

GFF PORTFOLIO OVERVIEW

OVERVIEW

This paper provides an update on the GFF portfolio. Part 1 outlines implementation progress, along with challenges and proposed mitigation actions relating to the initial 16 countries which are currently in implementation phase. Part 2 of the report outlines steps take to-date in the new wave of 10 new countries which joined the GFF in November 2017. Annex 1 presents complementary financing for a sample of countries. Annex 2 provides a summary of the RMNCAH-N situation and the GFF value added, as well as progress achieved over the last six months and the prospects for the next six months in the 16 initial GFF countries.

SUMMARY OF FINDINGS

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. Key lessons have emerged in important areas such as the Investment Case preparation process, the country platform, domestic resource mobilization and mobilization of complementary financing. These lessons formed the backdrop for a Country Workshop held in January 2018 to orient the 10 new countries which joined the GFF in November 2017. These 10 new countries are currently proceeding with the creation of their country platforms and the preparation of their GFF Investment Cases.

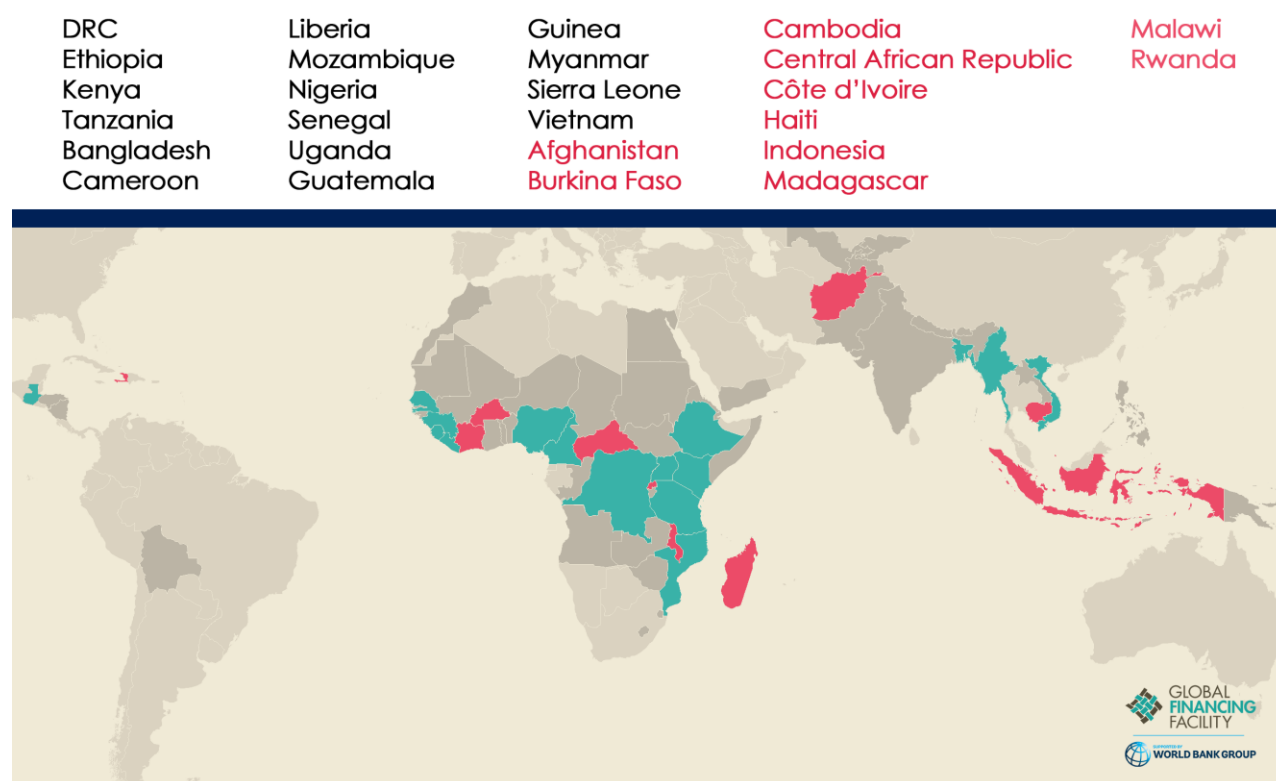
ACTION REQUESTED

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

GFF PORTFOLIO UPDATE

The GFF is currently active in 26 countries (Figure 1) which in total represents 59 percent of the financing gap for RMNCAH-N in the 67 GFF-eligible countries. The portfolio can be separated into two broad categories: A first set of 16 countries that are at various stages of implementation of their Investment Cases and an additional 10 new countries which joined the GFF in November 2017 and have launched the process of development of their Investment Cases in recent months. This portfolio update is therefore structured in two parts: Part One covers the 16 countries currently in the implementation phase and Part Two covers the progress to date in launching the GFF process in the 10 new countries.

