

STRENGTHENING ALIGNMENT AT COUNTRY LEVEL

OVERVIEW

Health financing is a recurrent item on the agenda of the GFF Investors Group Meetings. At the last meeting, the health financing discussions focused on improving efficiency of health spending. This time, the discussion will focus on one specific area of efficiency, namely external financing. Aid efficiency and effectiveness remains an unfinished agenda and is at the heart of the smart, scaled and sustainable financing agenda. This paper examines the challenges involved in ensuring the effectiveness of Development Assistance for Health (DAH) drawing on the literature and country experience. It furthermore discusses how the GFF is contributing to this agenda. Finally, the paper suggests practical ways for GFF partners to improve alignment and harmonization of external financing as a contribution to the development of country health financing systems.

SUMMARY OF FINDINGS

- Improved efficiency is instrumental to achieve more health results: Freeing additional resources through efficiency gains can expand service coverage and contribute to save more lives. There are several sources of inefficiencies in the health sector and some of them relate to DAH, i.e., limited alignment of DAH to disease burden, high transaction costs and unpredictability.
- Given that DAH accounts for an average of 20% of total health expenditures in GFF countries, identifying mechanisms for getting the most value out of every DAH dollar is critical and it is still an unfinished agenda. For instance, several GFF countries do not use country public finance management procedures, creating additional transaction costs and missing opportunities to strengthen capacity.
- In the past 2 two years, country platforms have been contributing to donor alignment and harmonization. After testing resource mapping exercises in several GFF countries, it has become a key ingredient of the GFF approach, resulting in aligning donor and government funding to the priorities of the IC, if they are carefully costed. Comparing costs and resources matched to IC priorities allows the GFF platform to identify gaps and start discussion on re-prioritization or/and re-alignment of Development Partners (DP) to fill-out the gaps.
- Expenditure tracking is a crucial step to ensure the monitoring of the implementation of the IC; this is still work in progress.

ACTION REQUIRED

- Encourage GFF partners to support resource mapping, costing and expenditure tracking exercises and provide timely information.
- Support institutionalization of resource mapping, costing and expenditure tracking exercises as part of monitoring IC implementation.

SECTION 1. OBJECTIVES OF THE PAPER

Raising resources for RMNCAH is a key objective of the GFF, integral to the development of smart, scaled and sustainable financing as outlined in the GFF Business Plan (Box 1). The needs and opportunities for achieving more RMNCAH outcomes with available resources through efficiency gains were discussed at the fifth Investors Group Meeting. This time the focus is on achieving more results from the available DAH (Box 2).

Box 1: Smart, Scaled and Sustainable Financing Definitions

- 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 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 middle-income status.

Source: GFF Business Plan

Because DAH plays a crucial role in supporting the health sector of most low and some middle-income countries, in particularly in GFF countries, the objective of this paper is four-fold: 1) Examine challenges of achieving more results with the available external financing; 2) Monitor progress in aid effectiveness in GFF supported countries using the International Health Partnership (IHP+) Result framework; 3) Discuss the GFF contribution to alignment of external financing through mapping and tracking of resources related to IC and share progress in GFF countries in this regard; and 4) Discuss practical ways GFF partners can contribute to improved efficiency and better results from external financing.

Box 2. Definition of Development Assistance for Health (DAH)

OECD's formal definition of official development assistance (ODA) is financial or in-kind contributions provided by official governmental agencies (be they bilateral or multilateral) to developing countries for improving economic development and welfare. ODA is 'concessional in character', i.e., 'conveys a grant element of at least 25%'. Apart from ODA, the international flow of funds to developing countries includes 'other official flows' (OOF) and private flows (such as those from private foundations). In this paper, we refer to 'development assistance for health' (DAH) as including ODA, OOF and private grants – for all health areas including population & reproductive health and family planning. In this paper, DAH and external financing are used synonymously.

Source: Fan, 2016

SECTION 2. THE CHALLENGES OF ACHIEVING MORE RESULTS OUT OF DAH

Improved efficiency is critical to reaching better health outcomes. Improved efficiency (achieving more with the available resources) allows countries to obtain greater coverage of services, and to deliver better quality health services and financial protection for the same expenditure level.¹ It can also improve health outcomes. For example, a recent IMF working paper suggests that African countries could raise life expectancy at birth by about five years on average if they used their health resources more efficiently (Grigoli & Kapsoli 2013).

There are several types of inefficiencies in the health sector as were discussed in the previous IGG meeting².

1. “Doing the wrong things”: not choosing the mix of interventions that maximizes benefits.
2. Providing services in the “wrong setting”: for instance, providing services at hospital level that could be offered at primary or community care levels.
3. “Doing things wrongly”: not choosing the mix of inputs that achieves the desired output at the lowest cost. This also captures macro-issues related to health financing and organization (e.g., a country may establish several supply chain systems, leading to fragmentation and unnecessary administrative costs, resulting in waste). Some of these inefficiencies are also linked to DAH and are explicitly spelled out in the following paragraphs.

Limited harmonization and alignment of external financing contributes to inefficiencies in the health sector. Figure 1 provides the broad picture of common inefficiencies in the health system. All of them can be associated with expenditures from external sources as well as from domestic funding. Those highlighted in blue reflect inefficiencies associated with how DAH is prioritized or channeled to countries. In broad terms, efficient DAH can be defined as assistance that delivers full value and achieves maximum impact with the least waste or that delivers the greatest health benefit at the lowest cost. Effective aid, on the other hand, is defined as aid that produces the intended effect (or ‘reaches its objectives’) in the recipient country. The Paris Declaration on Aid Effectiveness remains the key reference on aid effectiveness. The Declaration highlights five dimensions that are crucial to aid effectiveness: (1) Ownership, (2) Alignment, (3) Harmonization, (4) Results, and (5) Mutual accountability.³

The idea of ‘efficiency’ and ‘effectiveness’ are closely linked in the health sector. They are distinct concepts in the sense that effective aid can be inefficient if the desired impact is achieved despite significant waste (and vice versa); but in the context of highly constrained resources (as in DAH), they often tend to be interrelated

¹ The following sections are based on the background paper for the second annual UHC Financing Forum on efficiency for better health and financial protection, which took place in Washington, D.C. April 20-21, 2017. See <http://pubdocs.worldbank.org/en/616561494511379987/UHC-Efficiency-Background-Paper-V10-170419-1100.pdf>

² IGG-Health Financing Paper presented in Washington, D.C. April 20-21, 2017. See: https://www.globalfinancingfacility.org/sites/gff_new/files/documents/GFF-IG5-4%20Financing%20for%20RMNCAH-%20background%20paper.pdf

³ (1) Ownership: Developing countries set their own strategies for poverty reduction, improve their institutions and tackle corruption; (2) Alignment: Donor countries align behind these objectives and use local systems; (3) Harmonization: Donor countries coordinate, simplify procedures and share information to avoid duplication; (4) Results: Developing countries and donors shift focus to development results and results get measured; and (5) Mutual accountability: Donors and partners are accountable for development results (OECD, 2014).

Figure 1. Common Types of Inefficiencies in the Health Sector

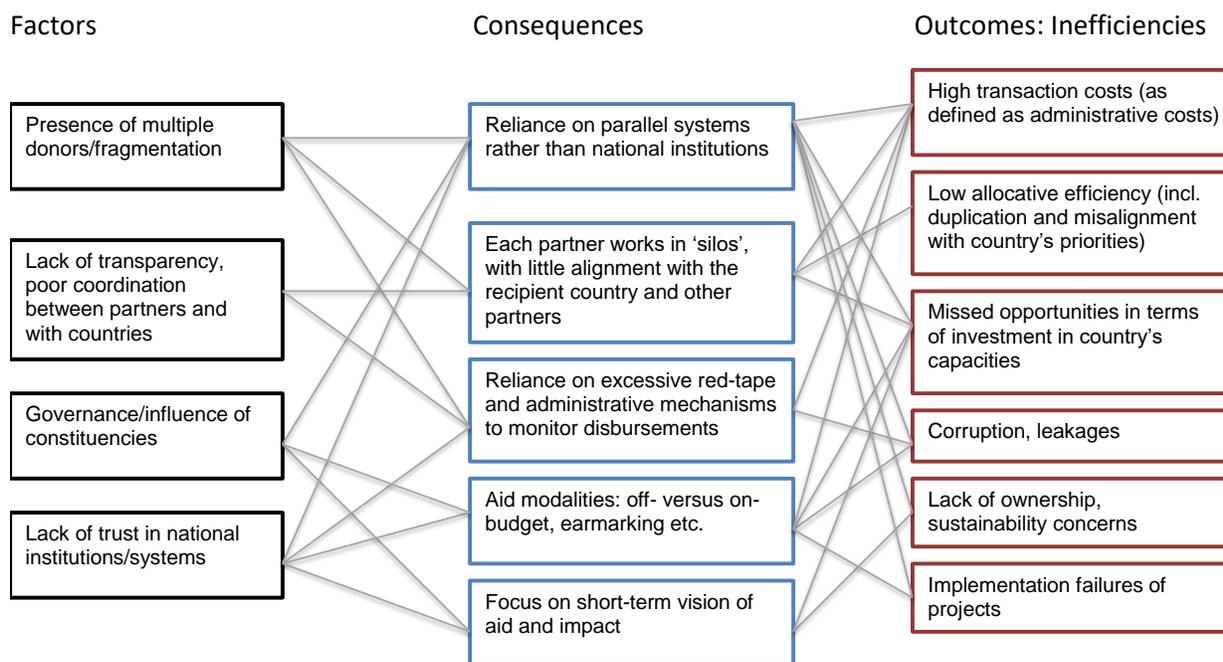


Source: Adapted from IG5-Health Financing Paper, April 2017

Unpredictability, limited alignment of DAH to disease burden and country priorities, and high transaction costs contribute to inefficiencies in the health sector. Annex 1 illustrates the types of inefficiencies found in the literature based on country experience, i.e., low allocative efficiency, lack of predictability and sustainability, , high transaction/administration cost, missed opportunities in terms of capacity development. The literature shows that development partners may contribute to inefficiency in the following ways: 1) not aligning investments with country disease burden (Piva & Dodd, 2009), hence decreasing allocative efficiency; 2) undermining health financing and health system organization due to limited predictability of DAH (e.g., short-term cycling of donor funding impairing the planning capacity of the Ministry of Health); 3) high transaction cost (e.g., the implementation of a vertical program with its own reporting mechanisms leading to several layers of administrative costs and waste); and 4) substituting local capacity rather than strengthening it and enhancing administrative costs.

