIRLS ARE USING MODERN CONTRACEPTION

IN 69 FP2020 FOCUS

COUNTRIES



30.2 MILLION

ADDITIONAL WOMEN & GIRLS ARE USING MODERN CONTRACEPTION COMPARED TO 2012

SWEDD

GFF

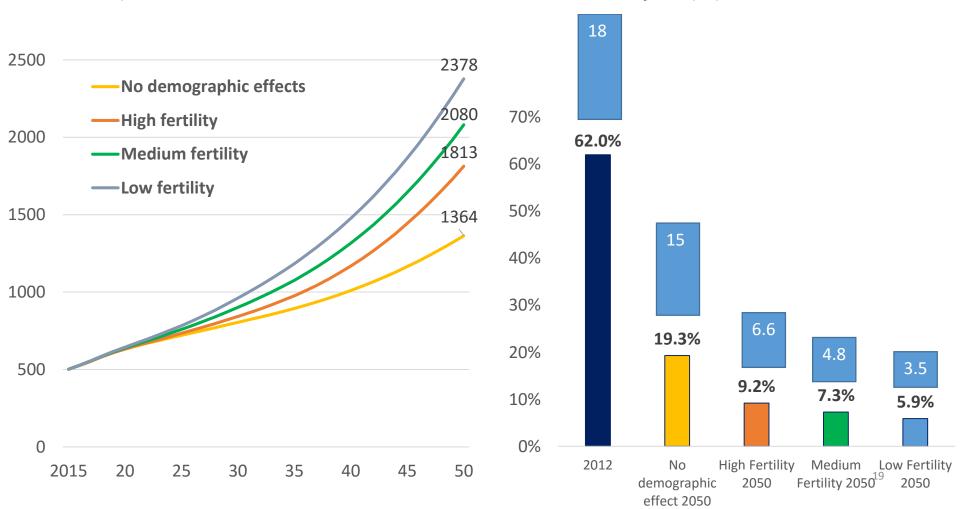
FP2020

Thank you

Huge potential for rapid economic growth and poverty reduction [Mozambique]

a. Real GDP per capita by fertility scenario (constant 2007 US\$)

b. Poverty headcount rate Number of poor (M)





FOURTH INVESTORS GROUP MEETINGS 2-4 November, 2016



INVESTORS GROUP CALENDAR 2017-2018

2017			
Month	Event	Purpose/Objective	
17 – 20 January	World Economic Forum, Davos	 GFF presence and advocacy 	
March	Launch GFF Annual Report	 Advocacy and Outreach 	
21 – 23 April	Spring Meetings	GFF Event	
24 April	Fifth Investors Group Meeting	 Portfolio Update Focus Country: Liberia Thematic Focus: Adolescents Financing for RMNCAH: Efficiency 	
Мау	World Health Assembly	 GFF Event 	
19-22 September	UN General Assembly (General Debate – Sept 19)	 GFF Event 	
October	WB Annual Meetings, Washington D.C.	 GFF Event 	
November	Sixth Investors Group Meeting	 Portfolio Update Focus Country Thematic Focus Financing for RMNCAH 	
	2018		
Month	Event	Purpose/Objective	
March	GFF Annual Report	First results	
April	Seventh Investors Group Meeting	 Portfolio Update Focus Country Thematic Focus Financing for RMCAH 	
November	Eighth Investors Group Meeting	 Portfolio Update Focus Country Thematic Focus Financing for RMNCAH 	



www.globalfinancingfacility.org



PARTICIPANTS

(as of 27 October)

COUNTRY REPRESENTATIVES

Canada

Member			Alternate
Name:	Ms. Sarah Fountain Smith	Name:	Ms. Susan Tolton
Title:	Assistant Deputy Minister Global	Title:	Director, Maternal, Newborn and
	Issues and Development		Child Health
Organization:	Global Affairs	Organization:	Global Affairs
Country:	Canada	Country:	Canada
Email:	Sarah.FountainSmith@internatio	Email:	Susan.Tolton@international.gc.ca
	nal.gc.ca		
	Attending IG4		
Member:	Ms. Sarah Fountain Smith		
Alternate:	Ms. Susan Tolton		

Ethiopia

Member		Alternate	
Name:	H.E. Dr. Kesete-birhan Admasu	Name:	
Title:	Minister of Health	Title:	
Organization:	Federal Ministry of Health	Organization:	
Country:	Ethiopia	Country:	
Email:	kesetemoh@gmail.com	Email:	
	Attending IG4		
Representative:	Mr. Abebayehu Haile, Grant Management Coordinator, <u>abebayehu111@gmail.com</u>		nator, <u>abebayehu111@gmail.com</u>
Presenter:	Mr. Tseganeh Amsalu, Technical A	Assistant, Federal Ministry of Health,	
	tseganeh2009@yahoo.com		

Japan

	Member		Alternate
Name:	Ms. Kae Yanagisawa	Name:	Mr. Ikuo Takizawa
Title:	Vice President	Title:	Deputy Director General Human
			Development Department
Organization:	Japan International Cooperation	Organization:	Japan International Cooperation
	Agency (JICA)		Agency (JICA)
Country:	Japan	Country:	Japan
Email:	Yanagisawa.Kae@jica.go.jp	Email:	Takizawa.Ikuo@jica.go.jp
	Attendir	ng IG4	
Representative:	Mr. Kenichi Ito, Director, Health Tear	n 1, Human Deve	elopment Department, JICA,
	Ito.Kenichi.2@jica.go.jp		
Representative:	Ms. Emiko Nishimura, Deputy Director, Human Development Department, JICA,		
	Nishimura.Emiko@jica.go.jp		

Kenya

Member		Alternate	
Name:	Dr. Ruth Kagia	Name:	Dr. Jackson Kioko
Title:	Senior Advisor to the President	Title:	Director of Medical Services
Organization:	Executive Office of the President	Organization:	Ministry of Health
Country:	Kenya	Country:	Kenya
Email:	ruthkagia@gmail.com	Email:	Jackson.kioko@health.go.ke
	Attending IG4		
Member:	Dr. Ruth Kagia		
Presenter:	Dr. Wangui Muthigani, Senior Program Officer (RMNH), Ministry of Health		

Liberia

Member		Alternate	
Name:	H.E. Dr. Bernice Dahn	Name:	Ms. Yah Zolia
Title:	Minister of Health	Title:	Deputy Minister
Organization:	Ministry of Health & Social Welfare	Organization:	Ministry of Health & Social Welfare
Country:	Liberia	Country:	Liberia
Email:	bdahn59@gmail.com;	Email:	yzolia@yahoo.com
	bernicedahn@gmail.com		
Attending IG4			
Alternate:	Ms. Yah Zolia		

Norway

Member		Alternate	
Name:	Dr. Tore Godal	Name:	Ms. Ase Bjerke
Title:	Special Adviser on Global Health	Title:	Section for Global Initiatives
Organization:	Ministry of Foreign Affairs	Organization:	Ministry of Foreign Affairs
Country:	Norway	Country:	Norway
Email:	Tore.Godal@mfa.no	Email:	ase.elin.bjerke@mfa.no
	Attending IG4		
Alternate:	Ms. Ase Bjerke		
Focal Point:	Mr. Ingvar Olsen, Policy Director, Department for Global Health, Education and Research, Norwegian Agency for Development Cooperation, Norway. <u>Ingvar.Theo.Olsen@norad.no</u>		

Senegal

Member		Alternate	
Name:	H.E. Awa Marie Coll-Seck	Name:	Dr. Bocar Mamadou Daff
Title:	Minister of Health	Title:	Director
Organization:	Ministry of Public Health	Organization:	Ministry of Public Health
Country:	Senegal	Country:	Senegal
Email:	amcollseck@yahoo.fr	Email:	bmdaff@gmail.com
	Attending IG4		
Member:	H.E. Awa Marie Coll-Seck		
Alternate:	Dr. Bocar Mamadou Daff		

Tanzania

	Invited Speakers			
Name:	H.E. Ummy Mwalimu	Name:	ТВС	
Title:	Minister of Health, Community	Title:		
	Development, Gender, Seniors			
	and Children			
Organization:	Ministry of Health, Community	Organization:		
	Development, Gender, Seniors			
	and Children			
Country:	Tanzania	Country:		
Email:		Email:		

United Kingdom

Member		Alternate	
Name:	Ms. Claire Moran	Name:	Dr. Meena Gandhi
Title:	Head of Human Development	Title:	Health Advisor
	Department		
Organization:	Department for International	Organization:	Department for International
	Development (DFID)		Development (DFID)
Country:	UK	Country:	UK
Email:	<u>c-moran@dfid.gov.uk</u>	Email:	m-gandhi@dfid.gov.uk
Attending IG4			
Member:	Ms. Claire Moran		
Representative:	Ms. Jane Hobson, Senior Social Deve	elopment Adviser	, <u>Jane-Hobson@dfid.gov.uk</u>

