

COUNTRY PORTFOLIO UPDATE

OVERVIEW

This paper gives an update on progress across the 16 countries in the current Global Financing Facility (GFF) portfolio. Reporting on achievements over the past six months in each country, the paper frames the focus for a country's progress in the context of the GFF approach, principles and value-add. This framing is drawn from the recent replenishment document, *A New Financing Model for the Sustainable Development Goals Era: The Global Financing Facility in Support of Every Woman Every Child*. A short overview of the themes and deliverables being supported through the GFF Exploratory Grants in 11 countries is also presented. Finally, a summary table (Annex 1) provides a snapshot of the 16 countries' progress on the GFF process milestones such as the development and implementation of Investment Cases and health financing strategies in support of reproductive, maternal, neonatal, child, and adolescent health and nutrition (RMNCAH+N).

SUMMARY OF FINDINGS

Moving solidly into the implementation phase in multiple GFF countries, the view across the portfolio highlights progress on the GFF key principles and approach: supporting countries to prioritize RMNCAH+N investments and health financing reforms to enable achievement of the SDGs, coordination and alignment of stakeholders to get better results for RMNCAH+N from existing and increased health resources, and strengthening systems for tracking progress.

ACTION REQUESTED

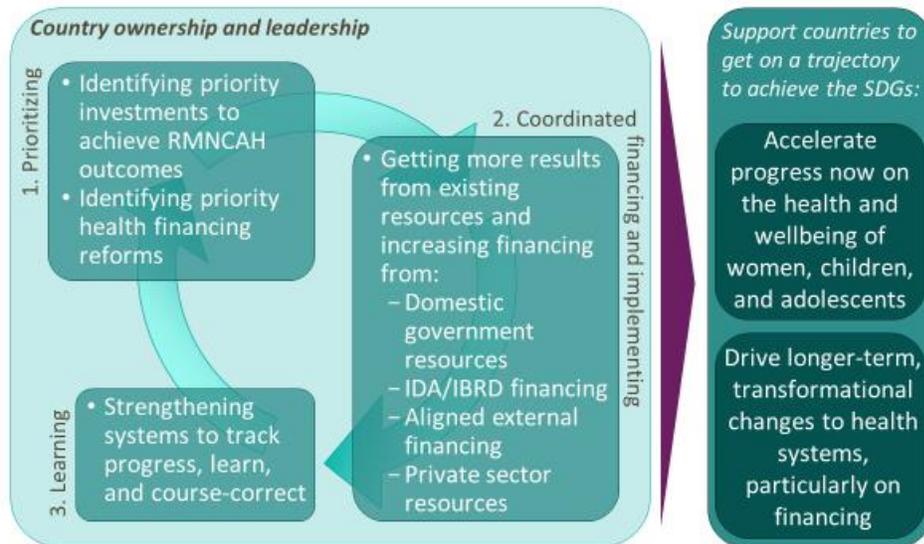
The Investors Group is requested to take note of this information.

BACKGROUND

The GFF supports countries to get on a trajectory to achieve the SDGs by:

- a) Strengthening dialogue among key stakeholders under the leadership of governments and supporting the **identification of a clear set of priority RMNCAH+N results that all partners commit their resources to achieving;**
- b) **Getting better results from existing resources and increasing the total volume of financing** from four sources:
 - Domestic government resources,
 - Financing from IDA and IBRD,
 - Aligned external financing,
 - Private sector resources; and
- c) **Strengthening systems to track progress, learn, and course-correct.**

How the GFF drives results



Using the GFF approach and key principles as the framing, this Country Portfolio update documents progress for each of the 16 GFF countries since the previous IG meeting through selected achievements and program developments aligned with the GFF model. A summary of the themes and deliverables being supported through the GFF Exploratory Grants in 11 countries is also presented.

COUNTRY OVERVIEW

Delivering on adolescent health through a multisectoral approach

Bangladesh has experienced consistent progress in health indicators for women and children over the last two decades, reducing maternal deaths by 40 percent between 2001 and 2010; lowering the under-five mortality rate below the MDG 4 target; and improving newborn morbidity and mortality. Remaining challenges include early marriage (adolescents form 25 percent of Bangladesh's population and 78 percent of adolescent girls marry before they are 18 years of age) and high unmet need for family planning (FP) services.

The health, nutrition, and population (HNP) service delivery system in Bangladesh is composed of community-level and facility-based services delivered by the government, non-governmental organizations (NGOs), and private for-profit providers. Each part of the system has largely distinct sources of financing: private providers are mostly financed by household out-of-pocket payments (OOP), NGO providers are supported by international funding as well as OOP, and government services depend on the government budget, including on-budget international financing. Given Bangladesh's evolution to a lower middle income country, the share of development partner financing has seen a slow decline with the current share being around 20 percent. Bangladesh aims to achieve the Sustainable Development Goals by 2030 and is committed to ensuring Universal Health Coverage for its citizens.

The Government of Bangladesh's Fourth Health, Nutrition and Population Sector program (2017-2022) aims to ensure the delivery of a package of essential services with equity and efficiency, guaranteeing universal access and improved quality of HNP services. The HNP Sector Investment Plan and Program Implementation Plan serve as the GFF Investment Case; they encompass a strong equity focus, prioritization of RMNCAH+N outcomes and the need for multisectoral action to achieve them. In addition to an important emphasis on sustaining and expanding FP gains through strengthened post-partum FP services in low performance districts and mainstreaming nutrition in Health and FP services, the GFF Trust Fund resources are contributing to a major push to improve the health and well-being of adolescents. To achieve its goal of becoming a middle-income country by 2021, Bangladesh must address the issues of early marriage and childbearing and adolescent health and nutrition as building blocks for its economic advancement, particularly as they affect the ability of girls to complete secondary school education.