Sources of inefficiencies linked to external funding are often related to both development partners and recipient countries. The most common reasons for limited aid effectiveness stem from poor coordination between partners and countries, institutional constraints, influence of constituencies, limited capacities of national institutions/systems and presence of multiple donors/fragmentations. The diagram in Figure 2 shows that each inefficiency linked to DAH is often the result of multiple causes and processes. For instance, several factors lead to transaction costs: in some cases, donors may decide not to channel funding on-budget due to low local capacity in domestic Public Financial Management (PFM) systems, resulting in utilization of parallel systems, yielding higher administrative/transaction costs (Moon & Omole, 2013; Acharya, et al. 2006; Knack, & Smets, 2013). In some other cases, donors may face administrative constraints including internal rules that are set by their constituencies (e.g., parliaments in the donor country) that influences their work. For instance, some countries cannot channel resources directly to national governments, making them use parallel systems (Eichenauer & Reinsberg, 2017). In a nutshell, the causes behind the inefficient use of external resources are multi-dimensional, making improving aid effectiveness a shared responsibility of both recipient and donor countries.

Figure 2. Sources of Inefficiencies in the use of DAH

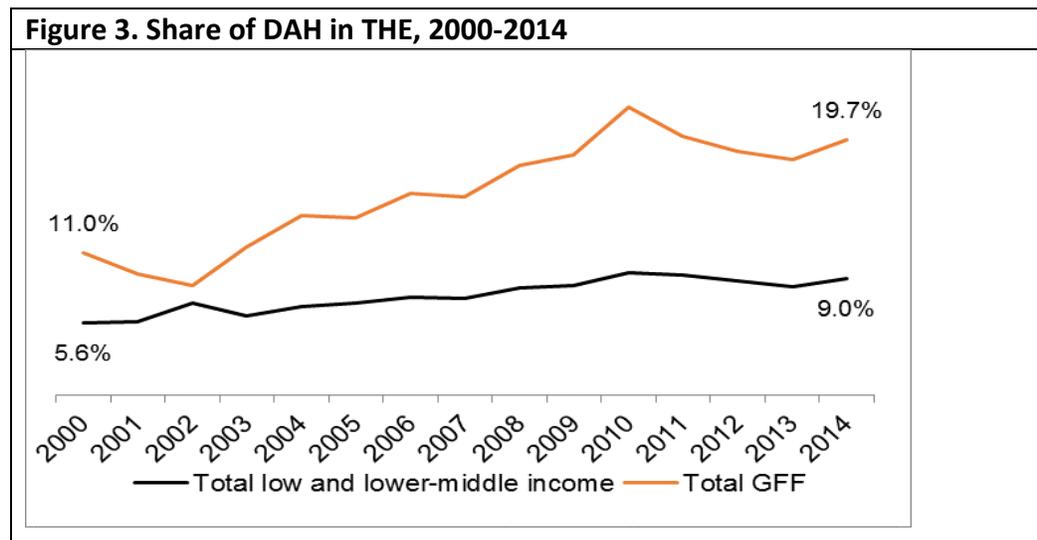


Source: Authors based on Moon, S., & Omole, O. (2013); Eichenauer, V. Z., & Reinsberg, B. (2017) ; Acharya, A., Fuzzo de Lima, A., and Moore, M. (2006); Knack, S., & Smets, L. (2013); <https://www.oecd.org/dac/effectiveness/48780908.pdf>

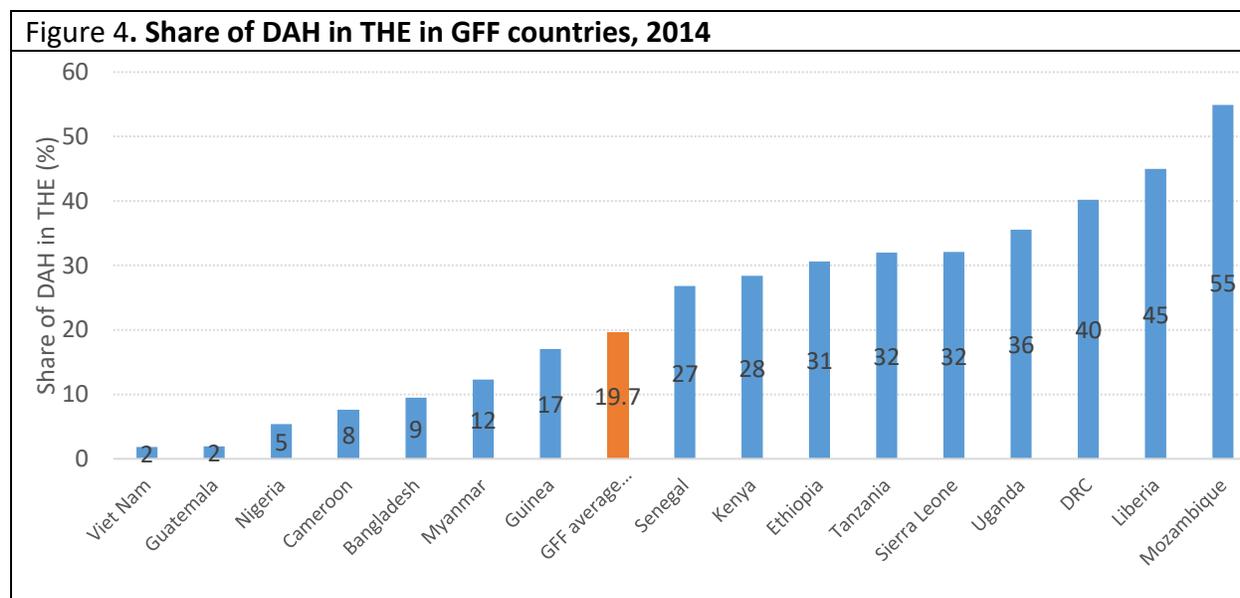
SECTION 3. IMPORTANCE OF MONITORING AND STRENGTHENING DAH EFFICIENCY IN GFF COUNTRIES

Improving donor coordination is crucial given that DAH has grown rapidly and comprises a major share of financing in many GFF countries. At the global level, DAH has grown significantly. Between 1996 and 2016, total disbursements of DAH reported by donors grew by 308% to reach \$37.6 billion in 2016 (Institute of Health Metrics and Evaluation, 2016). DAH reported from health account studies at the

country level represents a large share of the Total Health Expenditure (THE), on average (weighted) 19.7% in GFF countries compared to 9.0% in Low- and Lower-Middle-Income Countries (LMIC) (Figure 3). In 9 out of 16 GFF countries DAH accounts for more than 20% of THE, and the proportion exceeds 40% in DRC, Liberia, and Mozambique (Figure 4). This picture makes clear that it is crucial to make sure that DAH is spent wisely is crucial.



Source: GHED, 2014 (population weighted average)



Source: GHED, 2014 (population weighted average)

Ensuring the highest value from DAH is not an easy task given increased fragmentation. The global health landscape has undergone an important transition from a system dominated by relatively few bilateral donors, to a more nebulous and fragmented one (Szlezák et al., 2010) (Annex 2). The sector today is characterized by the high number and diversity of actors (ranging from multilateral organizations to Non-Governmental Organizations, private charities, etc.), each with their own objectives, motivations and

institutional constraints. This fragmentation is also the result of more disease-specific programs (IG2 Paper on DAH Trends), which has generated more vertical approaches and parallel implementation arrangements (e.g., Kieny, et al., 2014; Panter-Brick, Eggerman and Tomlinson 2014; Gostin and Friedman, 2015; WB, 2016).

Despite progress in aid effectiveness in the health sector, more work is needed in crucial steps such as registering external contributions on the national budget. While the WHO estimated that globally between 20-40% of health resources could be wasted through major forms of inefficiency (WHO, 2010), there is no specific estimate of inefficiency applied to external support. Yet, the International Health Partnership+ Monitoring & Evaluation (M&E) framework has shown some progress in donor alignment, although much remains to be done (see Annex 3). For instance, the number of parallel implementation units decreased by 39% in countries with a IHP+ Compact and 13/19 countries reported progress on the PFM/ country policy and institutional assessment (CPIA) scale since the previous year. Despite these improvements, only 1 out of 17 Development Partners (DPs) met the target of having 85% of their health aid recorded on the national budget (IHP+ 2014). Insufficient progress in relation to the Paris agreement has also been observed in the use of countries' financial management and procurement systems: In 2013, 41% of DPs declared using national public financial management systems (target of 80%) and the proportion of development health funds recorded in the national budgets was 71% (target of 80%). In 2012, only 32% of DPs used local procurement systems.

Aid effectiveness remains an unfinished agenda in GFF countries. Annex 4 emphasizes there is room for improvement at both DPs and recipient country levels to achieve better value out of DAH. For instance:

- In Sierra-Leone, Nigeria, and Senegal, only 22%, 17% and 15% of donors respectively use country PFM procedures, creating additional transaction costs and missing opportunities to strengthen capacity in these three countries.
- In some countries (e.g., Nigeria, Liberia), DPs' budget execution rate is below the GFF countries' average (84%) and could be improved.
- Half of the funding is off-budget in GFF countries (51%), pinpointing to the fragmentation of the system and undermining countries' planning capacities.
- Likewise, only half of the DPs could communicate their planned resources for the next 3 years to the MOH (See Annex 4), demonstrating limited predictability of external funding. Recipient countries also have room for improvement and there is some statistical evidence that donors are more willing to use country systems they perceive as relatively efficient (See recipient countries' indicator)⁴.