USA

	Member		Alternate
Name:	Dr. Ariel Pablos-Mendez	Name:	Dr. Jennifer Adams
Title:	Assistant Administrator for Global	Title:	Sr. Deputy Assistant Administrator
	Health		for Global Health
Organization:	USAID	Organization:	USAID
Country:	USA	Country:	USA
Email:	apablos@usaid.gov	Email:	jeadams@usaid.gov
	Attend	ing IG4	
Alternate:	Dr. Jennifer Adams		
Representative:	Dr. Aye Aye Thwin, Special Advisor, Office of the Assistant Administrator, Bureau for Global		
	Health, USAID, <u>aathwin@usaid.gov</u>		

INTERNATIONAL ORGANIZATIONS

	Member		Alternate
Name:	Ms. Anuradha Gupta	Name:	Ms. Hind Khatib-Othman
Title:	Deputy Chief Executive Officer	Title:	Managing Director, Country
			Programmes
Organization:	Gavi, the Vaccine Alliance	Organization:	Gavi, the Vaccine Alliance
Country:	Switzerland	Country:	Switzerland
Email:	agupta@gavi.org	Email:	hkhatib@gavi.org
	Attendin	g IG4	
Member:	Ms. Anuradha Gupta		
Representative:	Ms. Jonna Jeurlink, Senior Manager, Advocacy and Public Policy, Gavi, the Vaccine Alliance,		
	Switzerland, jjeurlink@gavi.org		

Member		Alternate		
Name:	Dr. Marijke Wijnroks	Name:	Dr. Viviana Mangiaterra	
Title:	Chief of Staff	Title:	Senior Technical Coordinator	
Organization:	Global Fund to Fight AIDS,	Organization:	Global Fund to Fight AIDS,	
	Tuberculosis and Malaria (Global		Tuberculosis and Malaria (Global	
	Fund)		Fund)	
Country:	Switzerland	Country:	Switzerland	
Email:	Marijke.Wijnroks@theglobalfund.org	Email:	viviana.mangiaterra@theglobalfun	
			<u>d.org</u>	
	Attending IG4			
Member:	Dr. Marijke Wijnroks			

PRIVATE SECTOR

Member		Alternate		
Name:	Dr. Peter Singer	Name:	Mr. Jan-Willem Scheijgrond	
Title:	Chair of the EWEC Innovation Working Group & Chief Executive Officer	Title:	Global Head of Government Affairs Business to Government Royal Philips	
Organization:	Grand Challenges Canada	Organization:	Royal Philips	
Country:	Canada	Country:	The Netherlands	
Email:	peter.singer@grandchallenges.ca	Email:	Jan- Willem.Scheijgrond@philips.com	
	Attending IG4			
Alternate:	Mr. Jan-Willem Scheijgrond			

Member		Alternate	
Name:	Mr. Bob Collymore	Name:	
Title:	Chief Executive Officer	Title:	
Organization:	Safaricom	Organization:	
Country:	Kenya	Country:	
Email:	BCollymore@safaricom.co.ke	Email:	

FOUNDATION

	Member		Alternate
Name:	Dr. Chris Elias	Name:	Dr. Nosa Orobaton
Title:	President of Global Development Program, IG Chair	Title:	Deputy Director, Maternal, Newborn and Child Health, Global Development
Organization:	Bill and Melinda Gates Foundation	Organization:	Bill and Melinda Gates Foundation
Country:	USA	Country:	USA
Email:	Chris.Elias@gatesfoundation.org	Email:	Nosa.Orobaton@gatesfoundatio
			<u>n.org</u>
	Attending	IG4	
Member:	Dr. Chris Elias		
Alternate:	Mr. Nosa Orobaton		
Focal Point:	Ms. Samantha Galvin, Associate Program Officer, Bill and Melinda Gates Foundation, USA, Samantha.galvin@gatesfoundation.org		

MULTILATERAL ORGANIZATIONS

Office of the UN Secretary General

Member		Alternate		
Name:	Dr. David Nabarro	Name:	Ms. Taona Kuo	
Title:	Special Adviser on the 2030 Agenda for Sustainable Development	Title:	Senior Manager	
Organization:	Office of the UN Secretary General	Organization:	Office of the UN Secretary-General	
Country:	USA	Country:	USA	
Email:	nabarro@un.org	Email: kuot@un.org		
Attending IG4				
Alternate:	Ms. Taona Kuo			

PMNCH

Member			Alternate
Name:	Mrs. Graça Machel	Name:	Dr. Emanuele Capobianco
Title:	Board Chair	Title:	Deputy Executive-Director
Organization:	The Partnership for Maternal,	Organization:	PMNCH
	Newborn & Child Health, WHO		
Country:	Switzerland	Country:	Switzerland
Email:	vimla@nelsonmandela.org	Email:	capobiancoe@who.int
Attending IG4			
Alternate:	Dr. Emanuele Capobianco		
Focal Point:	Ms. Kadidiatou Toure, Technical Officer,	PMNCH, tourek	@who.int

UNICEF

Member		Alternate		
Name:	Dr. Stefan Swartling Peterson	Name:	Mr. Ted Chaiban	
Title:	Associate Director, Chief Health Section	Title:	Director Programmes	
Organization:	UNICEF	Organization:	UNICEF	
Country:	USA	Country:	USA	
Email:	Speterson@unicef.org	Email: Tchaiban@unicef.org		
Attending IG4				
Member:	Dr. Stefan Swartling Peterson			

UNFPA

Member		Alternate	
Name:	Dr. Babatunde Osotimehin	Name:	Dr. Benoit Kalasa
Title:	Executive Director	Title:	Director, Technical Division
Organization:	UNFPA	Organization:	UNFPA
Country:	USA	Country:	USA
Email:	osotimehin@unfpa.org	Email:	kalasa@unfpa.org
	Attending	; IG4	
Alternate:	Dr. Benoit Kalasa		
Representative:	Dr. Natalia Kanem, Deputy Executive Director, <u>stojanovic@unfpa.org</u>		
Focal Point:	Ms. Jacqueline Mahon, Senior Policy Adviser, Global Health and Health Systems,		
	mahon@unfpa.org		

The World Bank

Member		Alternate			
Name:	Dr. Tim Evans	Name:	Dr. Michele Gragnolati		
Title:	Senior Director	Title:	Practice Manager		
Organization:	World Bank	Organization:	World Bank		
Country:	USA	Country:	USA		
Email:	tevans@worldbank.org	Email:	mgragnolati@worldbank.org		
	Attending IG4				
Member:	Dr. Tim Evans				
Alternate:	Dr. Michele Gragnolati				

World Health Organization

Member		Alternate		
Name:	Dr. Flavia Bustreo	Name:	Dr. Anshu Banerjee	
Title:	Assistant Director-General, Family,	Title:	Director	
	Women's and Children's Health			
Organization:	World Health Organization	Organization:	World Health Organization	
Country:	Switzerland	Country:	Switzerland	
Email:	bustreof@who.int	Email:	banerjeea@who.int	
	Attending IG4			
Alternate:	Dr. Anshu Banerjee			
Representative:	Dr. Ian Askew, Director, Reproductive Health and Research			

CIVIL SOCIETY

Member		Alternate	
Name:	Dr. Mesfin Teklu Tessema	Name:	Ms. Angeline Mutunga
Title:	Partnership Leader – Health &	Title:	East Africa Regional Program
	Nutrition and Director WBI Geneva		Advisor
Organization:	World Vision International	Organization:	Advance Family Planning,
			JHPIEGO Office
Country:	Switzerland	Country:	Kenya
Email:	mesfin_teklu@wvi.org	Email:	Angeline.Mutunga@jhpiego.org
Attending IG4			
Member:	Dr. Mesfin Teklu Tessema		
Alternate:	Ms. Angeline Mutunga,		

Member		Alternate	
Name:	Dr. Joanne Carter	Name:	Dr. Aminu Magashi Garba
Title:	Executive Director	Title:	Coordinator
Organization:	RESULTS	Organization:	Africa Health Budget Network
Country:	USA	Country:	Nigeria
Email:	carter@results.org	Email:	aminu.magashi@africahbn.org
Attending IG4			
Member:	Dr. Joanne Carter		
Alternate:	Dr. Aminu Magashi Garba		