With GFF support, an innovative engagement with the Education sector enables a partnership between Health and Education to deliver on the relatively neglected area of adolescent health in Bangladesh. In recent months, the GFF has been part of the design process for a catalytic disbursement-linked indicator (DLI) in the *Health Sector Support* project on strategic planning and joint implementation of the adolescent health program that directly links disbursement to performance in the Education sector. Activities in the education sector are embedded in the *Transforming Secondary Education* project, which is supported by a USD 10 million GFF investment and scheduled for WBG Board approval in October 2017. GFF and IDA support to the education project focuses on enhancing the numbers of girls able to complete secondary education by addressing critical issues influencing dropout rates among adolescent girls. Key activities cover incentives to female students in grades 9-12 from economically disadvantaged areas; provision of separate functional toilets for girls and menstrual hygiene with disposal facilities at schools; health curricula including sexual and reproductive health, gender equity, good nutrition and physical activity; teacher training, awareness raising, and peer counseling; nutrition services for girl students to address underweight and anemia; and improved linkages between schools and local health services.

Cameroon

Implementing the Investment Case in an inclusive manner in high burden regions

Cameroon has made some improvements in child health in recent decades but much less on maternal mortality (which is now among the highest in the world, at 782 maternal deaths per 100,000 births in 2011) and on neonatal mortality. Additionally, there are stark regional disparities, with the three northern regions and the East region having considerably worse health indicators. For example, adolescent fertility rates are far higher in the East and Far North, with 44.2 percent and 23.4 percent of young women aged 15 to 19 having delivered a child in 2014, respectively, compared to 7.6 percent in the capital Yaoundé. Similarly, these four regions are affected by high rates of stunting, with 44 percent in the Far North, 40 percent in both the North and Adamawa, and 38 percent in the East.

The process of developing the Investment Case in Cameroon was conducted in a highly inclusive manner, and that same spirit characterizes the approach as the focus shifts to implementation. The Investment Case has a strong equity focus and so prioritized four regions that have poor RMNCAH indicators (three of which are also affected by the conflict with Boko Haram). The government has been holding planning meetings in these regions with a wide range of key partners. To ensure that this is tied to existing planning efforts and not treated as a vertical initiative, the priorities of the Investment Case have been integrated into annual district health planning processes at the regional and district levels. Additionally, to highlight the importance of a multisectoral approach, the meetings have been opened by the governors of the regions.

In parallel, the government has been rapidly rolling out a performance-based financing (PBF) scheme in the priority regions outlined in the Investment Case, with financing from IDA and the GFF Trust Fund. The program was piloted in other parts of the country, allowing for scale-up to be built on lessons learned, which has enabled the priority regions to be reached rapidly. Over the past nine months, the coverage of PBF has increased from 25% of the population to 47% and will reach over 50% by the end of the year, prioritizing the Investment Case focus regions. In addition, PBF has been extended to the central level, with performance contracts signed with a number of key actors in the Ministry of Health to reinforce the regulatory, training and stewardship functions of the health system. A PBF pilot in basic education has begun and a CRVS PBF pilot will start by the end of the year.

The health financing and UHC strategies are nearing finalization. The process was delayed slightly in order to undertake some additional actuarial analyses and to ensure coherence between different workstreams, but validation at the national level is expected in December 2017.

Democratic Republic of Congo

Strong country ownership and alignment of development partners around Investment Case priorities underpins rapid implementation of the RMNCAH+N agenda

The potential to miss out on the gains of the demographic dividend is a key driver of DRC's focus on RMNCAH+N. Chronic malnutrition rates remain high (43 percent of children under five years are stunted) and stagnant. DRC's maternal mortality ratio of 846 (per 100,000 live births) is among the highest in the world. Adolescent fertility rate is high with 21 percent of adolescent females between 15 and 19 having given birth in 2014. Through the GFF's engagement, the government embraced the need to chart a new course for RMNCAH+N by focusing on adolescent health and child nutrition, the delivery of a minimum package of health services provided through performance based financing (PBF), community-based delivery approaches and the development of a health financing strategy.

A combination of supportive leadership and a commitment to the goals of the GFF process from the new Minister of Health in DRC, along with significant upstream investment of time for dialogue and joint planning with development partners in DRC, led to remarkable progress in setting the stage for rapid program implementation. Fragmentation in funding and service delivery have been addressed through alignment of donor funding in support of prioritized RMNCAH+N objectives; the development of a single manual for PBF including a single quality checklist and other common tools; and validation of the unique contracting approach at the provincial level by all donors and stakeholders. This has led to multiple efficiencies with a unified accounting system and a single reporting structure for the government. At the provincial level, harmonization among the group of 18 donors in DRC has led to agreements delegating sign off on all clearances to a single donor on behalf of the group, with additional efficiencies related to supply chain logistics among others.

In 2016, donors started aligning around the Ministry of Health (MOH) for strategic purchasing and developed the common PBF Manual. PBF was rolled out in a phased manner across several provinces: first in Bandundu (February-March 2017), followed by Maniema (April-June 2017), Equateur (May- June 2017) and then Kantaga (August-September 2017). In October 2017, PBF was being implemented in 1,979 health facilities. Overall, the quality scores of health facilities have improved in all health zones with PBF and the project is identifying mechanisms to support health facilities with lower performance. Utilization of curative visits has also increased since PBF implementation. For instance, the number of curative visits tripled in Kwilu and Kwango provinces and doubled in Maitland province. The PBF model has also advanced the governance and health financing system of health facilities through the provision of a bank account that is used for the payment of incentives.

The MOH has been finalizing the Health Financing Strategy which provides a road map to reach Universal Health Coverage in DRC by 2030. Some activities have already begun, in particular, interventions fostering efficiencies and autonomy, such as the described PBF and Single Contract. In addition, the MOH started planning the launch of several key health financing interventions of the Investment Case aligned with the Health Financing Strategy, which include: 1) assessing the feasibility of a resource allocation formula to ensure resources are allocated to provinces based on population needs; 2) assessing the feasibility of user fee removal to improve financial protection of households; 3) assessing the political and economic feasibility of earmarked taxes for the health sector to generate additional revenues for the health sector; and 4) conducting regular resource mappings of external resources in order to address inefficiencies in the health sector.

Ethiopia

Improving delivery and use of quality health services and strengthening the civil registration and vital statistics (CRVS) system to provide critical data for monitoring maternal and child health

Ethiopia has made enormous gains in RMNCAH+N in recent decades with major declines in the maternal mortality and under five mortality among other indicators. These achievements have been largely driven by allocating resources to high-priority primary health care interventions and an extensive community health workers program. Yet, preventable maternal and neonatal deaths remain high and nutrition is a serious under-addressed issue with more than 1 in 3 children (38 percent) under-5 suffering from chronic malnutrition (stunting).