⁴ On average GFF countries have a score of 2.2 out of 3 for 3 IHP+ financing indicators assessing the progress of recipient countries on meeting commitments to transparent and predictable health sector financing. These 3 financing indicators are: 1) The proportion of the national budget allocated to the health sector and the level of execution of the budget; 2) The predictability of health sector funding over the next three years through a rolling budget or a medium-term expenditure framework (MTEF); 3) the World Bank's country policy and institutional assessment (CPIA) scale. The positive relationship between the percentage of DPs using country PFM procedures and the average score in financing indicators of recipient countries (0.96), indicates that DPs may be incentivized to better align to country system as recipient countries improve their fiduciary systems

SECTION 4. GFF CONTRIBUTION TO DONOR ALIGNMENT THROUGH RESOURCE MAPPING AND TRACKING

The GFF builds on previous efforts to improve alignment of external financing in the health sector. GFF is cognizant of several efforts (Sector Wide Approach (SWAp,) Budget Support, IHP+) developed in the hope of enhancing aid effectiveness and DAH efficiency and builds on the lessons learned from these initiatives. More details on SWAPs, Budget Support and IHP+ are provided in Annex 5.

4.1. GFF Approach to donor alignment

Several instruments are used in GFF countries to align financing behind the priorities of the Investment Case. The objective of this section is to drill down on specific instruments that GFF country platforms have used to foster donor alignment to countries' Investment Cases for RMNCAH, i.e., resource mapping, costing and expenditure tracking. These instruments are led by the GFF country platform and used in the planning, implementation and monitoring phase of the IC⁵. As discussed previously, often DAH is not fully aligned with the country's health sector strategic plan; similarly, it is often difficult to know what priorities or areas are under-financed, sufficiently financed and over-financed. One reason for this, is that the national strategic plans might not be costed, or might be too broad or too ambitious to be fully funded with available resources and therefore financiers do an implicit prioritization. To overcome these challenges, GFF supports the development of an IC, a country led process prioritizing high-impact investments in RMNCAH funded by both government, development partners, and sometimes by the private sector.

Countries typically conduct two resource mapping exercises as part of developing and implementing the Investment Case and expenditure tracking to monitor its implementation. Figure 5 summarizes the steps that are usually followed to align financing to national priorities in GFF countries. First, during the planning process of the IC, the GFF platform conducts a *high-level resource mapping* of the health sector⁶ (See Annex 6 for more detailed methodological steps on resource mapping). This is usually a straightforward exercise to identify resources committed by different partners in specific areas and, if possible, at national and sub-national level. This resource mapping (RM) provides an overview of the resource envelope for the health sector and helps the GFF country platform prioritize per resources available or likely to be available. It can also help DPs and governments re-align commitments to priorities or act as an advocacy tool to mobilize more resources from the government, DPs and the private sector to improve coverage and quality of health services. This exercise is done before or during the IC preparations. Second, a *detailed resource mapping* is conducted at the end of the IC development process. The objective is to ensure that funds align to the identified IC priorities and that they match the identified gaps. This second step also implies a costing of the priorities against which available resources are mapped to identify possible gaps or surpluses. This helps clarify who finances each priority area and tries to ensure that there is no duplication or gaps. Both resource mapping and costing of priorities can be disaggregated by sub-priority, geography and cost-category to derive a detailed gap. Third, with

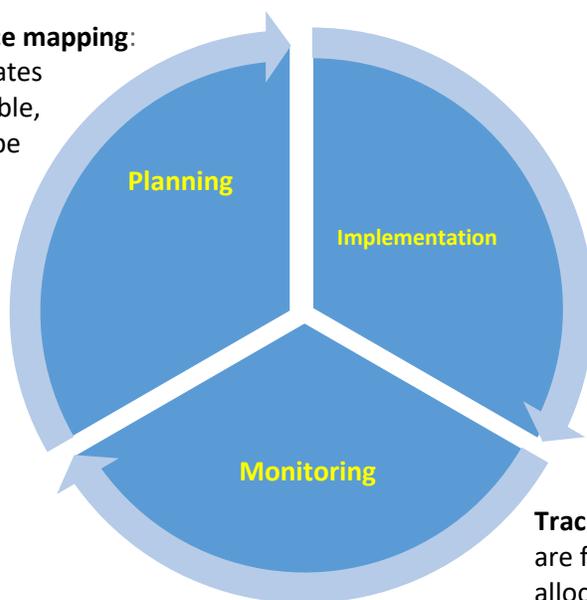
⁵ Include definition of IC and GFF country Platform from Business Plan, 2014

⁶ In GFF countries with an existing RMNCAH Strategy and a resource mapping exercise, the GFF platform will use this exercise to estimate the resources committed by DPs to RMNCAH. In other cases, the Focal Point of the GFF Platform will contact the main DPs to gather the budget envelope for RMNCAH. For the second and more detailed resource mapping, the GFF Platform will typically hire a consultant (funded by one of the DPs of the GFF platform) to support with this resource mapping exercise, unless this exercise was conducted as part of the RMNCAH strategy.

support from DPs, Ministries of health conduct *expenditure tracking* with the objective of ensuring that IC priorities are implemented and that the funds flow to identified priorities, through monitoring of country expenditures from both domestic and external resources. Country Platforms are closely involved in this effort.

Figure 5. GFF Cyclic Approach to Investment Case (IC)

High-level resource mapping:
Prospective estimates of financing available, to provide envelope for prioritization



More detailed resource mapping to capture commitments from partners and costing of IC: external financing aligned to the priorities of IC

Tracking expenditures to ensure commitments are followed through and that resources are allocated to IC priorities: Health accounts; purpose-build systems (e.g., specific follow-up from resource mapping) and annual reviews

4.2. Resource Mapping (RM)

The following section provides an overview of resource mapping exercises implemented as part of the IC and their added value. The section also discusses the learning curves of GFF in conducting resource mapping exercises and its effort to develop a more standardized approach.

Resource mapping exercises were tested in several GFF countries and have now become a key ingredient of GFF approach to donor alignment. RM have been tested in DRC, Liberia, Cameroon, Uganda, Kenya and Ethiopia. More detailed analysis was produced in DRC, Liberia and Cameroon, hence the continuous references to these three countries along the paper (see Box 3 on Approaches to Resource Mapping). Sierra-Leone, Guinea, Senegal and Mozambique are under the process of developing their Investment Case and the resource mapping is under way. Most Investment Cases encompass a high-level resource mapping by which it is possible to assess the resource available for the Investment Case or health sector plan (Ethiopia) by source/financing agent (figures 6, 7, 8, 9). There are however slight differences in the way of presenting these findings. Some countries have included the contribution from households (Kenya, DRC, Ethiopia), others from the decentralized level (Kenya) and some from the private sector (Cameroon, DRC). Uganda, DRC, Liberia, Cameroon have provided more detailed resource mapping, with not only the resource mapping by financing agent, but also by geography and program/priorities (Figures

10, 11, 12). While there is a resource mapping by program and geography in Uganda, it is not compared with the cost and it is not possible to assess the extent of the funding gap at these levels.

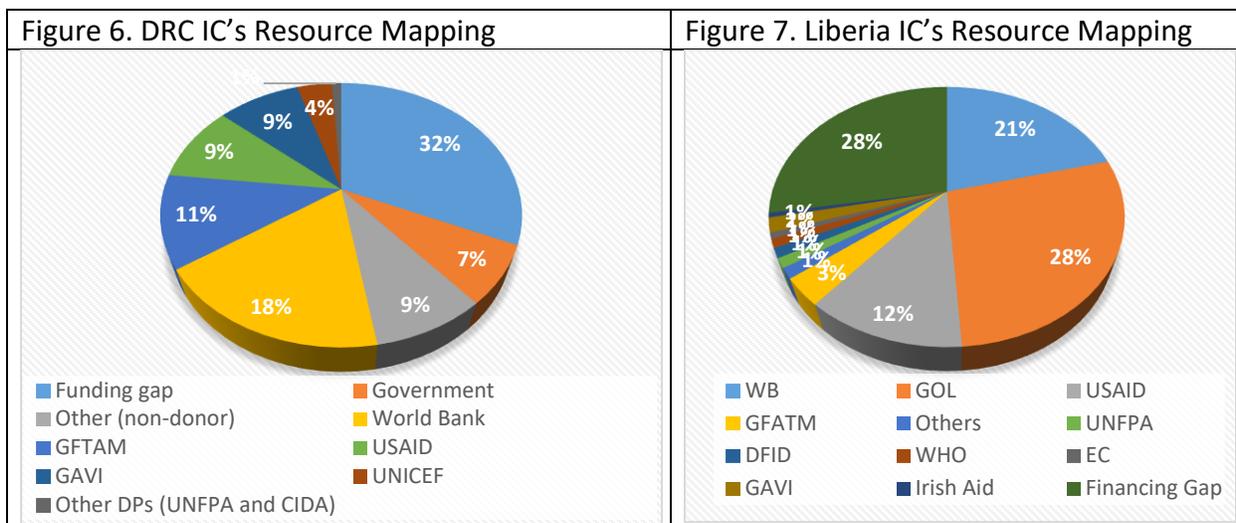
Box 3. GFF Approach to Resource Mapping

GFF has been embracing a “learning by doing” approach when providing guidance on resource mapping to countries. Some GFF countries have successfully used the comprehensive resource tracking tool developed by the Clinton Health Access Initiative (CHAI), in particular in Cameroon. Other GFF countries have opted for a much simpler tool or matrix to collect DPs commitments (Liberia, DRC). With time, the main lesson learnt is that less detailed resource mapping tools may be more appropriate for countries that haven’t conducted such exercise yet. As the resource mapping gets institutionalized and that both international and local stakeholders better understand the aim of such exercise, more sophisticated resource mapping tools can be used to generate more granularities (e.g., understand the gap at micro-level and activity level). Contracting one or two consultants to support the MOH/GFF Platform in conducting a resource mapping exercise has also been a best practice (Liberia, DRC, Cameroon).