PRESENTERS

Centre of Excellence for CRVS

Attending IG4	
Name:	Dr. Simon Carter
Title:	Regional Director
Organization:	IDRC- Regional Office for sub-Saharan Africa
Country:	Canada
Email:	<u>scarter@idrc.ca</u>

Nigeria

Attending IG4	
Name:	Dr. Abdullahi Dauda Belel
Title:	Executive Chairman
Organization:	Adamawa State Primary Health Care Development Agency, State Primary Health Care
	Board
Country:	Nigeria
Email:	drbelel@gmail.com

Family Planning 2020

Attending IG4	
Name:	Ms. Beth Schlachter
Title:	Executive Director
Organization:	Family Planning 2020
Country:	USA
Email:	bschlachter@familyplanning2020.org

OBSERVERS

European Commission

Attending IG4	
Name:	Ambassador Roland van de Geer
Title:	Head of the EU Delegation to Tanzania and to the EAC
Organization:	International Cooperation and Development, European Commission
Country:	Tanzania
Email:	

Germany

Attending IG4	
Name:	Ms. Nina Siegert
Title:	Health Financing Advisor
Organization:	GIZ
Country:	Tanzania
Email:	nina.siegert@giz.de

Attending IG4	
Name:	Ms. Julia Hannig
Title:	Head of Cooperation of the Federal Republic of Germany
Organization:	German Embassy
Country:	Tanzania
Email:	wz-1@dare.auswaertiges-amt.de

South Korea

Attending IG4	
Name:	Mr. Chang-seok Kim
Title:	Chief Representative
Organization:	Korea Eximbank
Country:	Korea
Email:	<u>chaseokim@koreaexim.go.kr</u>

Sweden

Attending IG4	
Name:	Ambassador Lennarth Hjelmåker
Title:	Ambassador for Global Health
Organization:	Ministry of Foreign Affairs
Country:	Sweden
Email:	lennarth.hjelmaker@gov.se

GFF SECRETARIAT

Name:	Dr. Mariam Claeson, GFF Director
Email:	Mariam.claeson@gatesfoundation.org
Name:	Dr. Monique Vledder, Practice Manager
Email:	mvledder@worldbank.org
Name:	Dr. Rama Lakshminarayanan
Email:	rlakshminarayana@worldbank.org
Name:	Mr. Toby Kasper
Email:	tobykasper@gmail.com
Name:	Ms. Dianne Stewart
Email:	dstewart4@worldbank.org
Name:	Mr. David Evans
Email:	devans4@worldbank.org
Lindii.	
Name:	Ms. Maletela Tuoane-Nkhasi
Email:	mtuoanenkhasi@worldbank.org
Name:	Ms. Linda Kelly
Email:	Lkelly2@worldbank.org
Name:	Ms. Petra Vergeer
Email:	Pvergeer@worldbank.org
Name:	Ms. Leslie Elder
Email:	lelder@worldbank.org
Nome	
Name:	Ms. Aissa Socorro
Email:	asocorro@worldbank.org

Name:	Ms. Stephanie Saulsbury
Email:	ssaulsbury@worldbank.org

TECHNICAL SUPPORT

Name:	Dr. Gayle Martin
Title:	Program Leader
Organization:	The World Bank
Country:	Tanzania
Email:	gmartin2@worldbank.org
Name:	Dr. Prashant Yadav
Title:	Consultant supporting Commodities Task Team
Organization:	University of Michigan
Country:	USA
Email:	yadavp@umich.edu



www.globalfinancingfacility.org

Ethiopia Health Care Financing reform: The Achievements, opportunities and ways forward

Global Financing Facility (GFF) 4th Investors Group (IG) Meeting

> Federal Ministry of Health, Ethiopia

Achievements - HCF (1998 – 2015)



HCF Reform (1st & 2nd Generation)

Over all health budget increased

□Efficiency of resource allocation/utilization – Focus on PHCU

□Robust partnership platform: Harmonization and alignment to government priorities (one plan, budget and report);

□Pooling mechanism:

- Pooled fund for on-budget resources (gov't and DP),
- MDG performance fund (pools external aid and focuses on reaching MDG targets (11 Partners)
- Health facilities pool funds (retained revenue, gov't allocation, CBHI and community contribution).

400% increase in THE
 between 1996-2012
 (USD4.5bill to 20.77 bill)

□ MDGPF: Underfunded areas got better share of funding, (55% of the fund used for RMNCH and health systems 2015/2016, total allocation was about 1 Bill million),

Duplication of effort and huge transaction cost was reduced

Rollout of CBHI is being implemented (30% of districts - 2016)
Astronomic increase in access to PHC
Outcomes/Impact: CPR (6 - 40), U5MR (166-88)

of partners have shown interest or committed to support the Health Care financing agenda (USAID, DFID, EU, Gates, WB, UN Agencies and possibly GF etc). USAID and Gates TF will complement the GFF-ET MDG PforR in support of the RMNCH and health financing agenda.

Challenges - Areas to work on

Quality and Equitable access to services – Households still finance 34% of THE (as per NHA 2012)

Improving domestic resource for health – Focus on DRM

 Strengthening harmonization - Improving the efficiency of different funding channels (Budget used outside of government system)

 Limited Capacity in HCF expansion – National and Sub national level

Areas to work on

Capacity Building:

- Institutional and organizational Health Economics & financing unit, GMU, EHIA.
- Technical support for implementation of the revised health care financing strategy - national and sub national level
- Evidence Generation and Decision Making
 - Policy implementation research
 - Joint Mid term review and



Strong Political Commitment:

- A new national HCF Board/council MOH, MOFEC, MRA, MOLSA, EHIA
- A comprehensive HCF strategy (2015 2030) with emphasis on domestic resource mobilization
- Sub national structures formed and endorsed by regional proclamations
- Govt DPs mutual accountability innovative performance review by government and DPs (Vice versa)

Renewed interest and strong commitment from partners to support HCF:

- More Development partners joining the MDG/SDG Pool Fund (World Bank, UK-DFID, European Union, UNICEF, UNFPA, WHO, Italian Cooperation (IC), Spanish Aid, Irish Aid, Gavi, Embassy of the Kingdom of the Netherlands (EKN).
- Development Partners commitment to support the implementation of HCF strategy : Gates Foundation, WB, USAID, UK-DFID
- DPs Implementing counter partners strong interest and active participation in the HCF technical working panel

Ensuring Equity and quality health care is a priority of the government of Ethiopia

 The health sector has identified <u>"transformation in equity</u> and quality health care" as one of the four health care transformation agendas of the national health sector strategic period (2015/16 - 2019/20).

• The Global Financing Facility Platform!!:

 Refreshed the in-country, regional and international discussions on sustainable domestic health financing. Its unique in a way that put Health Care Financing, specially Domestic Health Care financing, as a priority and cross cutting piece of the RMNCAYH agenda.

Ameseginalehu! Thank you! Asante Sana! Mercy beaucoup!

The Roadmap

- The RMNCAH investment framework is the outcome of an eightmonth long, MOH-led consultative process involving all 47 counties,
- A wide range of stakeholders involved (MOH, Ministry of Interior and Coordination of National Government, the National Treasury, different government entities at the national level and various stakeholders including CSO, FBOs, private sector, professional associations and development partners.)
- Two MOH-appointed national consultants and two focal points from the Planning, Policy and Health Financing Unit and the Division of Family Health facilitated the consultative process .
- 4 technical consultation meetings held and a validation Meeting was held on July 31, 2015



Kenya: background information

Kenya Country platform

 Inclusive coordination platform in place with RMNCAH & Health Financing TWGs. GFF country focal point appointed by PS-Director of Medical Services

Kenya Investment Framework

- National RMNCAH Investment Framework finalized and approved.
- Focus on supply-side performance incentives, vouchers, CCTs to boost demand.
- Prioritization on 20 selected counties to address inequities, though all counties to be eligible for some level of support based on needs and performance.

Technical assistance provided by DfID, JICA, UNAIDS, UNFPA, UNICEF, UN Women, USAID, WHO, and the World Bank

Kenya: recent developments

• Latest updates

- Concept note for MDTF to provide TA to priority counties and national government:
- Main challenges
- Devolution Coordination -Planning and Budgeting cycles
- Key opportunities
 - Devolution
 - Trust fund for TA will be paired with results-focused financing → strong incentive for improving quality of implementation.
- Complementary financing
 - Commitments in place from Governments of Denmark, Japan, United Kingdom, and United States, as well as World Bank with resources from IDA and Trust Funds (GFF/PHRD) ; GAVI and Global Fund also now on board.
 - World Bank/GFF Trust Fund financing: board approved US\$150m
 IDA, US\$40m GFF trust fund, US\$1.1 PHRD trust fund.