As one of the GFF front runner countries, Ethiopia has focused on strengthening the utilization and quality of RMNCAH+N services as laid out in the Health Systems Transformation Plan (HSTP-2015-2020, which serves as the Investment Case). A cornerstone of the HSTP is the focus on quality and equity as well as supportive supervision and tracking performance of the health system. It establishes goals around improving equity, coverage and utilization of essential health services, quality of health care, and enhancing implementation capacity of the health

sector at all levels of the system. Ambitious targets for nutrition, maternal and child health outcomes to be achieved by 2020 are included in the HSTP to set the country on track to achieve its SDG commitments. High impact interventions to address RMNCAH+N and the prevention and control of communicable and non-communicable diseases are prioritized. Making gains in adolescent health, particularly in the context of reproductive health and nutrition, also receive high priority in Ethiopia's HSTP.

The IDA/GFF Trust Fund-financed *Health Sustainable Development Goals Program-for-Results*, approved in May 2017, contributes to improved RMNCH+N outcomes along with helping Ethiopia move toward UHC and a more sustainable health care financing system. The program aims to improve the delivery and use of a comprehensive package of maternal and child health services; build the Government's capacity in key areas including fiduciary management; coordinate the early years and nutrition multisectoral agenda; support the expansion of community-based health insurance; and strengthen the national CRVS system. Disbursement linked indicators cover maternal and child nutrition, child immunization, skilled birth attendance, and quality of health service delivery for drug supply systems, antenatal/postnatal care, family planning services and adolescent health, among others.

The emphasis that GFF places on strengthening data systems to monitor and improve RMNCAH+N outcomes led to support for the Federal Vital Events Registration Agency. Ethiopia launched the official registration of births, deaths, marriages and divorces in August 2016, having enacted a law that makes registration of these vital events compulsory, permanent and universal in 2012 and subsequently establishing the Vital Events Registration Agency (VERA) in 2013.

With GFF support, Ethiopia is moving rapidly to convert from the manual paper-based registration to an electronic civil registration system which is essential for timely, accurate, and efficient registration. Preparation of a costed CRVS IT strategy, system design, and procurement of required ICT equipment is underway. A procurement implementation manual is being developed with the technical support of the program.

Progress has also been made on private sector engagement in the health sector. A recent workshop was organized jointly with the MOH brought more than 60 representatives from private sector, NGOs, professional associations, the Health Sector and the Ministry of Finance. The discussion revolved around three topics: the policy and regulatory environment, financing and investment in health care, and strengthening public private partnership dialogue.

Guatemala

Addressing nutrition through a multisectoral approach to improve the health and well-being of women and children in Guatemala

Despite significant progress on several health indicators in the last 25 years, maternal mortality and chronic malnutrition (stunting) remain high in Guatemala. Although child stunting decreased from 55 percent in 1995 to 46.5 percent in 2014/15, it continues to be the highest in the Latin America and the Caribbean (LAC) region and among the highest in the world, exceeding rates of countries with significantly lower per capita incomes, such as Bangladesh, Ethiopia, and Vietnam. Guatemala is also among the countries with the highest poverty rate and inequity in LAC, which is reflected in the country's health indicators such as child stunting, which affects the poor (66 percent), rural dwellers (59 percent), and Indigenous groups (61 percent) disproportionately.

Budget constraints, funding flow bottlenecks, and inefficient spending limit the coverage and quality of services and social programs in Guatemala. While public health expenditures increased from 1.8 percent of GDP in 2007 to 2.2 percent in 2014, they are lower than the LAC average of 3.8 percent. Despite the 2008 Government policy mandating free-of-charge provision of health services in public facilities, private spending as a share of total health expenditures has been almost twice as large as the public share (63 percent vs. 37 percent respectively). Budget allocations to the health sector are inadequate to address the significant coverage gaps and quality issues related to staffing and availability of essential inputs, while funding delays and inefficient resource management, such as poor targeting and lack of coordination, hamper implementation.

Although the IBRD/GFF Trust Fund-supported project was approved in FY17, implementation is currently on hold due to a political crisis causing the resignation of most of the Cabinet ministers in August 2017. Up to that point, there had been significant progress on the RMNCAH+N agenda. For example, over the past six months, the technical assistance strategy for the IBRD investment was developed, and priority areas were identified for the Investment Case. The Investment Case will focus on the implementation of the multisectoral *National Nutrition Strategy to Prevent Chronic Malnutrition 2016-2020*, emphasizing results-based budgeting and intra-sectoral coordination to achieve national targets for child stunting reduction. This Strategy seeks to address the main determinants of chronic malnutrition in Guatemala by increasing access to improved primary health care services, water and sanitation services, as well as information and additional resources to promote and support healthy behaviors. The strategic areas for GFF-supported technical assistance include process evaluation of the roll-out of the Inclusive Health Model (*Modelo Incluyente de Salud, MIS*) which has already shown impressive reductions in the prevalence of stunting in pilot districts. The MIS integrates essential traditional Indigenous health beliefs and practices into public health services.

Another area identified for technical assistance is the development of a Health Financing Strategy (HFS) to propose options for reaching UHC. Increased efficiency in public health spending through support to a fiscal observatory in the health sector and a focus on improved procurement of drugs and other strategic areas are included in the technical assistance strategy.

Guinea

Strengthening health finance planning, management and monitoring capacities (including for PBF) is laying the foundation for more systematic and longer term health financing reform

Health outcomes for women, children and adolescents in Guinea are among the worst in the region. RMNCAH+N service utilization, particularly by the poor, is extremely low. Challenges include lack of health workers, insufficient equipment and supplies (including lack of access to water), lack of pharmaceuticals, and weak governance and accountability structures. An underlying issue in Guinea is the historically low government financial contribution to the health sector. Health services are largely funded by donors (especially since the Ebola crisis) and by OOP expenditures.