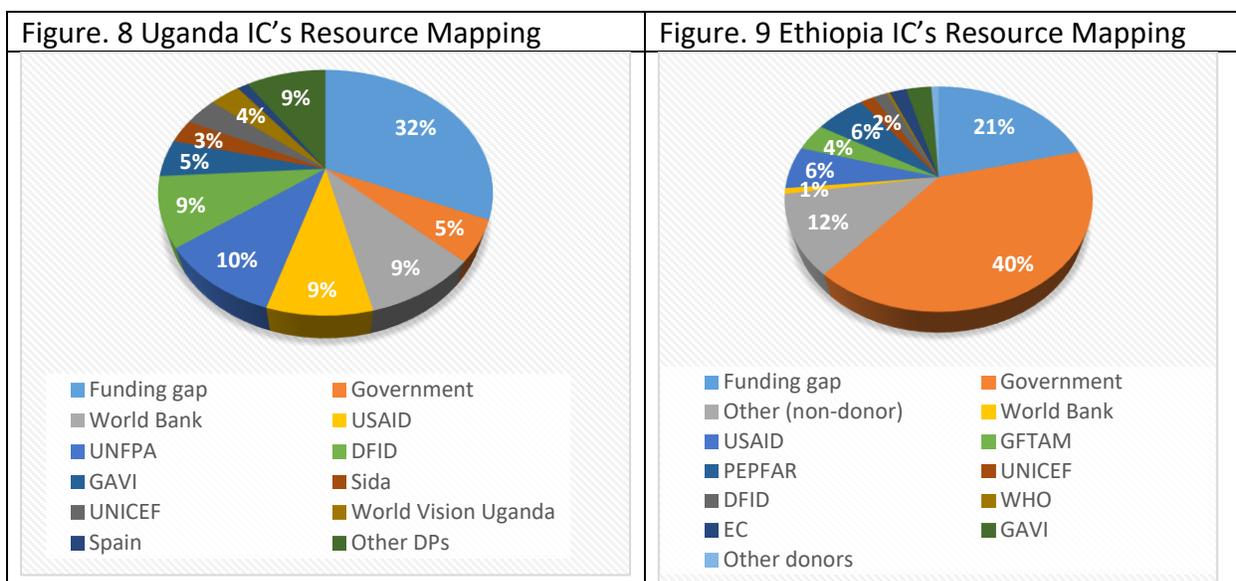
See more detailed on the resource mapping approach in Annex 6.

Resource mapping exercises of Investment Cases have been instrumental in ensuring the alignment of donors and governments resources to Investment Cases. Resource mapping show the extent to which donors align and coordinate with government in making financial commitments in the subsequent disbursements. In Liberia, the Investment Case estimated cost is US\$ 719 million over five years with a funding gap of 28% or US\$ 201 million. The government is funding 28% of the Investment Case while 44% is committed by donors (Figure 7). In DRC, the total cost of the IC is US\$2.645 million over five years for the 14 provinces (out of 26 provinces) with the highest population needs, which roughly cover 40 million inhabitants. There is a funding gap (Figure 6) of 32% or US\$ 846 million over 5 years or \$ 4.14 per capita per year. The government is covering 7% of the total budget of the IC while the donors are funding the rest⁷. In Uganda, the total cost of the IC is at 1.6 billion USD while the total resources available amount 1.1 billion USD, over 5 years hence a gap of 500 million USD or 32%. The resource mapping and costing processes of the Investment Cases have also helped to improve predictability of funding given such exercises are conducted for at least 3 years in GFF countries.

⁷ USAID remains the main development partner in the health sector in DRC but finances fewer activities in comparison to other donors in the 14 provinces of the Investment Case, hence their contribution appears to be lower than that of other DPs, which country-wide spend less than USAID in the health sector but have a stronger focus on the IC provinces.



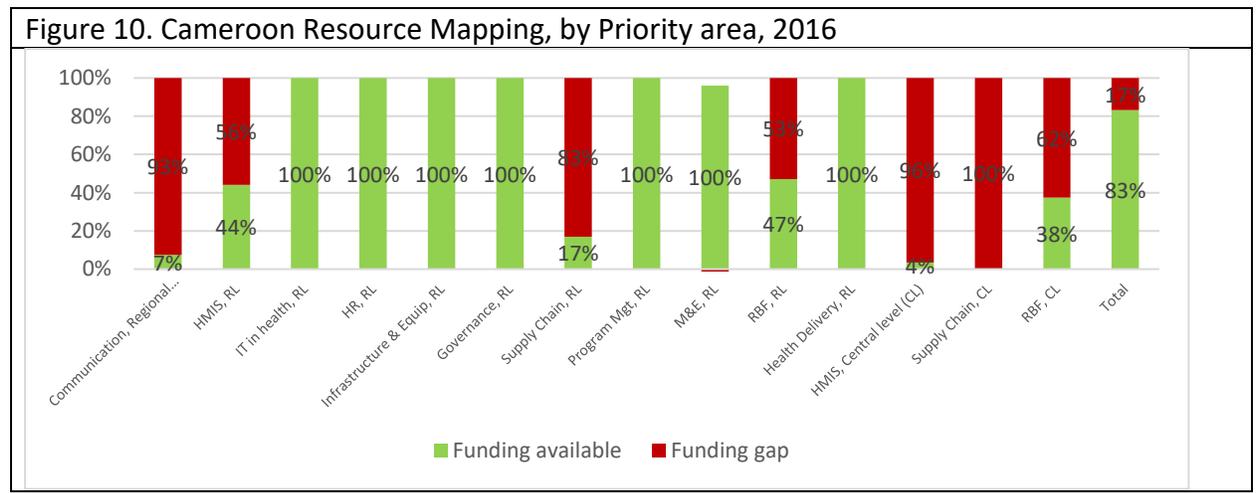
Source: Republic of Liberia, Investment Case for Reproductive, Maternal, Newborn, Child and Adolescent Health, 2016-2020; Cadre d'Investissement pour la Santé Reproductive, Maternelle, du Nouveau-Né, de l'Enfant, de l'Adolescent en vue de l'atteinte de la Couverture Universelle en République Démocratique du Congo, 2017-2021. Note that WB funding encompasses GFF Trust Fund funding



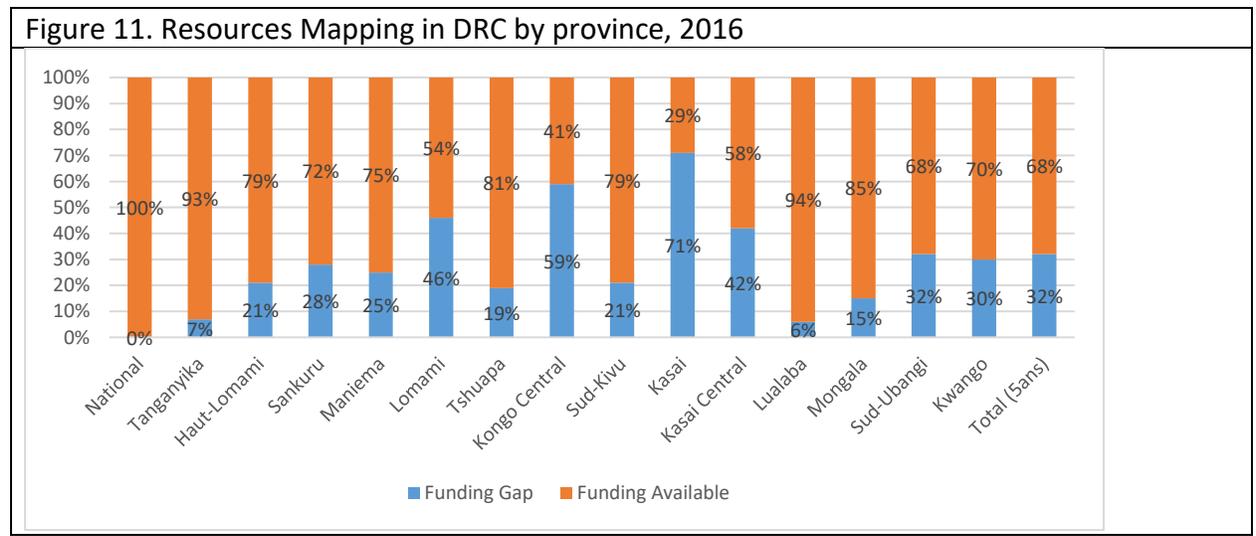
Source: Reproductive, Maternal, Newborn, Child and Adolescent Health Sharpened Plan for Uganda 2016/17 – 2019/20, April 2016; Health Sector Transformation Plan, Federal Democratic Republic of Ethiopia, 2015/16 - 2019/20 (2008-2012 EFY) October 2015.

Resource Mapping has also acted as a planning tool for most donors and governments and as a mechanism to improve allocative efficiency. Resource mapping can pinpoint needs for specific areas, regions and can be used as a planning tool by prospective donors and/or private sector investors planning their future contribution to the sector. In Cameroon, the resource mapping revealed that the Health Management Information System (HMIS) in the prioritized regions (Adamaoua, Est, Extrême-Nord et Nord) was underfunded by US\$ 6.7 million over four years (56% of total budget for HMIS priority in the IC) (Figure 10). In DRC, the resource mapping revealed funding gaps for certain provinces (Figure 11). Kasai

appears to be the province with the largest gap; 71% of the total cost for this province remains unfunded, representing US\$123 million. Resource mapping can also raise awareness about overfunding in some areas and hence low allocative efficiency, based on which both governments and DPs can allocate funds. For instance, in Liberia, financing gaps were identified for 2017/18 and 2018/19. For 2016/17 and 2029/20, some surpluses were evident while some gaps remained. The biggest financing gap was found in the areas of medical supplies and diagnostics, operational research, and community health while, at least in two of the years, donors have jointly allocated more than enough to health infrastructure, human resources and management in the 6 counties of the IC (Figure 12).