- Strengthen operationalization of RMNCAH IF by building capacity in planning, avoiding duplicate planning processes, and supporting all partners.
- Build a coherent country platform enabling ease of planning and resource mobilization and supporting the principle of aid effectiveness



Fransforming Health Systems for Universal Care Project uses a Performance Based Approach-Operationalizing the Investment Framework

Situation (health outcome/systems) varies widely by county; thus the project focuses on results at county level and the institutional capacity building at national/county levels:

Year 1	Year 2-5
 All 47 counties will be eligible to receive seed funding to jump start implementation based on need once they meet conditions—e.g., performance agreement, opening bank account, assigning responsible staff, etc.] Need measured by: (a) proportion of births not attended by skilled birth personnel and (b) County Revenue Allocation (CRA) ratio 	 i. Annual performance based allocations will then be shared among all eligible counties based on improved results and CRA ratio ii. Performance measured by improved results: (a) ANC4+; (b) SBA; (c) FIC; (d) mCPR: (e) quality of care; (f) HMIS



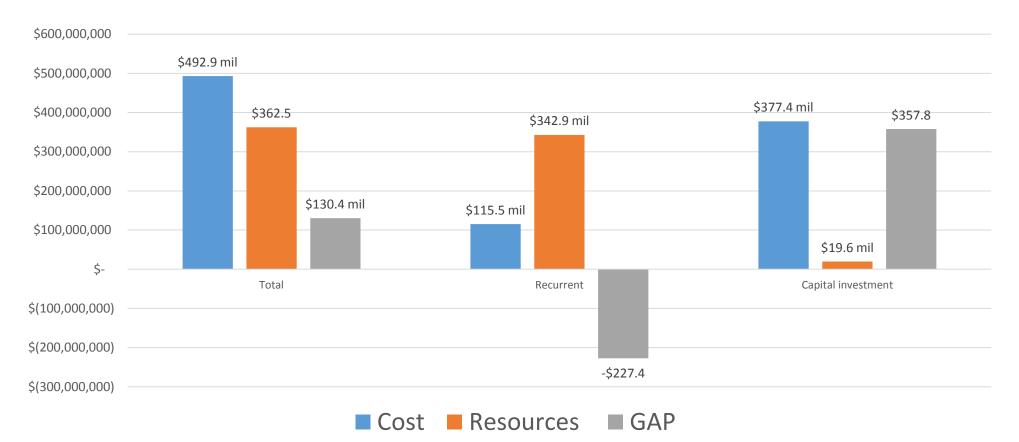


GFF for RMNCAH

Complementary Financing:

Experiences from Liberia

Total Cost, Resources and Gap Analysis for RMNCAH Investment Case: FY 16/17-FY 18/19

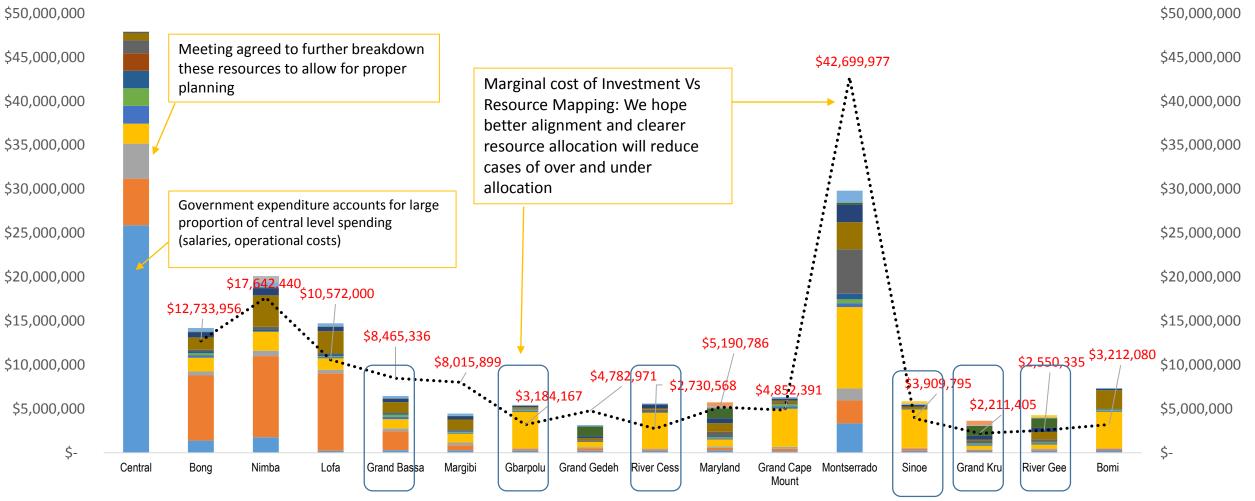


- Resources: government and external for FY 16/17-FY18/19
 - Government RMNCAH resources estimated using NHA disease splits and applied to FY 15/16 actual expenditure
- Cost for national investment case FY16/17 FY 20/21
- Infrastructure investments are more than 50% of total costs
 - The recovery period requires significant investment in infrastructure

Source:

- Cost: MBB, Liberia, 2016
- Resources: MOH Resource Mapping 2016

Resources across Counties, Government and External, FY 16/17



- Resource mapping is done on an annual basis, it guides the discussion in resource allocation.
- As we achieve better alignment to the Investment Case, we shall be able to reduce on the over subscription as seen in counties such as Lofa, avoid over crowding of resources at the central level and improve on resource availability in counties like Margibi

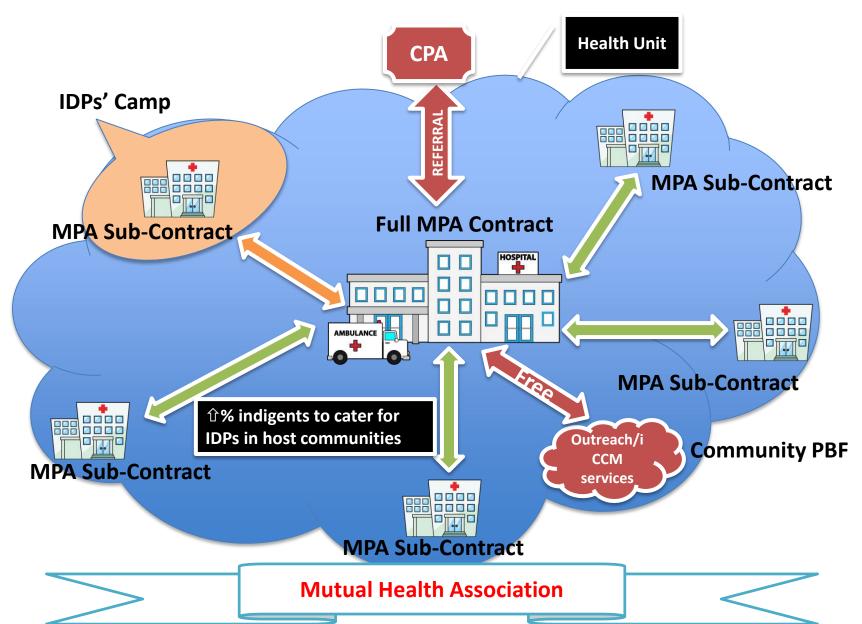
Outcomes of the Resource Mapping Exercise

- The discussion/meetings needs to be institutionalized to allow for follow up
 - Coordination from partner-side needs to improve
- Budget classifications need to be made much clearer
 - De-congest the central level classification
- Budgets need to be disaggregated in much more detail
- Going forward:
 - Expenditure tracking needs to be institutionalized to hold donors accountable
 - Operational plan costing will be done for all 15 counties in January 2017. The GOL will use this document as a tool to
 ensure that donors align their resources towards national priorities represented by tangible activities.