In July 2017, the GOG approved the RMNCAH+N Investment Case. Generated in collaboration with, and endorsed by donor partners, the IC provides the first national-level view of the total costs needed for Guinea to achieve targets for RMNCAH+N intervention coverage. It also highlights not only the incremental financing needed to deliver priority RMNCAH services, but also the importance of investing in strengthening the financing of the health system and the need for technical support to achieve health financing reforms. For implementation, the Investment Case prioritizes geographic regions with the greatest health financing gaps and identifies a basic

package of high impact health services. Furthermore, there is consensus that strengthening the community health approach through a Community Health Strategy is a key priority.

Strengthening institutional capacity in health care financing includes building capacity, both through training of existing staff and the appointment of new staff in the Bureau of Strategy and Development (BSD); strengthening public financial management together with development partners; and developing a health financing strategy with all relevant partners. Initial steps with GFF support include undertaking a Health Financing System Assessment to inform an upcoming health financing workshop that is planned for early 2018.

The focus of the health financing work includes achieving greater technical and allocative efficiencies in service delivery through piloting a PBF program in the high-priority regions and a focus on human resources for health. Analytics include studies on how to reform the current human resources for health (HRH) situation (e.g., delinking salaries from health workers towards decentralized funded posts, delinking recruitment efforts) and a shift towards supporting, better integrating, and increasing the number of frontline health workers in Guinea. The analytical work is explicitly linked to the implementation of pilot reforms (such as PBF and various models of contracting and incentivizing community health workers) to ensure its policy relevance.

Kenya

Improved harmonization of development partner funding and RMNCAH+N programs in high burden counties

Although Kenya's health indicators have improved remarkably over the past 10-15 years, there are remaining challenges that are being addressed through the work of the GOK and development partners. These include unacceptably high rates of maternal and newborn mortality, child stunting, and adolescent pregnancy. Both demand- and supply-side barriers hamper utilization and coverage of essential RMNCAH+N services and weak health information and CRVS systems limit evidence-based decision making.

As one of the four GFF front-runner countries, Kenya has moved from the early phases of the GFF process to operationalization of the national RMNCAH+N Investment Framework (IF) This includes implementation of prioritized interventions aligned to the IF in six high burden counties by H6 partners through the second phase of the UN joint program on RMNCAH and advancement of the IDA/GFF/Government of Japan Policy and Human Resources Development (PHRD)-funded *Transforming Health Systems for Universal Care* project. Key project activities underway in the last six months comprise the procurement of family planning commodities and the training of nurse midwives.

Within the challenging context of Kenya's devolved health system (two-thirds of the health budget was transferred as part of the equitable share to 47 county governments), the GFF continues to work with the GOK and development partners to strengthen planning and budgeting for health at the county level. Sector resource mapping, providing technical assistance and capacity building for new county teams including the development of an IF-centered partnership framework and coordination are key priorities of the GOK financed by the GFF.

An exciting recent development is the establishment of a multi-donor trust fund for RMNCAH+N Technical Assistance in Kenya with support from USAID, DfID and Danida. The Trust Fund will provide timely, high quality technical assistance for county and national capacity building in support of the implementation of the IF.

Liberia

Reforms to strengthen service delivery at the county level and discussion of longer-term health financing plans

Liberia's experience with the Ebola outbreak eroded health gains and weakened an already fragile health system. For the country with the lowest density of physicians in the world (14 MDs/1,000,000 population), the estimated loss of 8 percent of its health workforce during the Ebola crisis was devastating. In addition to excessive numbers of preventable deaths nationwide, there are large geographical disparities in the coverage of quality health services that translate into significant regional variation in health indicators.

The GFF process in Liberia has supported rigorous analysis to inform prioritization of high impact interventions including a focus on adolescents in the RMNCAH+N Investment Case and a geographic focus on the six counties with the worst RMNCAH+N outcomes. Implementation of the Investment Case is taking place in a phased roll-out across counties, depending on available financing. Performance-based financing in the prioritized counties will provide financing to counties and health facilities to address key issues identified in the Investment Case and improve results with technical assistance to strengthen capacity at the county level.

Since April 2017, work on health financing reform has been a key feature of the GFF process in Liberia, including finalizing the Liberia Health Equity Fund (LHEF) to support the development of Liberia's approach to achieve UHC. The broad concept of the LHEF is the development of a national health insurance system pooling government, contributory and donors' revenues to purchase output-based health services for all citizens, with subsidies for the poor. The development of health insurance can take decades, hence the LHEF is a long-term goal. To move on a path toward LHEF, the government needs to launch incremental reforms. An example is using PBF to build capacity in purchasing and paying providers.

In August 2017, the Liberian National Health Financing Conference took place, with the aim of reaching a consensus on short- and long-term reforms for health financing for UHC. In addition, participants from the Liberian government attended the flagship course on *Health System Strengthening and Sustainable Financing* held in Ghana (August 2017).

Mozambique

Shifting the focus of the health sector from inputs to results

Over the past two decades, Mozambique has achieved mixed progress in improving health outcomes. A persistently high fertility rate, increasing numbers of adolescent births and high levels of stunting are among the critical health issues that still need to be addressed.

A broad consultative process with leadership from the GOM has defined the GFF engagement in Mozambique. Recently, the coordination of the GFF process moved from the Director of Public Health to the Director of Planning, and a dedicated GFF coordinator is soon to be installed within the Directorate of Planning to further ensure that all stakeholders stay connected and well-informed.

The Investment Case prioritizes increasing the readiness and effectiveness of care providers (particularly at Type 1 health centers and districts hospitals in densely populated districts); scale-up of the Community Health Worker Program; and mobile teams to deliver nutrition, family, and child health services in sparsely populated districts. On the demand side, the Investment Case highlights issues concerning family practices and cultural norms that

require a multisectoral approach and community-based interventions to address vulnerable groups (e.g. adolescents), considering inequalities of gender, geography, education, income, and other vectors.