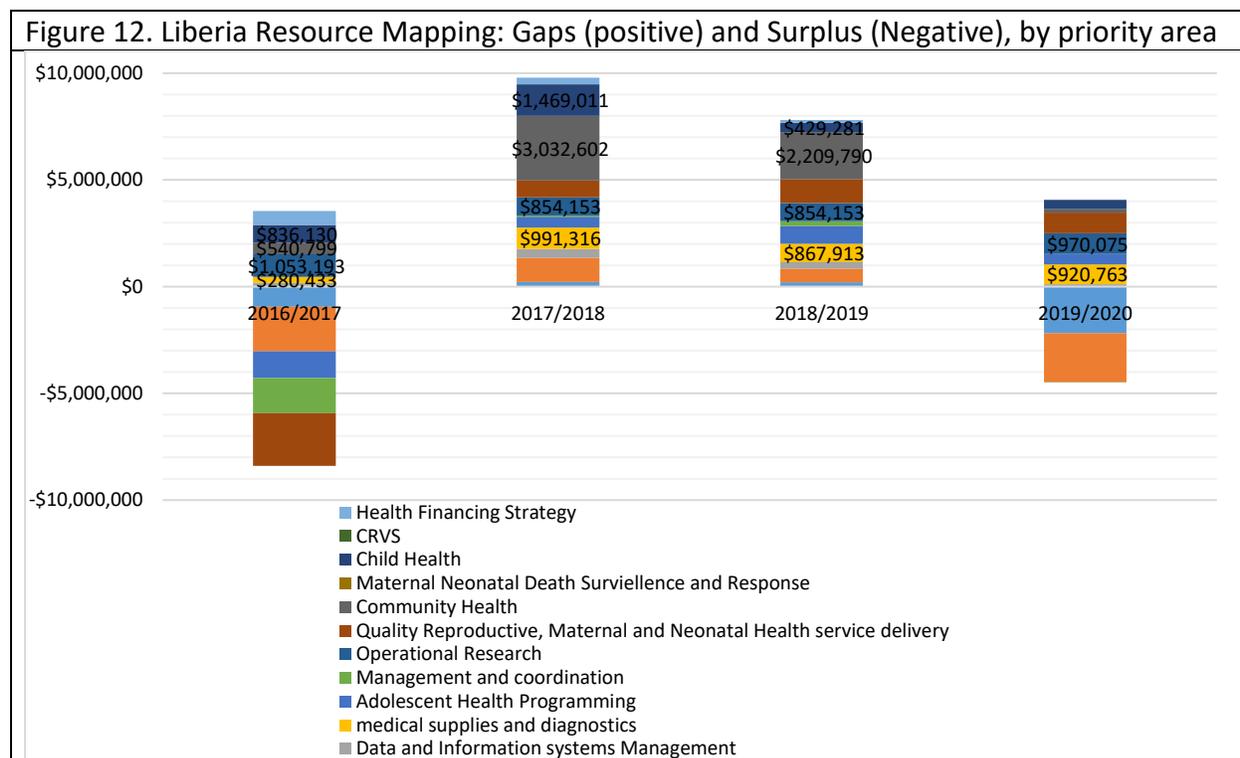
Source: Cameroon Investment Case, 2016



Source: DRC Investment Case, 2016

Resource Mappings has not always been a smooth process. Resource Mapping can be time consuming for several reasons: 1) development partners have diverse priorities; 2) the RM tools used (often Excel sheets) are not user-friendly and sometimes too complicated to read; 3) the resource mapping template comes with limited explanation on the methodology used and objectives of the exercise; 4) the budget structures of donors are often not aligned with the priorities of the Investment Case (e.g., requiring some specific calculation to match some budget lines with the IC priorities) and 5) donor fatigue in some cases.

For instance, in Guinea, there have been six failed efforts to conduct a resource mapping before the one related to the IC. There have been other limitations: not all donors have been able to submit their contribution affecting the planning process. For instance, in DRC some key donors are active in several provinces of the IC, but were unable to share financial information. Hence, funding gaps of these provinces are over-estimated. Additionally, because resource mapping sometimes does not go to the level of activity, some priorities appear over-funded (e.g., several donors may finance Health Management Information System (HMIS) but donors may be funding a specific activity of HMIS, and such detail is not captured in the resource mapping, leading to the implication that there are duplications). Such evidence is a starting point for donors to share information and better coordinate to avoid duplication of external funding and to not perpetuate a potential situation in which donors are not funding the right priority.



Source: Liberia Investment Case, 2016

Notwithstanding these challenges, progress has been made and lessons have been learned from the previous processes. Resource mapping is usually relatively successful when conducted with a simplified data collection tool (Liberia, DRC). For instance, in Liberia the resource mapping focused on collecting budget information from donors on the high-level priorities of the Investment Case at national and county level. It was also helpful that resource mapping became institutionalized at MOH and focused on the entire health sector. Cameroon was also successful in that it relied on a health sector resource mapping conducted by Clinton Health Access Initiative (CHAI), which provided relevant information for the resource mapping of the Investment Case and did not require a separate data collection tool. Another key lesson learned is around communication of preliminary results. It is important that the GFF platform shares preliminary results of the resource mapping among partners so that all understand the relevance of this exercise, and see these resource mappings as a mean to better plan resources at national and decentralized level and not as an end by itself.

Costing the Investment Case is a key step contributing to align partners behind IC priorities and monitoring their commitment at a later stage. The costing output consists of cost breakdown by priority, sub-priority and by geography. Once donors and government resources are mapped to each priority, they are compared to the cost of these priorities to identify the potential gap, based on which re-prioritization or/and re-alignment of donors occur. Along the process of costing IC, GFF has learned that, regardless of the costing methodology used (see Annex 7), it is important that the priorities are costed in a way that is aligned with the MOH budget nomenclature. To be able to monitor the implementation of the IC, government disbursement will be compared with commitments on the costed IC priorities. In the same way, actual disbursement of DAH at country level will be compared with donors' commitments on the costed IC priorities. The following section expands further on expenditures tracking of both domestic and external resources.

4.3. Expenditure Tracking

Expenditure tracking mechanisms are important to monitor the implementation of the Investment Cases. Resource mapping at the country level shows the promises from domestic and external sources to commit funds to priorities.⁸ Health expenditure tracking refers to the various frameworks, methods, and data systems for measuring and analyzing the flow of resources that are actually made available to the health sector in a country and how they are used –For including for the priorities in the IC (Center for Global Development, 2007). In the context of the Investment Case, the main added value of expenditure tracking is to determine if the promised expenditures occurred, and if they were spent in the intended way in terms of priorities and beneficiaries. Current methods for tracking expenditures at the country level were developed jointly by the OECD, WHO and Eurostat, which allows for a number of breakdowns including by source and by use and beneficiary, including on child health and reproductive and maternal health.⁹ Health accounts studies also show the levels of household out-of-pocket health expenditures and the hope is that they will fall over time in most of the GFF countries (scaled financing).

GFF is at the early stage of providing support to countries to track domestic expenditures and external financing on-budget with respect to IC priorities. Integrating the IC into the government's state budget (and subnational budgets where relevant) requires aligning the IC priorities and process with annual planning and budgeting conducted at decentralized and central levels. As countries initiate the process of defining priorities for achieving improvements in RMNCAH through the IC, the costing of these strategies is not always conducted in alignment with national planning and budgeting processes. The result is a set of expenditure priorities and funding strategies that might not directly translate, or is not adapted to the structure, classifications and timing of the national budget.¹⁰ Tracking the implementation of these

⁸ Resource mapping is also undertaken at the global level through the Creditor Reporting System (CRS) database of the OECD which shows donors' reported commitments, disbursements and country programmable aid subdivided into various categories. The Institute of Health Metrics and Evaluation also reports on donor's reported disbursements of DAH annually partly using the information in the CRS.

⁹ WHO and USAID have led the way in supporting countries to use the methods for their own policy purposes. WHO has also developed a data-upload tool as a way of supporting institutionalization of health accounts and reports annual estimates after country consultation in its Global Health Expenditure Database. WHO has received financial support and technical input on this work from a number of IG partners, while the Bill and Melinda Gates Foundation has recently been working with WHO on methods for tracking expenditures on primary health care.

¹⁰ For instance, a basic package of reproductive, maternal, newborn, child, and adolescent health (RMNCAH) services is often a key priority of IC. The MOH will usually cover the salary of staff in charge of providing this package in public facilities and sometime medicines. However, monitoring MOH expenditure on the RMNCAH

priorities, and the resulting commitments in the national budget, can present a challenge during the implementation of the IC. To address these issues, GFF is now supporting countries in adapting IC costing with the budget nomenclature using BOOST¹¹, a user-friendly excel platform to access budget and expenditure data for enhanced expenditure analysis. In Mozambique, GFF has been trying to align the IC categories with those used in the country's budget processes to facilitate the inclusion of IC priorities in the budget and then to monitor commitments and expenditures (Box 4).

Box 4: Aligning the IC priorities to the budget process in Mozambique

The Ministry of Health in Mozambique is committed to incorporating the priorities of the Investment Case into its Economic and Social Plan, which is the government's main annual planning and budget mechanism. Annual budgeting is a bottom-up process, with health activities planned by districts and provinces, but there is also a parallel top-down planning mechanism led by the Ministry of Health to coordinate the budget with overall sector strategies. To ensure that Investment Case priorities are a part of this process, the Ministry of Health is planning to take a proactive role in promoting the priorities included in the Investment Case at the provincial and district levels, where important budget decisions are being made.

A key challenge in this process is that IC priorities do not correspond to existing budget categories. Continued technical assistance (TA) throughout the implementation of the IC is planned to support greater alignment of the IC with Government budget categories, facilitate planning and monitoring of expenditures, and to induce progressive budgetary shifts towards IC priorities through engagement of budget-holders at various levels. Strong Government commitment and TA will also be required to strengthen Public Financial Management capacities. This includes capacities to better align annual, bottom-up planning and budgeting with the Investment Case, to strengthen fiduciary controls and timely funds flow to decentralized budget units (provinces, districts, and health facilities).

The inclusion of Investment Case priorities in the Economic and Social Plan is important, not just to shift public expenditures toward those Investment Case priorities, but also to align external financing around the Investment Case for greater impact. As part of the annual planning process, the priorities in the Economic and Social Plan are also presented to development partners, and the Ministry of Health requests all donors to contribute in line with the Government's priorities in the Economic and Social Plan.

Source: Draft Project Appraisal Document Mozambique Primary Health Care Strengthening Program and the GFF Annual Report.

There is an increasing willingness from donors and governments to improve transparency at country level by developing some digital tools on resource mapping or/and aid management database (Box 5).