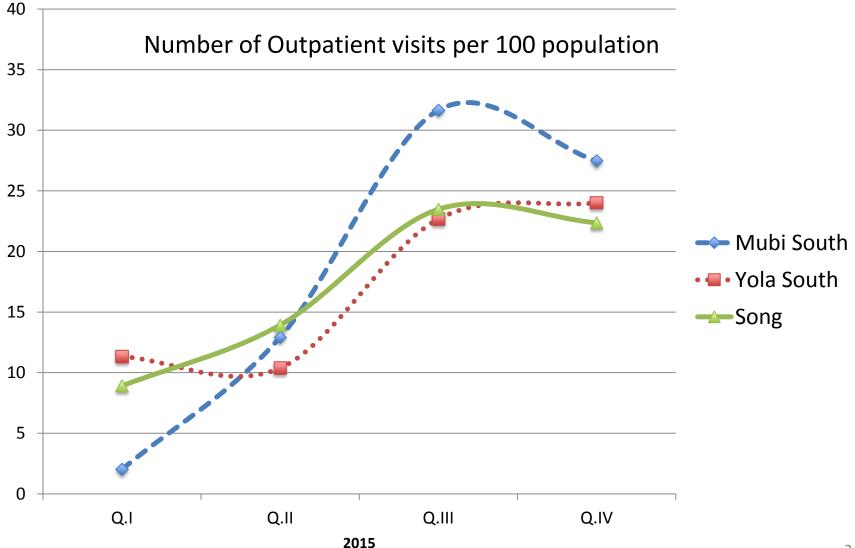
Key Tangible Successes to Date

- GAVI asked to have the HSS proposal integrated into the Investment Case
- USAID currently working on mechanisms to align implementation at country level
- The process created a momentum being used to complete the IHP+ process
- World Bank providing technical support to further refine the resource and Program Mapping

Adamawa PBF during insurgency



Effectiveness of PBF in Conflict Affected LGA (Mubi South) vs. Non-affected LGAs



Successes	 Functional Health Units established Communities managing PBF contracts very well Service packages are clearly defined and targets pursued High synergy between PBF and input based support like immunization, ATM, IDPs, FP etc IDPs in camps fully covered by basic services
Challenges	 Financial barrier to healthcare access- high proportion of indigents Low capacity (human resources) to increase coverage No demand side intervention Difficult terrain - hard to reach areas/insurgency prone areas. Poor Communication and Reporting system
Roles of GFF	 Total cost coverage of MPA for IDPs in host communities, indigents and hard to reach communities including CCTs and transport vouchers Use of private sector care providers through performance contracts. Mobile Clinics for hard to reach areas Volunteer Workforce Scheme – CORPs Using private sector firms as Contract Management and Verification Agencies (CMVA); and Independent Verification Agencies

BRIDGE DAY *FP2020 REFERENCE GROUP & GFF INVESTORS GROUP MEETINGS*

Dar es Salaam, Tanzania November 2, 2016



MEETING OBJECTIVE

Provide Reference Group and Investment Group members an opportunity to define ways to ensure that sexual and reproductive health and rights, with a focus on family planning, are integrated within the RMNCAH continuum and financed by being actively addressed in the development of GFF investment cases, budgets and results frameworks by eligible countries.

AGENDA

τιμε	AGENDA
8:30 – 9:00 am	[Session 1] Welcome & Overview of Sexual and Reproductive Health with a Focus on Family Planning and the GFF
9:00 – 9:20 am	[Session 2] Overview: FP2020 and the GFF
9:20 – 11:00 am	[Session 3] Country Perspective: Perspectives from FP2020 & GFF Country Partners
11:00 – 11:15 am	Coffee Break
11:15 – 12:45 pm	[Session 4] Discussion
12:45 – 1:00 pm	Next Steps & Closing
1:00 – 2:00 pm	Lunch

[SESSION 1] WELCOME & OVERVIEW OF SEXUAL AND REPRODUCTIVE HEALTH WITH A FOCUS ON FAMILY PLANNING AND THE GFF





Tanzania's One Plan II

Hon. Minister Ummy Mwalimu

FP2020 and GFF Bridge Day November 2, 2016 – Dar es Salaam, Tanzania



How did the Ministry include the National Family Planning Costed Investment Plan (NFPCIP) in the GFF Investment Case?



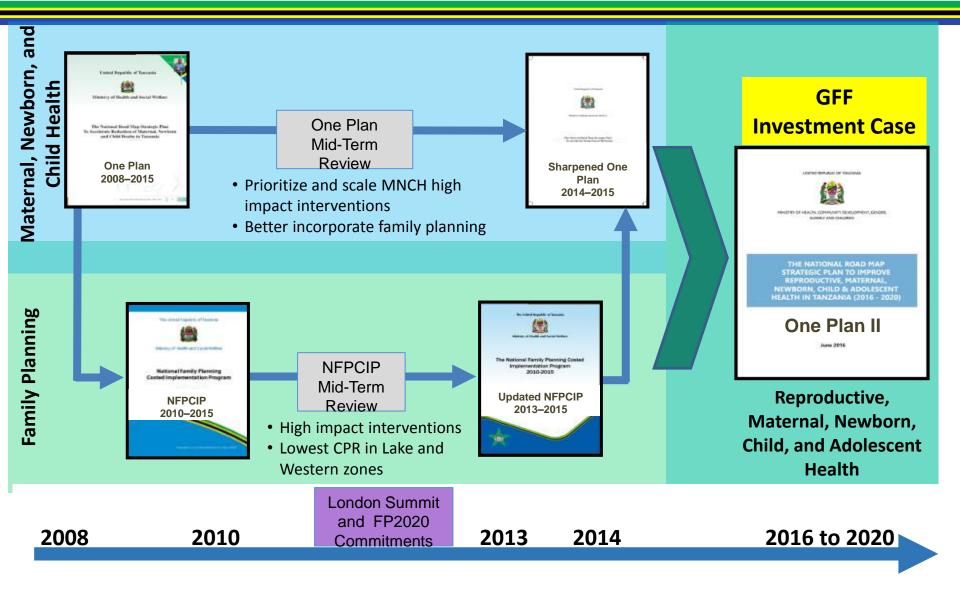
- Health Policy (2007) has prioritized RMNCH services
- RMNCAH services have been built on the HSSP IV which implements Health Policy
- Through One Plan II which was launched 2016
- Guides the implementation of RMNCAH interventions in an integrated manner across all levels of the health system and across the continuum of care
- Key areas of focus:
 - Re-defined FP within the broader RMNCH context
 - Care at birth, Post Partum and PNC (HRH Skilled health care providers)
 - Commodity Security
 - Prioritized Adolescent and youth SRH services
- One Plan II Constitutes the Investment Case for the Global Financing Facility (GFF) for Tanzania





How did the Ministry include the National Family Planning Costed Investment Plan (NFPCIP) in the GFF Investment Case?







How are stakeholders included in the RMNCAH Coordination Platform?



Technical Working Groups			
RMNCAH- specific TWGs	Other TWGs		
 RMNCAH TWG Sub-TWGs Family Planning RH Commodity Security Safe Motherhood Adolescent RH Newborn and Child Health RH Cancers PMTCT Immunization and Vaccines Gender 	 Health Financing Health Commodities and Technologies Human Resources for Health District, Regional, Zonal and Nationa Health Services Public Financial Management Public Private Partnership Social Protection and Nutrition 		

Funding Mechanisms Health Basket Fund Steering Committee Results-based Financing Steering Committee

FP indicators are part of the RBF and HBF

<u>Results-based Financing</u> "Use of modern family planning" Quantity indicator in RBF "Availability of FP commodities" Quantity indicator in RBF

<u>Health Basket Fund LGA Scorecard</u> "Use of modern family planning" "Availability of 10 tracer drugs" [FP is one of the 10 drugs]



Overview of One Plan II



MISSION: To promote, facilitate, and support in an integrated manner, the provision of comprehensive, high impact, and cost effective RMNCAH and nutrition services, along the continuum of care to men, women, newborns, children, and adolescents

KEY STRATEGIES:

- Strengthen reproductive, maternal, newborn, child, and adolescent health
- Scale-up the child health program
- Strengthen response to crosscutting issues, e.g., commodities, community involvement, demand, HMIS

SERVICE AREAS:

- Adolescent health
- Family planning
- Maternal health
- Newborn and child health
- Reproductive cancers and reproductive health for the elderly
- Gender and male involvement
- Cross-cutting issues

[SESSION 2] OVERVIEW: FP2020 AND THE GFF

FP2020 MOMENTUM AT THE MIDPOINT 2015-2016



www.familyplanning2020.org #FP2020Progress @FP2020Global Facebook.com/familyplanning2020

FP2020 MOMENTUM AT THE MIDPOINT TOPLINE PROGRESS 2015-2016

AS OF JULY 2016 AT THE MIDPOINT OF FP2020

MORE THAN **300**MILLION

WOMEN & GIRLS ARE USING MODERN CONTRACEPTION IN 69 FP2020 FOCUS COUNTRIES





30.2 MILLION ADDITIONAL WOMEN & GIRLS ARE USING MODERN CONTRACEPTION COMPARED TO 2012

AS A RESULT OF MODERN CONTRACEPTIVE USE FROM JULY 2015-JULY 2016:



82 MILLION UNINTENDED PREGNANCIES WERE PREVENTED



25 MILLION UNSAFE ABORTIONS WERE AVERTED

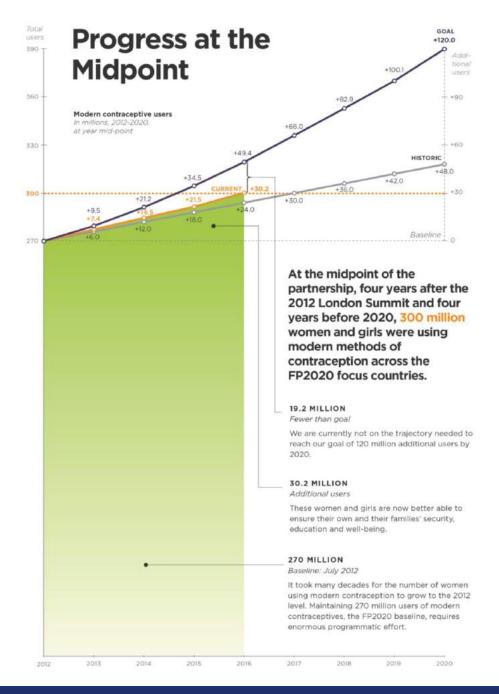
124,000 MATERNAL DEATH WERE AVERTED

IN 2015, DONOR GOVERNMENTS PROVIDED:



US\$1.3 BILLION

IN BILATERAL FUNDING FOR FAMILY PLANNING



CONVENING DONOR AND COUNTRY FOCAL POINTS

Common priorities have surfaced across countries and regions:

- Building high-level political support for family planning in country
- Expanding data use
- Mapping resource mobilization
- Scaling up LARCs
- Improving supply chain and delivery systems
- Investing in demand-side efforts and behavior change communications
- Increasing private sector involvement



FP2020 COUNTRY PAGES: RESOURCES AT YOUR FINGERTIPS

Features of redesigned pages include:

- Key documents, including government strategies and plans, GFF materials, and selfreported commitment updates
- 2016 Core Indicator data
- Country-specific research and news
- Enhanced shareability easily share data and information by email or social media



Country Resources at Your Fingertips.

Tanzania's country page provides access to family planning data, key government strategies, plans, and documents, and the latest research and news to support the efforts of all those committed to advancing the rights of women and girls to decide—freely and for themselves—whether, when and how many children they want to have.



RIGHTS AND EMPOWERMENT: CREATING A COMMUNITY OF PRACTICE

- Growing number of partners are injecting a rights approach into new and existing programs, resulting in first evidence about what it takes to operationalize and measure RBFP.
- The coming year will focus on further advancing the body of evidence and creating a community of practice.
- FP2020 will support this work by convening and amplifying discussions, developing and sharing tools and resources, and driving forward our shared agenda.



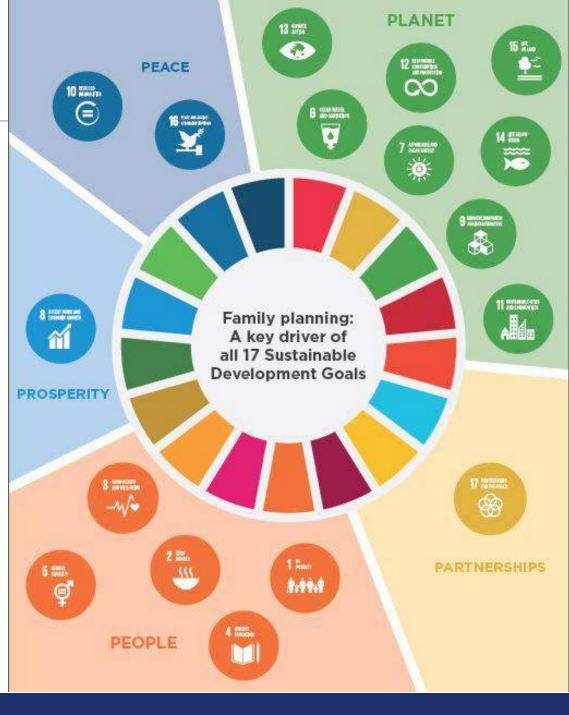
YOUTH ENGAGEMENT: STRENGTHENING THE EVIDENCE BASE

Three main areas of activity characterize FP2020's work in youth engagement:

- Improving data on young people and encouraging the use of this data to inform strategic decision making
- Amplifying voices of young people and supporting their inclusion in mainstream advocacy work in countries and within the FP2020 partnership and leadership structures; and
- Cultivating acceptance of evidence-based interventions for youth, including postpartum and post-abortion family planning and LARCs

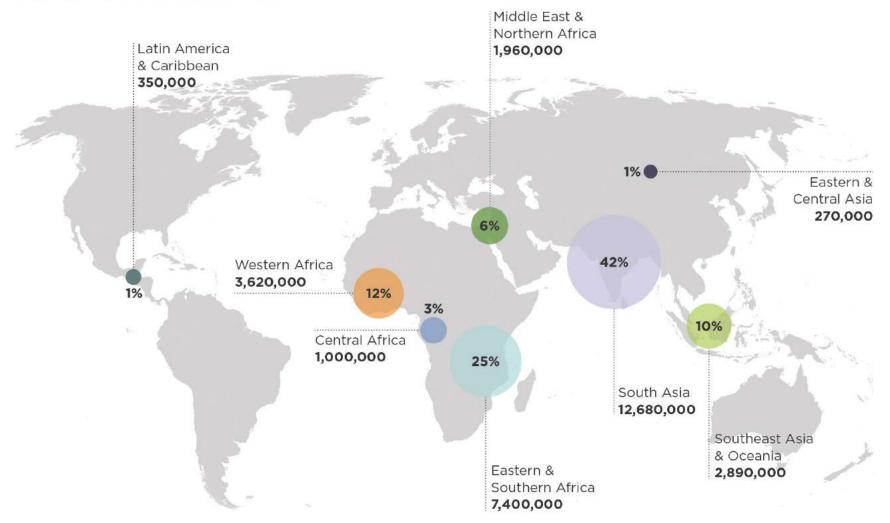
FAMILY PLANNING AND THE SDGS

- Progress on family planning is inextricably linked with all 17 SDGs.
- The FP2020 goal is explicitly linked to SDGs 3 and 5, but is also a critical milestone on the path to the other 15 as well.
- Whether or not women and girls have access to contraception will have an enormous impact on our ability to reach the SDGs in every country.



Additional users by region, 2016

30.2 million total additional users



Note: Due to rounding, regional-based total of additional users (30,170,000) differs slightly from country-based total presented in Indicator No. 1 Estimate Table (30,220,000).

MCPR CHANGE – ALL WOMEN

- In Eastern and Southern Africa, the region that has experienced the fastest growth in modern method use, for the first time more than 30% of all women are using a modern method.
- Emerging signs of mCPR growth in some countries in Western and Central Africa.
- Many countries in Asia, including several of the largest FP2020 countries such as India, Indonesia, and Bangladesh, have shown little growth in the proportion of women using a modern method since 2012.

UNMET NEED FOR FAMILY PLANNING

- In 2016, 22% of married or in-union women of reproductive age across the FP2020 countries had an unmet need for modern methods.
- This amounts to approximately 134 million women who would like to prevent a pregnancy but are not using a modern method of contraception.
- There are large variations in unmet need, ranging from 11% in Nicaragua to 40% in DRC.
- Despite higher levels of contraceptive use more than 90 million married women in Asia have an unmet need.

MOBILIZING RESOURCES 2015 KEY FINDINGS

- For the first time since the Kaiser Family Foundation began tracking, bilateral family planning funding has declined
- Of the 8 donor governments that made commitments at the 2012 London Summit, 7 are still on track to meet those commitments
- Foundations invested approximately \$190 million to support family planning—ranking them on a level with the top donor countries



Mobilizing the financial resources needed to sustain family planning services—for the 300 million women and girls using contraceptives today and for the 390 million we aim to reach by 2020—is a critical measure of FP2020 progress.