As part of the complementary financing for the Investment Case, a Program-for-Results operation (*Primary Health Care Strengthening Program*), financed through IDA and the GFF Trust Fund, with additional contributions from several development partners, will link disbursements to priorities in the Investment Case. With an impending WBG Board approval date in December 2017, there has been a major push in the past several months to finalize the Program-for-Results (PforR) project design and the disbursement-linked indicators (DLIs) for which achievement of results will trigger payments. The 11 DLIs focus on a mix of results in the areas of service delivery (increased coverage of institutional deliveries, family planning and, nutrition services), health financing (increases in domestic resources, shifts in resources to priority districts) and health system strengthening (share of staff allocated to primary care, percentage of hospital and health centers meeting performance standards, increased use of civil registration system). Under the leadership of the GOM and supported by development partners, more than 100 people have participated in working groups that produced 11 technical notes describing each DLI, the targets for each indicator, and what it will take to achieve the DLI.

Myanmar

Strengthening dialogue among key stakeholders to support the identification of a clear set of priority results that all partners commit their resources to achieving

Despite improvements in health outcomes in Myanmar (for example, between 1990 and 2010, the maternal mortality ratio fell from 520 to 200 per 100,000 live births and the under-five mortality rate from 100 to 52 per 1,000 live births), the infant mortality rate remains high (40 deaths per 1000 live births). Contributing factors include low levels of births attended by skilled providers (52 percent) and exclusive breastfeeding under 6 mos (24 percent). Childhood malnutrition is also persistent with 29 percent of children under five experiencing chronic malnutrition (low height for age or stunting). Constraints to progress on RMNCAH+N include conflict, health financing, human resources, the state of physical infrastructure, and lack of quality HMIS systems.

Myanmar is still in the initial phases of the GFF process. Like several other GFF countries, Myanmar has not developed a standalone Investment Case because the country has recently completed a new National Health Plan (NHP) which is centered around the roll-out of an essential package of health services that includes a significant focus on RMNCAH+N. The NHP also calls for the development of a health financing strategy which is underway.

The country has a complex operating environment with a history that continues to influence the situation today. This history is a major factor in the fragmentation of financing in the country, with a large majority of external support being off-budget. Additionally, the organization of the Ministry of Health and Sports is being reassessed.

The GFF process presents an opportunity to address some of these challenges. For example, reinvigoration of the RMNCAH Technical Support Group, established originally under the existing health sector coordination mechanism but historically not very active, will serve as a platform to bring key stakeholders together. The government has requested support from the GFF Trust Fund to support the hiring of an RMNCAH consultant to improve coordination between the government and development partners and help to develop a prioritized set of high-impact interventions for women and children behind which the entire community can coalesce.

The current political and humanitarian crisis in Myanmar has impacted progress in the country, including affecting a proposed IDA project with GFF Trust Fund co-financing. It was intended to be presented to the World Bank Board

of Directors for approval in December 2017 but that timeline is now in flux, and there is a possibility of additional financing directed specifically at Rakhine.

Nigeria

Piloting a crucial demonstration of the structures for the implementation of the Basic Health Care Provision Fund (BHCPF) which will galvanize domestic resources for health

Nigeria has high rates of maternal mortality, one in eight children die before reaching their fifth birthday, and there has been minimal progress on reducing child malnutrition. There has also been little progress on limiting fertility. The country achieved only 8 percent reduction over the last 25 years in total fertility rate with the average Total Fertility Rate (TFR) remaining high at 5.5 children per woman.

Low public funding for health is compounded by a complex fiscally decentralized system. Primary health care centers, which are meant to serve as the entry point to the healthcare system, receive little-to-no operating budget and frequently lack basic infrastructure, equipment, and drugs. Relying heavily on user fees to operate, even for services that are meant to be free, contributes to high out-of-pocket spending or forgone care. The bulk of health expenditures are for curative rather than preventive care. Health worker deployment, productivity, and inadequate knowledge contribute to poor performance. This points to opportunities for improving efficiency and outcomes from better resource allocation, training, and provider incentives. The overarching GFF approach in Nigeria supports the financing of crucial RMNCAH+N services in the northeast through a private contracting approach and more broadly in support of the Basic Health Care Provision Fund as the principle funding vehicle for delivery of a minimum package of health services.

The Boko Haram insurgency in northeast Nigeria has also contributed to stagnant and worsening health indicators. It has destroyed health infrastructure, displaced millions of people, and disrupted the delivery of social services. In response to a request from the Government of Nigeria for assistance with the extreme conditions in the northeast regions, IDA and GFF Trust Fund resources have supported the re-establishment of primary health care services within communities in five northeastern states (Borno, Yobe, Taraba, Gombe and Bauchi) most directly affected by conflict through a private sector contracting approach for a comprehensive package of RMNCAH+N interventions.

Implementation in the five northeast states began in June 2017 and preliminary data from four local government areas or LGAs (64 health facilities) looks promising with improvements in service delivery in all the states. Taraba is making especially rapid progress and saw an increase from five percent coverage of skilled deliveries to 40 percent. Increases are also documented for the number of vitamin A capsules distributed, completely vaccinated children, new outpatient consultations, and the total of new and existing users of modern family planning methods.

The GON has reiterated its commitment to achieving UHC by focusing on primary health care. In 2014, it passed the National Health Act entitling all Nigerians to a Basic Minimum Package of Health Services (BMPHS) and specifying the Basic Health Care Provision Fund (BHCPF) as the principal funding vehicle. Contributions to the BHCPF are expected from: i) an annual grant of no less than 1 percent from the Consolidated Revenue Fund of the federation (CRF); ii) grants from donors; and iii) funds from other sources. However, the resource envelope for the BHCPF is inadequate to guarantee access to the BMPHS, especially without more efficient use of resources and the GON has yet to allocate funds to the BHCPF.

Over the past six months, with the Federal MOH in the lead, the RMNCAH+N Investment Case has been developed. Near completion, it reflects consultations culminating in the decision to add family planning services to the BMPHS and finance these services through the BHCPF (along with other high impact interventions to address RMNCAH+N). The remaining GFF Trust Fund resources are playing a crucial catalytic role by supporting the startup phase of the BHCPF. This will set the stage for scale up of the BHCPF across Nigeria, delivering the BMPHS promised to all Nigerians under the National Health Act. With proof of concept planned to be rapidly available from the BHCPF startup, GFF directly supports increased domestic resource mobilization for provision of high impact, evidence-based interventions that are free at point of care to the poorest and most vulnerable Nigerians. The BHCPF start up design has been the focus of the GFF process over the past several months and it is anticipated to be ready to go the WBG Board by the end of 2017.