Several GFF countries are moving towards institutionalization of the resource mapping which will allow better predictability of external funding flows and efficiency of DAH. Liberia and Kenya and DRC are now exploring ways to create a digital platform to report donor funding and integrate them into their yearly budget and planning exercises. Similar initiatives could be conducted focusing on actual disbursements of DAH at the country level (and country budget disbursements), while institutionalization of health accounts

package is not that straightforward, as there might not be a specific budget line for an "RMNCAH package" disaggregated by staff and medicines costs in the MOH budget. Instead, the staff related cost for this RMNCAH package may be embedded in the overall staff budget line of the MOH budget and some hypothesis may be necessary to estimate the portion of the staff budget line pertaining to the implementation of the RMNCAH package. The same comment applies for medicines: the MOH budget might include one budget line for medicines and if any, it may not be possible to track the consumption of RMNCAH related medicines as the medicine budget line will not explicitly refer to the RMNCAH package

¹¹ For more information, see: <http://wbi.worldbank.org/boost/tools-resources/topics/general-techniques/how-usebuild-boost>.

would help identify how expenditures on reproductive, maternal, and child health change over time. This will allow governments to address the lack of predictability of external funding and donors to diminish the risk of duplications. However, the linkage between various existing information systems at country level (health accounts, aid management database, financial management information systems) and international level (CRS, IATI databases) requires some work. The starting point could be a digital platform reporting donor commitment in the health sector and IC priorities initially and progressively integrating disbursement with more granularity and potential linkages with government funding.

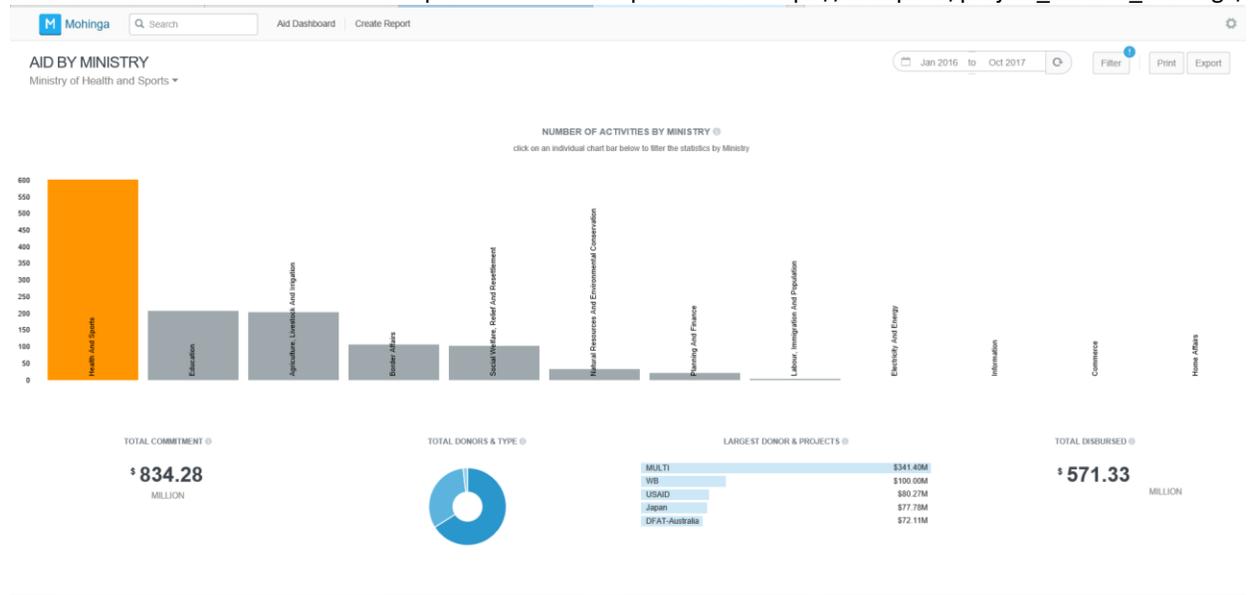
Box 5. Example of Aid Management Information System

Myanmar has developed an aid management database with technical and financial support from development partners. In phase 1 of the project, the foundation of the software was designed and developed with national Foreign Economic Relations Department (FERD) counterparts. In phase 2, the web-application was extended to include an online reporting form, enabling FERD and Myanmar’s development partners to submit their aid data through an online web-interface. The International Aid Transparency Initiative (IATI) publishing framework for aid data was also integrated during the second phase. This means that all of Myanmar’s aid data including data from development partner home offices and locally collected data can be stored in one integrated database.

As a result of progress made during phases one and two, the Myanmar AIMS is now tracking over US\$3.51 billion in aid commitments comprising over 1488 individual development partner related activities. The recently developed web-application is also mapping, graphing and visually representing aid flows by location, sector, program status and commitment status. All this information is stored and presented in both the English and Myanmar languages. Additionally, the web application facilitates basic report generation and a simple "print to PDF " feature for visually representing aid flows, assisting FERD staff with their internal reporting requirements.

This initial success has now generated significant interest in expanding this foundation to further assist FERD, development partners and other stakeholders’ groups. This will go a long way towards enhancing the ability of all groups to access aid information in accordance with the Busan Partnership Agreement principle of strengthening the capacities of all relevant stakeholders to make better use of aid information in decision- making and to promote accountability (Busan Partnership Commitment 23(b)).

Source: The content of this box was copied from the catalpa website: https://catalpa.io/project_feature_mohinga/



Source: <https://mohinga.info/en/dashboard/ministry/MM-FERD-14>

SECTION 5. CONCLUSIONS AND TAKE AWAY MESSAGES

5.1. Final Thoughts

All GFF countries can improve the efficiency of their health expenditures, whether they are financed from domestic or external resources. This requires continual, explicit attention to whether the country is doing the right things, in the right settings, and in the right way. This was the focus of the health financing paper discussed at IG5. This paper focused on the additional efficiency issues linked to the way external partners set their priorities, and how they channel funds to countries and account for their use. The conclusions in these areas follow.

Building on previous initiatives to enhance aid effectiveness in the health sector, GFF contributes to improved efficiency in external financing to expand RMNCAH service coverage and support countries to move more rapidly towards Universal Health Coverage (UHC): On average, DAH accounts for 19.7% of total health expenditures in the 16 GFF countries, twice as much as for LMICs. Getting the most value out of every DAH dollar invested in health is crucial to progress toward UHC in GFF countries.

Despite progresses, aid effectiveness remains an unfinished agenda. Improving efficiency in health systems is a long-term process, so is efficiency related to DAH. Addressing root causes of transaction costs, allocative inefficiency, limited predictability of funding, and sustainability of health aid is as much a development partners' agenda as a recipient countries' agenda. Many donors continue to programme their DAH off-budget and do not use country PFM systems. Roughly 50% of donors use country PFM procedures and half of the external funding is off-budget on average in GFF countries. In turn, several GFF countries have financial systems that require improvement and insufficient capacity in public financial management. Improvements can happen if development partners and recipient countries work collaboratively to yield better value for DAH. Building trust is critical in this endeavor and the GFF process can contribute to increased understanding, dialogue and identification of shared goals. It is also important to recognize that the increase of the number of donors in the health sectors has complicated the aid effectiveness agenda.

One of the instruments used to fostering donor alignment in GFF countries is resource mapping combined with an accurate costing of the IC priorities. After testing resource mapping exercises in several investment cases, it has become a key ingredient of the ICs, resulting in progress in first understanding donor financing and second, aligning donor and government funding to the priorities of the IC if they are carefully costed. Today most GFF countries with an Investment Case have a resource mapping showing to what extent DPs and government have committed to IC. Most IC encompass a costing component too. Comparing cost and resource matched to IC priorities allows the GFF platform to identify gaps and start discussion on re-prioritization or/and re-alignment of DPs to fill-out the gaps.

Beyond advancing donor alignment, resource mapping identifies allocative efficiency issues and strengthens the health financing system of GFF countries. In some countries, resource mapping is becoming a key component of health financing strategies (Liberia, DRC) to improve efficiency of external resources. In Liberia, resource mapping is used to identify gaps, surpluses and duplication in the health sector and in funding the Investment Case. This exercise also attempts to estimate external funding over time and to assess the share of health aid channelled through government budget. In the future, resource mapping is to become a key exercise conducted by the Joint Project Coordination Unit (JPCU), responsible for donor related fund management and reporting.

As the GFF countries are moving into implementation of their Investment Cases, more work needs to be done on expenditure tracking to ensure financing is following the priorities of the IC. Most GFF countries have undertaken health accounts exercises and some undertake them annually. With the introduction of the new system of health accounts framework in 2011 (called SHA2011), the methods for identifying expenditure on reproductive and maternal health, and on child health are now available and an increasing number of countries are beginning this type of exercise. BOOST can be another relevant way to track RMNCH expenditures. Some BOOST however do not include programmatic budget classification which will make the tracking of RMNCH related expenditures programs limited. Technical assistance can be provided to address this challenge.

5.2. Take Away Messages

There is a shared responsibility of governments and their external partners on aligning resources and efforts behind the IC. Timely information is needed from donors and governments to complete the resource mapping and ensure a more effective prioritization process and efficient use of resources. It is critical that donors allocate time to fill out resource mapping templates to allow the GFF platform to acquire the needed data to align external financing behind the priorities identified in the Investment Cases.

Despite progress, resource mapping exercises need to improve and GFF welcomes initiatives from donors willing to design, fund and lead resource mapping of IC in GFF countries. Resource Mapping and costing have been time-consuming exercises. Despite this, they remain very powerful in pointing out gaps and inefficiencies (duplications, transaction costs) and addressing them. Now, it is important that the GFF platform focuses on ways to make these templates user friendly and combine them with the data collection process from health accounts or other instruments (BOOST). An option is to set up a digital platform of resource mapping managed by MOH or a local university. That would be a practical way to improve and institutionalize data collection on external funding and would enhance donor and government coordination as long as this database is connected to existing aid management system or/and financial management information systems. It is also crucial to cost the IC priorities using the codification of the MOH budget with the support of BOOST databases when available.

Linkages between resource mapping and expenditure tracking is to be explored. Now that GFF countries are getting more experience in resource mapping and costing, the question is whether resource mapping can go beyond commitments and also track expenditures on IC priorities. To do this it is important that the health accounts exercise is institutionalized in all GFF countries, and that the links between the priorities of the IC and the data collected in the health accounts are explored.