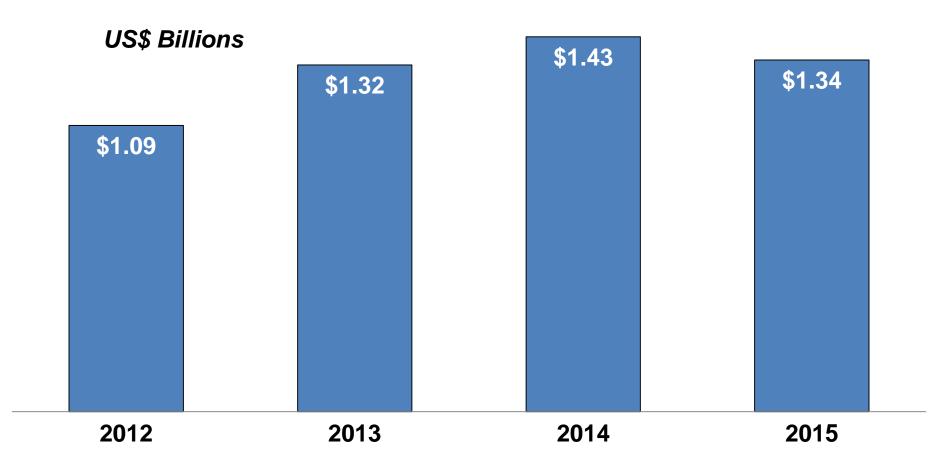
INTRODUCTION

- Kaiser Family Foundation started collecting data on donor government funding for family planning following the London Summit
- Adapted the methodology used to monitor donor government spending on HIV
- Current report presents 2015 funding data, the most recent year available
- Data now available for 2012-2015
 - Track trends in total donor government assistance for family planning
 - Measure donor progress towards FP2020 commitments

BILATERAL ASSISTANCE

- Donor governments disbursed US\$1,344.0 million for family planning activities in 2015, a decrease of US\$88.6 million (-6%) below 2014 levels (US\$1,432.7 million) and essentially a return to 2013 (US\$1,325.0 million)
- Decline is largely due to the appreciation of the U.S. dollar after exchange rate fluctuations are taken into account, 2015 funding essentially matches 2014 levels
- In currency of origin, five donors (Denmark, France, Germany, the Netherlands, and Sweden) increased funding, two donors (Canada & the U.S.) remained flat, and three donors (Australia, Norway, and the U.K.) declined

DONOR GOVERNMENT BILATERAL ASSISTANCE FOR FAMILY PLANNING, 2012-2015

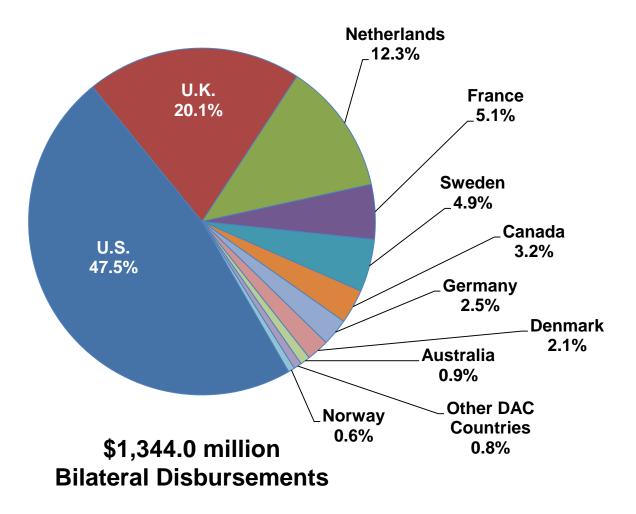


SOURCE: Kaiser Family Foundation analyses of data from donor governments and OECD CRS database.

BILATERAL ASSISTANCE

- U.S. was the largest bilateral donor, accounting for almost half (47%) of total bilateral funding in 2015
- U.K. was the second largest bilateral donor (20%), accounting for a fifth of all bilateral funding, followed by the Netherlands (12%), France (5%), and Sweden (5%)
- U.S. and U.K. have accounted for approximately two-thirds of funding over the entire period; recent trends have been largely driven by these two donors

DONOR GOVERNMENTS AS A SHARE OF TOTAL BILATERAL DISBURSEMENTS FOR FAMILY PLANNING, 2015



SOURCE: Kaiser Family Foundation analyses of data from donor governments and OECD CRS database.

FP2020 MOMENTUM AT THE MIDPOINT

2015-2016

COUNTRY-POWERED INVESTMENTS FOR EVERY WOMAN, EVERY CHILD.





2 November 2016

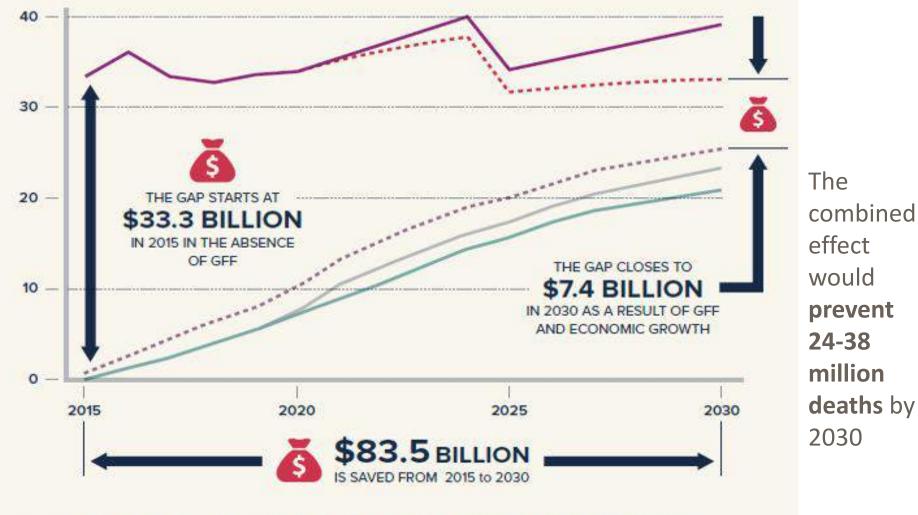
GFF is a financing partnership in support of EWEC and country leadership



<u>Smart</u>, <u>scaled</u>, and <u>sustainable</u>

financing to help end preventable deaths in 63 high-burden countries by 2030

Bridging the funding gap for women's, adolescents', and children's health



Total Incremental financing (domestic financing and development assistance for health, including GFF Trust Fund and IDA/IBRD)
 Incremental domestic financing crowded-in as a result of the GFF
 Incremental domestic financing related to economic growth
 Incremental resource needs (after efficiency gains related to the GFF)

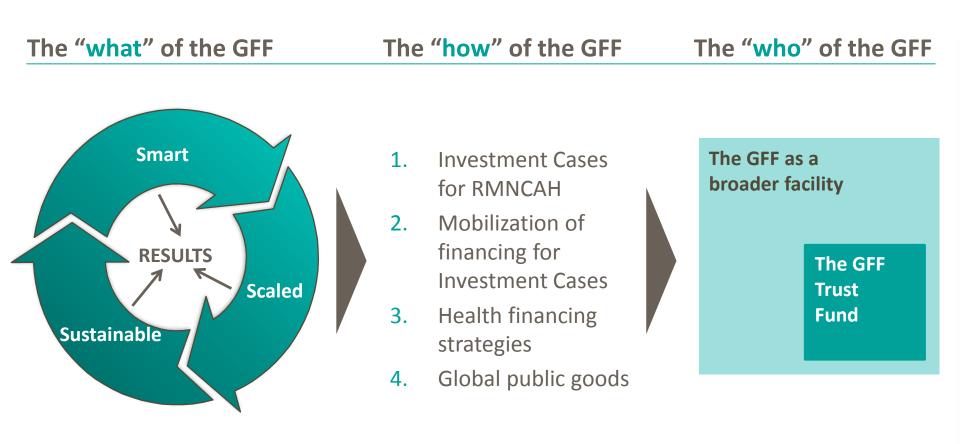
Incremental resource needs (no GFF)

GFF countries

- Bangladesh
- Cameroon
- DRC
- Ethiopia
- Guatemala
- Guinea
- Kenya
- Liberia
- Mozambique
- Myanmar
- Nigeria
- Senegal
- Sierra Leone
- Tanzania
- Uganda
- COUNTRIES WITH ACTIVE FINANCING
- - ELIGIBLE COUNTRIES