Senegal

Prioritization of key areas for RMNCAH+N during the development of the Investment Case, including a strong focus on adolescent health

Senegal has made substantial progress in reducing infant and child mortality over the last decade, but more needs to be done to ensure that reductions in stunting continue and that maternal and neonatal mortality reductions are accelerated. Senegal has a persistently high rate of low birth weight (18 percent of newborns) and anemia affects as many as four out of five children under five. The fertility rate of 5.0 remains high and 16 percent of adolescents under 20 years of age having already given birth to at least one child. Geographic and socioeconomic inequalities in health service coverage and health outcomes are common.

A bottleneck analysis of the health system conducted as part of the GFF process pinpoints financial accessibility, socio-cultural acceptability and coverage as key impediments to access to health service delivery. Further studies show that the following obstacles are limiting the access to quality health services: (i) density in health centers is low, thus reducing their geographical accessibility and their capacity for carrying out outreach activities; (ii) qualified health workers prefer to work in urban areas and especially in Dakar; (iii) the performance of these health workers (absenteeism, quality of care, etc.) is weak, and (iv) health facilities have limited funding for ensuring availability of drugs and supplies.

In terms of health financing, the overall General Government Expenditure (GGE) was 30 percent of GDP in 2014, above the median ratio for the group of L-LMICs (28.5 percent) and Senegal's revenue base has grown increasingly diversified in recent years. Yet, since 2005, the share of GGE spent on health has decreased from 12.1 percent to 8.0 percent in 2014. Given the important political support and commitment to achieving gains in health (through the implementation of UHC), prioritizing health in the budget appears to be the most likely and promising option to increase fiscal space as well as improving efficiency of public and external funding.

The GFF process in Senegal is very inclusive and under strong leadership by the GOS. There has been active participation from key donor partners including Gavi, Global Fund, JICA, UNICEF, USAID, WHO, UNFPA and the World Bank from the outset. The RMNCAH+N Investment Case will build on the existing RMNCAH+N strategy (currently being updated) and Health Financing Strategy.

Anticipated to be finalized by the end of 2017, the Investment Case focuses on scaling up successful health system strengthening interventions including cash-transfer programs for pregnant women; community-based health insurance; an informed push model (IPM) supply chain innovation through public-private partnership; and traveling midwives ("sage femmes itinérantes") to expand coverage of the RMNCAH+N package in (initially) five prioritized regions. A workshop in July 2017 with the country platform led to agreements about the key priorities

of the Investment Case, including: 1. Contents of the RMNCAH+N package; 2. Improving demand for/equitable to the RMNAH+N package; 3. Reinforcing supply and quality of RMNCAH+N services; 4. Developing a multisectoral approach to adolescent sexual and reproductive health to take full advantage of the demographic dividend; and 5. Implementing further CRVS reforms. The GFF-supported October 2017 workshop led to the development of a detailed workplan with results indicators for each priority component within the Investment Case.

Sierra Leone

Prioritization of interventions and health financing reforms to address the most critical determinants of poor RMNCAH+N outcomes and health system bottlenecks

While Sierra Leone has made considerable progress in the 15 years since the end of the civil war, its economy and health system remain vulnerable. Preventable maternal and child deaths persist and nearly 30 percent of children under five years are stunted. Adolescent pregnancies are common, and put girls at high risk of maternal mortality: nearly 25 percent of total maternal deaths occur among adolescent girls.

Despite a relatively high per capita spending on health, health outcomes do not compare favorably with other countries at similar levels of development. As part of the GFF engagement in Sierra Leone, diagnostics and consultations have identified issues of inequitable distribution of facilities and qualified health workers, problems of low productivity in some areas, lack of access in others and overall low quality of care. Weak supply chains and chronic stock outs lead households to procure medicines in the private sector. The high reliance of the health system on OOP, amounting to nearly 10 percent of GDP, limits equitable access to care and financial protection.

Extensive consultations and engagement with the government and development partners have identified key areas in which the GFF and partners can contribute to progress on RMNCAH+N. The GFF-supported development of an implementation plan is helping to identify gaps and prioritize key interventions in the government's new RMNCAH+N Strategy. The Strategy, together with the implementation plan, serve as the Investment Case. To ensure long term sustainability and possible scale up of key interventions, GFF supports analytical work on the feasibility of a tobacco tax to increase domestic resources for health and on the key drivers of inefficiencies in the health system. The GFF approach is very much one of linking discussions on RMNCAH+N service delivery to those on health financing, by supporting a redesign of the current PBF program to address key determinants of inefficiencies and by trying to foster better integration of PBF and the envisaged Social Health Insurance Scheme. To this end, GFF has led cross-country learning with stakeholders from across the GoSL, CSOs, USAID and the WBG with a study tour to Ghana to explore the challenges of establishing a social insurance scheme.

Tanzania

Positive results from the PBF approach show improved quality in RMNCAH+N service delivery

Although Tanzania was one of only a few African nations to achieve MDG4 (reducing the under-five mortality rate from 166 to 54 per 1000 live births between 1990 and 2013), there are still major RMNCAH+N challenges including unacceptably high rates of maternal mortality and child undernutrition. Health system constraints include absolute shortages and inequitable urban-rural distribution of skilled health workers; limited financial autonomy within facilities preventing efficient service provision; and a lack of accountability for performance at all levels of the health sector. Addressing service coverage gaps will require strategic allocation of sufficient and sustained financial resources. However, Tanzania is dependent on fragmented and largely off-budget external support for up to 48 percent of total health expenditure and the share of the Government's budget allocated to health fell from 11.9 in 2010/11 to 8.7 in 2013/14.

Tanzania's National Strategic Plan to Improve Reproductive, Maternal, Newborn, Child, & Adolescent Health (2016 – 2020) or the One Plan II, serves as the RMNCAH+N Investment Case. It aims to strengthen service delivery for maternal health; to scale-up coverage of child health and nutrition services including infant and young child feeding interventions; and to address cross-cutting issues including community involvement in RMNCAH+N services. Service delivery reforms focus on improved performance, governance and accountability in primary health care through: improved health worker performance through a facility accreditation scheme (the star rating initiative); enhancing equity in skilled health worker distribution in nine regions with absolute shortages through bonding policies and redistribution of permits for practice; improved essential commodity supply via governance, procurement and inventory reforms; and improved coverage and quality of essential care, particularly emergency obstetric and neonatal care (EmONC). Five regions that are poorly performing on maternal and neonatal mortality indicators are receiving priority focus.