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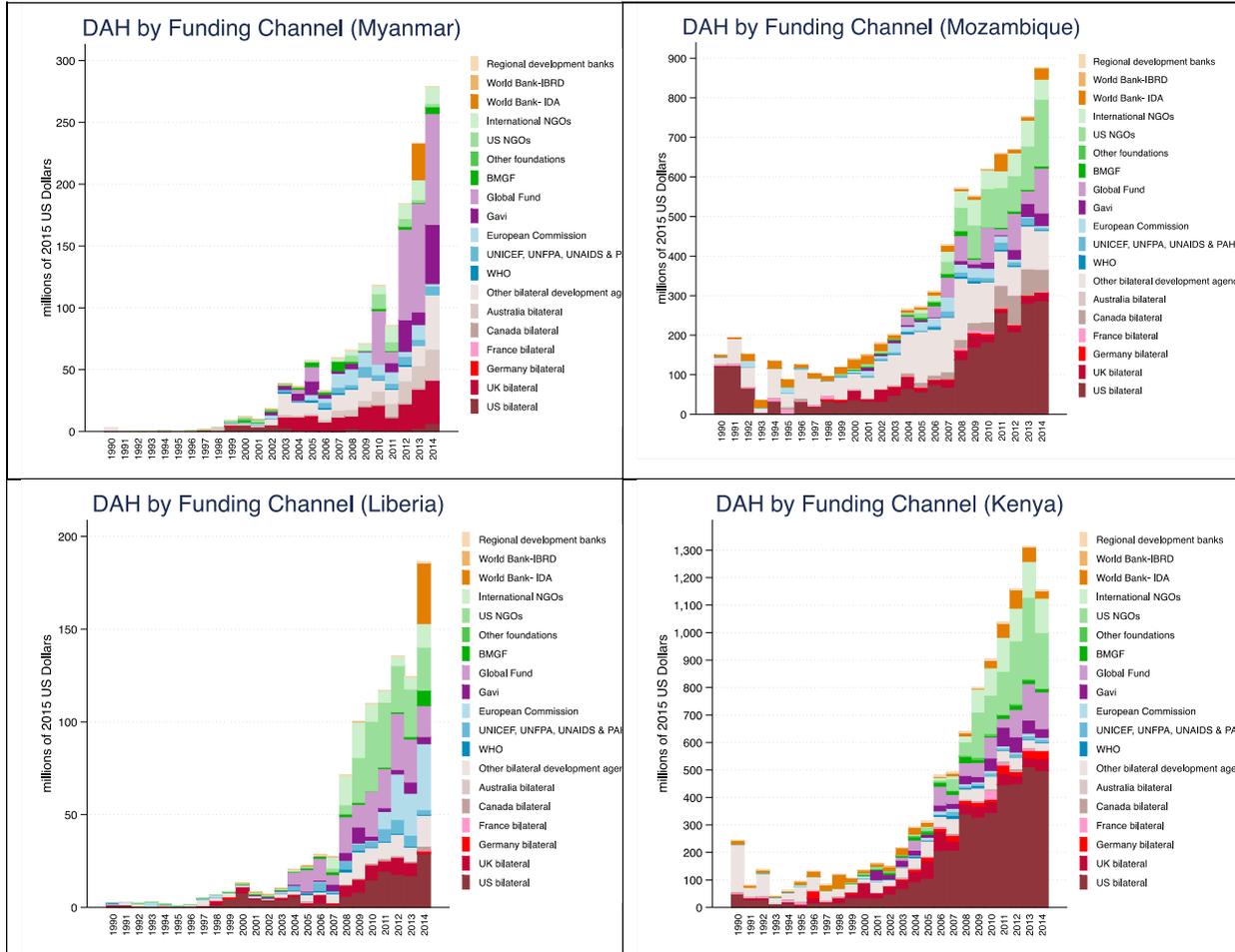
ANNEXES

Annex 1. Common types of inefficiencies in the use of DAH

Type of inefficiency	Definitions	Examples
High transaction costs	Refers to the administrative costs of transferring aid from donor to recipients, as well as management, monitoring, planning and evaluation (Lawson, 2009).	<ul style="list-style-type: none"> Donors have several project implementation units in the MOH leading to higher overhead costs (WHO, 2015). Fragmented implementation undermines opportunities for efficiencies of scale and lead to higher transaction costs. For example, laboratories only equipped for HIV procedures, or health care workers responsible only for polio campaigns, may miss an opportunity to use spare capacity for other essential health services.
Low allocative efficiency	Duplication of activities between donors, lack of alignment with health priorities defined by recipient countries, poor priority setting practices.	<ul style="list-style-type: none"> At the global level, there has been discussions about inadequacy between DAH and disease burden (Piva & Dodd, 2009).
Missed opportunities for capacity development	Use of parallel systems can undermine the development of local health system capacity, create brain drain from government to Development Partners (DP). Easterly (2006) suggests that aid even fosters bad governance practices.	<ul style="list-style-type: none"> Cox (2006) suggests that TA consisted of ‘capacity substitution’ rather than capacity building in Cambodia. A survey conducted in 2002 showed that around 13% of surveyed ODA was spent on technical assistance, but almost exclusively on paying for 740 staff from international organizations to assist with project implementation, and almost no local staff from Cambodia (Siddiqui, Strickler, & Vinde, 2004).
Lack of predictability and sustainability	Disruptions in disbursements can have very significant impact on how the money is spent. Lack of predictability also means that countries do not scale up activities or do not incorporate external funds in their long-term planning.	<ul style="list-style-type: none"> The tendency for donors to make short-term financial commitments prevents long term planning. It also leads to permanent losses in domestic investments (in the case of shortfalls) and encourages additional government consumption (in the case of windfalls) (Celasun and Walliser, 2008). The loss associated with aid volatility is between 15 and 20 percent of the total value of aid (Kharas, 2008), and it can also increase fiscal and monetary instability in recipient countries (Osakwe, 2008).

Source: Authors’ compilation based on extensive literature review (see references).

Annex 2. DAH by Funding Channel for Selected GFF Countries



Source: Institute for Health Metrics and Evaluation (IHME, 2016)

Annex 3. IHP+ National Performance Indicators

Issues	Government indicators	Development partner indicators
1. Health development cooperation is focused on results that meet developing countries' priorities	An agreed transparent and monitorable country results framework was used to assess progress in the health sector	Proportion of countries in which the country health sector results framework was used
2. Civil society operates in an environment which maximizes its engagement in and contribution to development	Civil society was meaningfully engaged in health sector policy processes- including health sector planning, coordination & review mechanisms	The meaningful engagement of civil society in health policy processes was supported, including in health sector planning, coordination and review mechanisms.
3. Health development co-operation is more predictable	A. Proportion of health sector funding disbursed against the approved annual budget B. Projected government expenditure on health provided for 3 years	A. Percentage of health sector development cooperation for the government sector disbursed in the year for which it was scheduled B. Estimated proportion of health sector development cooperation covered by indicative forward expenditure and/or implementation plans covering at least three years ahead.
4. Health aid is on budget	National Health Sector Plans/Strategy are in place with current targets & budgets that have been jointly assessed.	Percentage of health sector development cooperation scheduled for disbursement that was recorded in the annual budgets approved by the legislatures of developing countries.
5. Mutual accountability among health development cooperation actors is strengthened through inclusive reviews	An inclusive process for mutual assessments of the implementation of health sector commitments exists that meets at least 4 of 5 selected criteria: (i) the existence of an aid or partnership policy, (ii) the inclusion of development effectiveness indicators in the policy, (iii) the joint review of this policy, (iv) the involvement of civil society in the review, and (v) the public communication of the review results.	Proportion of countries in which DPs participated in mutual assessments of the implementation of commitments in the health sector, including on aid effectiveness.
6. Effective institutions: Developing countries' systems are strengthened and used	Country public financial management systems either (a) adhere to broadly accepted good practices or (b) have a reform program in place to achieve these	Percentage of health development cooperation disbursed for the government sector that used national public financial management systems

Source: IHP+ 2014 M&E Report

Annex 4: Selected IHP+ Aid Effectiveness Indicators by GFF country, 2013

Country	participating DPs have communicated their planned resources for the next 3 years to the MoH.	Development Partners Indicators			Recipient Countries Indicator
		% of DPs using PFM procedures (2014/15)	Development partner health sector budget execution in 2014/15	Health aid on-budget	Average scores of countries on 3 financing indicators (max=3)*, 2013
Bangladesh				71%	
Cameroon	24%	96%	84%	18%	1.6
Congo, Dem. Rep.	33%		93%	39%	2.7
Ethiopia	21%	95%	94%	65%	3
Guatemala					
Guinea	0%	30%	95%	46%	0.9
Kenya				40%	
Liberia	71%	83%	61%	54%	
Mozambique	46%	74%	82%	53%	2.9
Myanmar	25%	27%	95%	27%	
Nigeria	23%	17%	45%	5%	1.9
Senegal	45%	15%	88%	84%	2.8
Sierra Leone	57%	22%	82%	39%	3
Uganda	36%	96%	74%	88%	1
Tanzania					
Viet-Nam	30%	85%	100%	84%	2
Unweighted Average	54%	52%	84%	49%	2.3

Source: 2016 IHP+ Monitoring Round National performance review <https://www.uhc2030.org/what-we-do/accountability/2016-monitoring-round/> ; except for Health aid on-budget: Liberia; 2017; Kenya: 2010-11; Bangladesh: 2010.