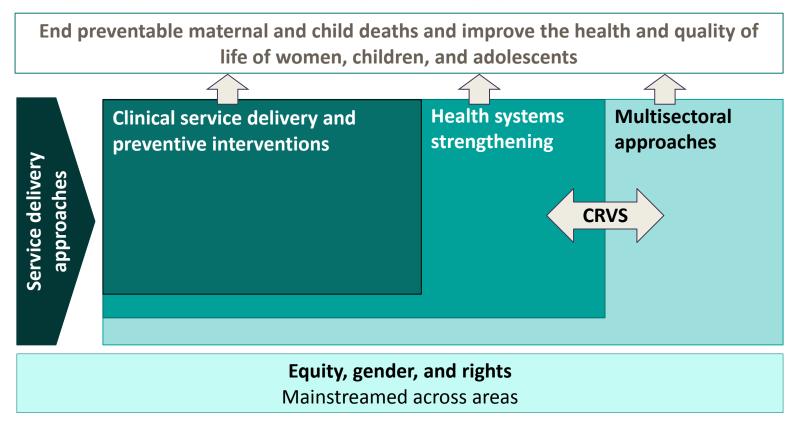
Vietnam

Overview of the GFF



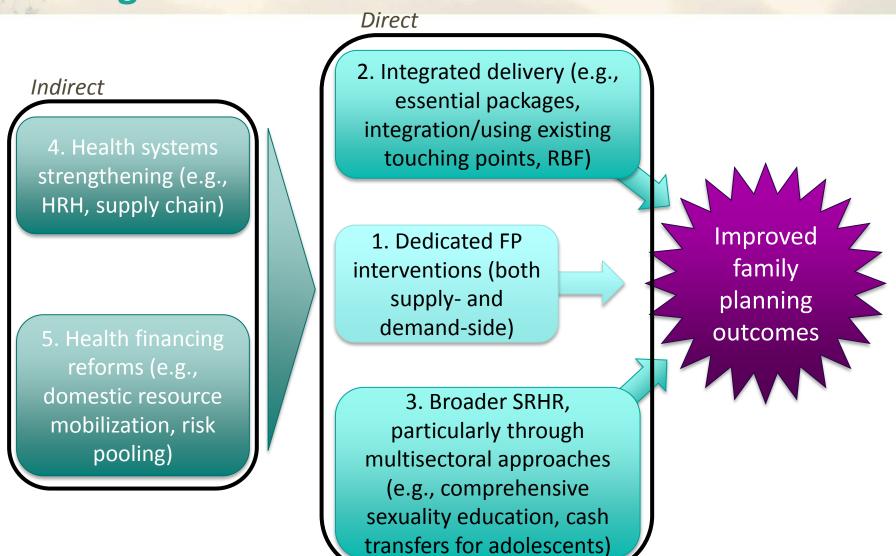
Governance

Scope of Investment Cases



- Prioritizes interventions with a strong evidence base demonstrating impact
 - Emphasizes issues (e.g., family planning, nutrition) and target populations (e.g., adolescents) that have been **historically underinvested in**
- Also covers how (service delivery modalities) and where (geographies, target populations equity focus)
- Encompasses financing from **domestic and external sources** not only World Bank

Pathways to impact: how the GFF improves family planning outcomes



1. Dedicated family planning interventions

- Investment Case process prioritizes evidence-based, high impact interventions, with a particular emphasis on areas that have historically been underinvested in
- Builds on rather than replaces existing strategies/plans → opportunities to leverage Costed Implementation Plans (CIPs)
- Two (of six) core indicators directly related to FP: adolescent birth rate and mCPR
- Seven final/near-final Investment Cases: all include FP
- Wide range of activities supported, on both supply- and demandsides (*illustrative*, not exhaustive):
 - Commodities: procurement (almost all countries), community-based distribution (DRC, Kenya, Uganda)
 - IEC/BCC: interpersonal communications via peer educators and/or teachers (Cameroon, Kenya, Liberia), social media (Kenya), advocacy/mass media campaigns/social marketing (Cameroon, Tanzania)
 - Community mobilization: engaging traditional and/or religious leaders (Cameroon, Tanzania), parents (Liberia)
 - Capacity development: community health assistants/volunteers and traditional midwives (Liberia), health extension workers (Ethiopia)
 - Promoting choice and expanding method mix: promotion of long-

Country experiences

Approach

Direct pathways

2. Integrated delivery

Approach

Country

experiences

 Substantial gains from integrating delivery of family planning services within broader health services

- Including FP services in an essential package: Kenya, Uganda
- Reducing missed opportunities by integrating FP into existing touching points: into post-partum care (DRC, Ethiopia), into HIV services (Kenya)
- Including FP in RBF payment schemes: Cameroon, Ethiopia Uganda
- Including FP in voucher programs: Cameroon, Kenya, Uganda

3. Broader SRHR

- Improving family planning outcomes by delivering on broader sexual and reproductive health and rights, particularly through multisectoral approaches
- Comprehensive sexuality education: Cameroon, Kenya, Uganda
- Cash transfers for adolescent girls: Cameroon
- Adolescent/youth-friendly health services/safe spaces: DRC, Liberia, Tanzania
- Strengthening the rights of girls by promoting marriage registration: Liberia

Indirect pathways

4. Health systems strengthening

Strengthening the broader health system indirectly benefits family planning services by improving service delivery

- Human resources for health: reforms on quantity, quality (training), payment, distribution, task-shifting (Cameroon, DRC, Ethiopia, Liberia, Tanzania, Uganda)
- Supply chain: capacity building to strengthen distribution systems, LMIS, regulatory systems (Cameroon, DRC)
- Infrastructure: construction/refurbishment of facilities (Liberia)
- Information systems: HMIS, capacity building on data for decision-making (Cameroon, DRC)
- Governance: strengthening decentralized capacity (Kenya, Uganda)

5. Health financing

- Integrated approach to smart, scaled, sustainable financing → increased/better financing for FP
- Increasing general government revenue without further prioritizing health (but larger pie increases total amount going to health)
- Increasing the share of government expenditure going to health
- Improving efficiency (including improving public financial management and budget execution rates)
- Improving resource tracking

Country experiences

Approach

GFF governance at the global level: GFF Investors Group





www.globalfinancingfacility.org





[SESSION 3] COUNTRY PERSPECTIVE: PERSPECTIVES FROM FP2020 & GFF COUNTRY PARTNERS

PANEL MEMBERS

Hon. Dr. Felix Kabange

Minister of Health, Democratic Republic of the Congo

•Dr. Wangui Muthigani,

Maternal and Newborn Health Program Manager, Kenya

Hon. Yah Zolia

Deputy Minister of Health & Social Welfare, Liberia

Dr. Adebimpe Adebiyi

Director, Family Health Dept., Ministry of Health Nigeria

Hon. Awa Marie Coll-Seck

Minister of Health, Senegal

Hon. Ummy Mwalimu

Minister of Health, Community Development, Gender, Elderly, and Children, Tanzania

RMNCAH Investment Case

Integrating Family planning & Adolescent Health Liberia







Why Adolescent Sexual & Reproductive Health?

Health Statistics at a glance

- Total population: 4,120,177
- Growth Rate: 2.1%
- Median age of first time mother is 19 years
- Total Fertility Rate (TFR): 4.7 (2013LDHS) children/woman
- Maternal mortality: 1072/100,000 live births (2013 LDHS)
- Infant mortality: 71/1,000 live births
- FP Unmet need: 34%
- 63% of the Population below 25 years of age
- Adolescent Pregnancy is at 31%

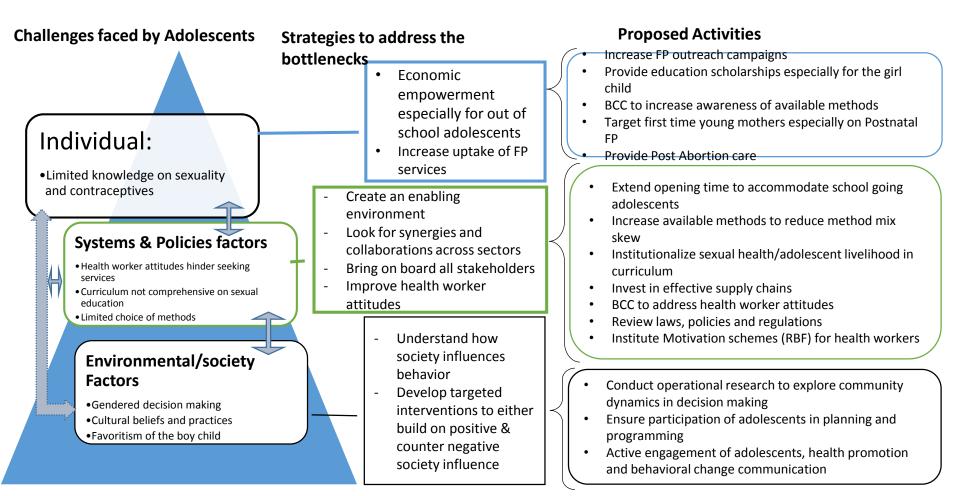
In Liberia, a significant population is within the adolescent to youth age bracket implying:

- A high fertility rate coupled with a very young age of first time mothers increases the risk of dependency
- High mortality rates mean the country misses out on productivity

This requires specific focus on the adolescent population if the country is to achieve the demographic dividend

With support from the Bill & Melinda Gates foundation, a WHO specialist was provided to sharpen the focus of adolescent health in the investment case

• A conceptual framework was developed to guide Implementation. (See next slide)



Family planning, including commodity security and program management are part of the core indicators of the proposed PBF mechanism

COFFEE BREAK

[SESSION 4] DISCUSSION

NEXT STEPS & CLOSING