Since the last IG meeting, implementation of the RMNCAH+N Investment Case includes progress on upgrading of 100 health centers to comprehensive emergency obstetric and newborn care (CEmONC) standards with additional funding of USD 15million through the Health Basket (a funding mechanism that pools resources in support of an agreed set of priorities and results at local government level in the health sector). The GFF is also supporting efforts by the government to roll out payment for results at the health facility level in the regions with the poorest health outcomes by incentivizing achievement of results through strategic purchasing. This PBF approach is now implemented in eight regions. A process evaluation is underway and a supervision mission of the PBF program was conducted together with USAID in August 2017. Preliminary findings reveal that the PBF and star rating assessments show clear differences in quality improvement of health services, especially in primary health care with a focus on RMNCAH+N. Quality improved in PBF dispensaries and health centers from about 55 percent in 2016 to more than 90 percent in March 2017 in Shinyanga, Mwanza, Simuyi and more recently Tabora Region. Further analysis of the data is needed to help inform possible changes in the indicators used so as to continuously improve the services delivered.

Uganda

Using PBF to achieve RMNCAH+N results in high burden areas

Despite major gains in health outcomes, many critical issues affecting women, children and adolescents persist in Uganda. Malaria is still the biggest killer of children under five. Low coverage of quality emergency obstetric care services is the main driver of the high maternal mortality. High total fertility rate (TFR is 6.2 percent), teenage pregnancy (24 percent) and unmet need for family planning (34 percent) coupled with early marriage increase the exposure to the risks of pregnancy and pregnancy-related morbidity and mortality.

Just recently finalized, Uganda revised its Sharpened Plan to serve as the RMNCAH+N Investment Case. The plan emphasizes delivery strategies to improve RMNCAH+N outcomes, including scaling-up supply-side PBF approaches at health facilities and vouchers to address demand-side constraints, and prioritizes the scale up of key RMNCAH+N interventions: safe delivery services, including antenatal care, post abortion care and management of pre/eclampsia; family planning and adolescent health services; and neonatal care, including resuscitation and preterm care. The plan establishes a multisectoral coordination mechanism under the MOH. It also prioritizes strengthening capacity at all levels with a focus on ameliorating constraints affecting human resources for health, supply chain management, and quality of care, and emphasizes strengthening capacity of service providers and promoting community based health services.

The Ugandan Health Financing strategy was approved in 2016 and the government is keen for partners (World Bank, USAID, DfID, and others) to help them flesh out an implementation roadmap to move quickly on a few key reforms. Central objectives of the strategy are increased mobilization of domestic resources, promotion of financial risk protection for all Ugandans as they access health services, and increased efficiency and effectiveness in the utilization of resources in the sector.

Since the last IG, the IDA/GFF Trust Fund project in support of the RMNCAH Investment Case became effective in May 2017, and is now in implementation. It targets districts with high disease burden and low service coverage and utilization and will be implemented in close collaboration and coordination with other programs to ensure alignment of the programs to the RMNCAH+N Sharpened Plan. The project assists the government to address critical health systems bottlenecks constraining RMNCAH+N service delivery, including strengthening supervisory functions and improving quality of care and strengthening institutional capacity for CRVS to scale-up provision and utilization of Birth and Death Registration services. The government has developed a national PBF Framework which reflects the country's commitment to results.

Vietnam

Vietnam is empowered to address issues of inequity in health service access and RMNCAH+N outcomes during a time of economic transition

Unlike many other GFF countries, Vietnam has made major progress in health outcomes over the past 20 years. The MDGs were achieved, many well in advance of the 2015 deadline; maternal, infant and child mortality has fallen along with child stunting prevalence. Skilled birth attendance has risen to 94 percent, nearly three-quarters of pregnant women receive 4 or more antenatal care visits and full immunization rates were at 97 percent in 2015. However, disadvantaged groups, especially ethnic minorities and those living in remote, mountainous areas continue to have limited access to health services and have worse health outcomes.

Vietnam is no longer highly dependent on external assistance for the health sector and with the achievement of middle income country status, the Government of Vietnam is entering a new phase in its relationship with the World Bank Group and other donors. Vietnam is facing less concessional lending terms and reduced volumes of World Bank financing. This is compounded by the pressure of the national debt ceiling and there is now reluctance on the part of the Government of Vietnam to borrow for health and other human development sectors. The GFF is playing a pivotal role in Vietnam's transition by buying down the interest rate of the WB health project loan to more concessional terms with the GFF Trust Fund's investment, thereby facilitating the Government of Vietnam's willingness to borrow for health.

Since the last IG meeting, design work for the Transitional IDA¹/GFF-supported project has progressed. The *Investing and Innovating for Grassroots Service Delivery Reform* project will ensure that all commune health stations (CHS) in the project provinces can deliver RMNCAH+N services with an emphasis on improving quality, efficiency, and patient confidence in the grassroots level. Over-reliance on hospital-centered care and bypassing lower levels of care is common. Although relatively well-utilized in the more disadvantaged parts of the country, the grassroots health system financing arrangements fail to incentivize effective and coordinated care.

¹ Transitional IDA is a special IDA allocation that has been made available to Vietnam during the FY18-20 cycle; it is lent at terms equivalent to IBRD.

In addition to progress on the design of the GFF Trust Fund-supported project, a program of analytical work and technical assistance was developed for implementation over the next 12 months. Technical assistance will help the MOH to strengthen the CRVS system in Vietnam with special emphasis on improved cause of death (COD) reporting, including support for implementation of new standards for COD diagnosis and improved reporting of COD at health facility and commune health station level.