Annex 5. Definition and Lessons Learnt from Aid Modalities

	Definition and Principles	Lessons Learnt
SWAp	<p>SWAp was developed in the 1990s in response to complex aid architecture. It is commonly designed as an approach to a locally-owned program for a coherent sector in comprehensive and coordinated manner, moving towards the use of country systems.</p> <p>SWAp relies on the following principles e.g., a single health sector strategy supported by all development partners (DPs) with a MTEF; a mutual accountability between Government and DPs in Partnership Arrangement Protocol; working arrangements that enable consensus building around managing the sector strategy and implementation plan; common M&E mechanisms to review the progress of the health strategy; commitment to move to greater reliance on government financial management systems</p>	<p>SWAp has made important strides in improving allocative efficiency. The literature shows that the budget allocations under SWAps are better aligned with national health priorities and disease burden than under alternative approaches (Sweeney & Mortimer (2016). Additionally, SWAp has been instrumental in fostering capacity building and sector stewardship (Vaillancourt, 2009; Peters, Paina, & Schleimann, 2012).</p> <p>Nevertheless, challenges remain and SWAPs do not necessarily decrease transaction costs. For instance, DPs may not comply with a country SWAp and continue working on parallel projects. Other studies show that the approach has not improved health outcomes (Natuzzi & Novotny, 2014). Furthermore, SWAp is associated with a decrease in health aid in the long-term, also referred as the ‘donor flight’ (Sweeney, Mortimer, & Johnston, 2014).</p>
Budget Support	<p>While still a marginal modality of aid, many donors choose to transfer resources directly to national treasury (and allocated either to the general budget or a specific sector) and managed using national public finance management procedures (similarly to any other funds raised domestically, e.g. through general taxation).</p> <p>Budget support includes grants or concessional loans that are not attached to a program but excludes debt relief (OECD definition).</p>	<p>In theory, general or sector budget support aims at allowing countries to set their own spending priorities and plan more efficiently for the use of their resources in the long-term. Budget support is in line with the principles set by the Paris Declaration, in particular in terms of harmonization, use of local institutions, and country ownership.</p> <p>However, few donors have expressed concerns relating to the fiduciary risk, weak management system, lack of capacity dedicated to the negotiation, preparation, implementation, monitoring and evaluation of budget support (Antunes, et al., 2013).</p> <p>There have been a few reviews on the impact of budget support, although mostly conducted between 2005-2013. Those reviews, again, show that the impact of budget support is very variable and ambiguous. A review conducted in 7 countries between 1994-2004 found a positive association between budget support and local ownership and institutional capacities in terms of public finance management. In turn, Caputo et al. (2011) find that sectoral budget support does not decrease transaction costs because other forms of monitoring and reporting</p>

		are requested from governments. In general, there is no certain evidence that budget support (general or sectorial) achieves superior outcomes compared to more traditional vertical projects. Concerns over PFM and leakages were an acute impediment to reach the effect of General Budget Support.
IHP+	<p>IHP+ began in 2007 aiming at improving effective development cooperation in health to help meet the Millennium Development Goals (MDG). In 2016, IHP+ transformed into UHC2030 to respond to the health-related Sustainable Development Goals (SDG).</p> <p>The partnership intends to support external partners and recipient countries to put the international principles for aid effectiveness and development cooperation into practice in the health sector by encouraging wide support for a single national health strategy or plan, a single monitoring and evaluation framework, and a strong emphasis on mutual partner accountability. IHP+ Compacts (non-binding agreement) are work plans that are negotiated between national governments and DPs to deliver on the national health strategy or plan.</p>	<p>The number of parallel implementation units decreased by 39% in countries with a IHP+ Compact.</p> <p>Nevertheless, only 1/17 DPs met the target of having 85 percent of their aid recorded on national budget.</p> <p>Insufficient progress has also been observed in the area of use of countries' financial management and procurement systems: In 2013, 41% of DPs declared using national public finance management systems (target of 80%). In 2013, the proportion of development funds recorded in the national budgets was 71% (target of 80%). In 2012, only 32% of DPs use local procurement systems</p>

Source: Authors based on literature review (see References)

Annex 6. Common Methodological Steps of Resource Mapping

Investment Cases' resource mappings match commitments of donors and governments (and sometimes from the private sector) by IC priorities with costed priorities to assess funding gaps by IC priorities. This planning tool leads to the re-prioritization of IC in the case of a financial gap. Another alternative is to have development partners and government re-align their funding towards established priorities to close the gap. However, this can only happen on the long term as donors may have a 3 to 5 years' commitment while government with a Medium-Term Expenditure Framework (MTEF) have a 3 years' commitment and little flexibility to shift budget priorities around.

Common Steps of resource mapping include:

Step 1. Start collecting basic budget envelop from donors and government through calls or meetings before starting the IC (*"High-level resource mapping"*)

Step 2. Develop the IC keeping in mind the available resource envelop discuss in step 1

Step 3. Develop a data collection tool capturing current resources and future commitment of donors and government following priorities established in the IC workplan (or RMNCAH strategy) and geography (*"detailed resource mapping"*)

Step 4. Validate the Resource Mapping Data Collection tool with the GFF platform or other relevant stakeholders

Step 5. Data Collection

Step 6. Dissemination of results, including funding gaps and duplication in some cases

The resource mapping will usually be led by the GFF Platform and/or the Ministry of Health. A consultant hired by one of the donors of the GFF platform or the GFF secretariat may support this effort.

Sometimes resource mappings of Investment Cases are part of a broad health sector resource mapping exercise. For instance, in Liberia, the MOH has been conducting a resource mapping of the Health Sector Investment Plan over the last two years, including priorities of the Investment Case. In Senegal, a resource mapping of the entire health sector was completed and results will be extrapolated to estimate the resource mapping of the IC priorities. In Cameroon, the starting point was the resource mapping of the entire health sector too.

In a few GFF countries, the GFF platform used a standardized resource mapping tool developed by CHAI (Clinton Health Access Initiative), a spreadsheet that allows data to be entered by multiple stakeholders and then aggregated into a master dataset (analyzable, chartable). All categories are pre-defined and standardized to collect a dataset that is comparable across development partners and government (USAID, 2016).

In other GFF countries, a basic excel-based matrix is developed and submitted to donors to help the GFF Platform address the following questions (see below): who/which donor, what are the RMNCAH interventions funded by DPs, where, and how much. A simplified resource mapping template has the advantage to be faster and easier to complete. With time, GFF platforms (in particular in Liberia and DRC) has learnt that donors buy more into simplified resource mapping template. Some resource mapping template only focus on donors' commitment and a separate exercise is conducted for government commitment.

The image shows a screenshot of a spreadsheet application with several callout boxes overlaid on the top portion of the grid. The callout boxes contain the following questions:

- Who?
- What RMNCAH activities are funded by DP?
- Where?
- For how long?
- How much?

The spreadsheet grid below the callouts has the following columns:

No.	Donor	Implementing Partner	RMNCAH investment Area	RMNCAH Intervention	Detailed description of RMNCAH Project/Program and Activities	Location of RMNCAH Project Implementation	Name, Email & Phone # of Contact Person in Country	Time Frame of Project(s)/Program(s) Activities			Project Budget FY 17/18		Project Budget FY 18/19	
								Start	End	Currency	Organization Overhead	Organization Operating Budget	Organization Overhead	Organization Operating Budget
1														
2														
3														
4														
5														
6														
7														
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23														
19														

The spreadsheet interface includes a status bar at the bottom with the text "Ready" and a zoom level of "71%". The active sheet is named "RMNCAH Activities".

Source: Adapted from the Liberia Resource Mapping Tool, MOH, 2017

Annex 7. Costing Methodologies used in the Investment Cases

Two third of GFF countries with an Investment Cases used OneHealth to cost their priorities. Some countries combined OneHealth with activity budgeting (Kenya, Tanzania, Uganda, Cameroon, Ethiopia), one GFF country used the Marginal Budgeting for Bottlenecks (MBB) Toolkit approach (Liberia) in combination with Activity Budgeting (Liberia) and one country used CORE Cost Revenue Analysis Plus (CORE Plus) with Activity Budgeting (DRC).

- OneHealth:
 - **What:** One Health is a program-based costing tool for medium term strategic health planning (3-10 yrs) at national level which can be adapted at sub-national level. It costs both system wide (i.e., governance, health financing, logistics, human resources, health information, and infrastructure) and health delivery programs.
 - **Output:** OneHealth yields costs and budget breakdown per year, per programme, incremental costs, and also changes in inputs required to meet certain outcome targets.
 - **Methodology:** Costs are calculated combining an “intervention approach” and a “health systems approach”. The intervention component includes variable costs associated with service delivery, e.g., drugs and commodities. The health systems component is modelled based on health system needs (using population and geographic norms).
- Marginal Budgeting for Bottlenecks (MBB):
 - **What:** The MBB is an excel-based tool focusing on maternal and child health (MCH) services and aims at understanding the costs of scaling up existing MCH services and estimate the impact of a scale up on health outcomes. The tool aims to identify bottlenecks and model impact of reducing them to increase coverage of interventions. It helps users design, plan and budget health programs.
 - **Output:** Marginal/Incremental cost per input, per bottleneck and service delivery mode. Estimates the expected increase in coverage and health outcomes obtained (decrease in mortality, etc.). Calculates the estimated additional (marginal) costs required to scale up existing MCH services.
 - **Methodology:** The user first needs to document the existing budget inputs (using defined categories built in the tool) and health outcomes in the “bottleneck module”. Then, users define priority outcomes and coverage level for those health outcomes. The MBB defines the activities to undertake in order to reach health and coverage targets using built in information on corresponding interventions and their resource requirements and effectiveness. It also identifies strategic changes in the delivery of services and models the consequences of those changes in terms of costs. This step generates new data on costs (including incremental costs), new resource requirement and forms a new budget.
- Activity Budgeting:
 - **What:** Activity budgeting is the simplest budgeting methodology used to predict the costs associated with a particular activity. These costs include labour, materials, and other related expenses. Activities are typically broken down by input costs.
 - **Output:** Cost per activity, sub-activity, intervention and cost driver.
 - **Methodology:** Each activity is classified according to the cost hierarchy (i.e. into unit-level, product level and facility level). In practice, Investment Cases of DRC developed a logframe and a detailed workplan which guided the budgeting process.
- CORE Plus:
 - **What:** an excel based tool which focuses on the cost of a comprehensive package of health services;

- **Output:** cost per service, cost per capita, total cost of the package broken down by input, programmatic areas and levels (hospital, PHC and community).
- **Methodology:** Uses a bottom-up methodology/ingredient costing approach. A normative cost for each intervention in the package is estimated by determining the normative resource requirements (in terms of technical staff for the provision of service, drugs, medical supplies, laboratory tests) and then applying the unit costs of each resource to obtain a unit cost per intervention. In addition, recurrent costs are split across each service proportionally to the time spent by staff. To estimate future use of interventions, the tool uses the target population with the incidence and prevalence rates for each disease.

Source: The Partnership for Maternal, Newborn and Child Health. Costing Tools. Downloaded on Jan 27, 2017 from: http://www.who.int/pmnch/knowledge/topics/costing_tools/en/index6.html
University of Washington, Costing Tool Comparisons. Review of costing tools. 2013.