A second stream of technical assistance will support work with the MOH and other relevant government agencies to strengthen the design and delivery of health public private partnerships (PPPs). Typically, PPPs in the health sector in Vietnam are geared towards joint venture models which focus more on revenue-generation than on achieving UHC objectives of providing needed care and protecting patients from excessive health spending. In addition, the MOH lacks capacity to effectively manage and negotiate complex PPP contracts. With GFF support, policy-making, planning, identification, selection, structuring, tendering and implementation of health PPPs will be more consistent with public health objectives. Pilot PPPs will focus on improved maternal and child health outcomes.

EXPLORATORY GRANTS OVERVIEW

In early 2017, the GFF Trust Fund launched an exploratory grants program. The objective of the grants is to contribute to advancing the GFF objectives in countries that are eligible for GFF Trust Fund support but not currently receiving a grant from the trust fund. Through a competitive selection process, grants of up to US\$200,000 were awarded to 11 World Bank Group country teams in May 2017: Afghanistan, Burkina Faso, Cote D'Ivoire, Haiti, India, Laos, Madagascar, Malawi, Niger, Rwanda, Yemen. The grants are expected to run for a period of 12-18 months and will be Bank-executed.

Each grant includes a review of the current context in the country regarding key RMNCAH+N technical issues and the GFF financing agenda such as opportunities for efficiency gains, domestic resource mobilization, potential partners that could provide complementary financing for RMNCAH priorities, and crowding in private resources. Major technical areas featured in the 11 grants are: adolescent health including diagnostics of determinants of child marriage and early pregnancy (Afghanistan, India, Niger); community health workers (Rwanda); resource mapping and donor alignment (Haiti, Madagascar); health service delivery in fragile, conflict and violence (FCV) settings (Yemen); and health financing (Burkina Faso, Ivory Coast, Laos, Malawi).

COUNTRY	INVESTMENT CASE RMNCAH PRIORITIES	COMPLEMENTARY FINANCING FOR THE INVESTMENT CASE		HEALTH FINANCING
		PARTNERS FINANCING THE INVESTMENT CASE	STATUS OF IDA/IBRD-GFF TRUST FUND PROJECT	
Bangladesh	Using national plan (SWAp); implementation underway	SWAp supported by pooled parallel and project financiers	Health project in implementation: US\$ 15 million from the GFF Trust Fund, US\$ 500 million from IDA; Education project due for Board approval in October 2017	Strategy being implemented
Cameroon	Investment Case developed; implementation underway	France, Gavi, Germany, Global Fund, Islamic Development Bank, US Government (CDC and USAID)	Implementation: US\$27 million from the GFF Trust Fund, US\$100 million from IDA	Strategy being prepared
DRC	Investment Case developed; implementation underway	Canada, Global Fund, Gavi, US, UK, UNFPA, UNICEF	Health project in implementation: US\$40 million from the GFF Trust Fund, US\$220 million + US\$ 120 million from IDA, US\$ 6.5 million HRITF, US\$ 3.5 million USAID CRVS project in implementation: US\$10 million from the GFF Trust Fund, US\$30 million from IDA	Strategy available; to be endorsed by the Minister of Health
Ethiopia	Using national plan; implementation underway	Financiers of SDG Performance Fund	Implementation: US\$60 million from the GFF Trust Fund, US\$ 150 million from IDA; supplemental financing through the project from US, Bill & Melinda Gates Foundation, and Power of Nutrition	Focus on implementation plan
Guatemala	Using national plan		Approved: US\$9 million from the GFF Trust Fund, US\$100 million from IBRD	Process recently begun; interrupted of political instability
Guinea	Draft Investment Case available	Discussions with partners underway	Early stages	Process recently begun
Kenya	Implementation of the Investment Framework through Annual Work Plans at county level	Denmark, Gavi, Japan, UK, US A Trust Fund has been established with financing from USAID for technical	Implementation: US\$ 40 million from the GFF Trust Fund, US\$ 150 million from IDA; supplementation	Draft strategy under development

COUNTRY	INVESTMENT CASE RMNCAH PRIORITIES	COMPLEMENTARY FINANCING FOR THE INVESTMENT CASE		HEALTH FINANCING
		PARTNERS FINANCING THE INVESTMENT CASE	STATUS OF IDA/IBRD-GFF TRUST FUND PROJECT	
		assistance to counties for implementation; DfID and Danida also considering contribution	financing through the project from Japan	
Liberia	Investment Case developed; implementation underway	Gavi, Global Fund, EC, Ireland, UK, US	Standalone grant approved: US\$16 million from the GFF Trust Fund; matching US\$16 million allocation from IDA expected in 2018	Strategy exists; focus on implementation plan
Mozambique	Draft Investment Case available	Discussions with partners underway	Appraisal	Strategy exists; focus on identifying reforms to implement
Myanmar	Using National Health Plan	Discussions with partners underway	Project under preparation	Process recently begun
Nigeria	Draft Investment Case available	Discussions with partners underway	North-Eastern Nigeria Emergency Project under implementation: US\$20 million from the GFF Trust Fund, US\$125 million from IDA Additional project (US\$ 20 million GFF Trust Fund) in preparation	Strategy being prepared
Senegal	Draft Investment Case available	Discussions with partners underway	Early stage	Strategy exists; focus on implementation plan
Sierra Leone	RMNCAH Strategy has been finalized. This strategy together with an implementation plan that is being finalized will serve as the Investment Case	Discussions with partners underway as part of the implementation plan	Early stage	Process recently begun
Tanzania	Investment Case developed; implementation underway	US, financiers of the Health Basket Fund	Implementation: US\$ 40 million from the GFF Trust Fund, US\$ 200 million from IDA; Supplemental financing through the project from US and Power of Nutrition	Draft strategy being consulted on

COUNTRY	INVESTMENT CASE RMNCAH PRIORITIES	COMPLEMENTARY FINANCING FOR THE INVESTMENT CASE		HEALTH FINANCING
		PARTNERS FINANCING THE INVESTMENT CASE	STATUS OF IDA/IBRD-GFF TRUST FUND PROJECT	
Uganda	Investment Case developed; implementation underway	Gavi, Sweden, UK, US	Implementation: US\$30 million from the GFF Trust Fund, US\$110 million from IDA	Strategy exists; focus on implementation plan
Vietnam	Determining approach	Discussions with partners underway	Project under preparation	Determining approach

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