Figure 1. Map of Current GFF Countries



The GFF supports countries across Latin America, East and South Asia and the Africa region. Eighteen of the countries are in Sub-Saharan Africa and two are in Latin America, two in South Asia and four in South East Asia. In terms of GFF Trust Fund allocations, approximately 77 percent (by value) is allocated to countries in Sub-Saharan Africa, 10 percent in South Asia, nine percent in South East Asia and three percent in Latin America.

The GFF portfolio is more heavily focused on countries which the World Bank classifies as “low income” (16 countries) than on countries classified as “lower middle income” (10 countries). A third of the countries (9) in the portfolio are classified as fragile states by the World Bank, notably: Afghanistan, Central African Republic, Cote d’Ivoire, Democratic Republic of Congo, Haiti, Liberia, Mozambique, Myanmar, and Sierra Leone. Twenty of the 26 countries are eligible to access IDA resources only, whereas

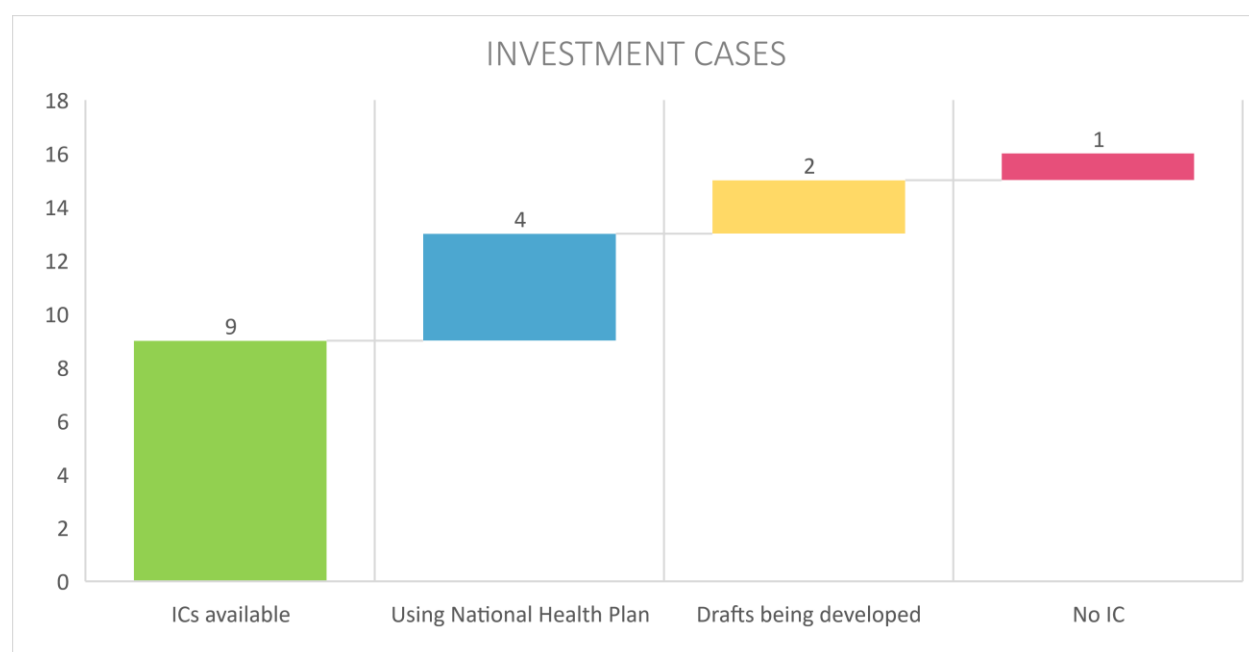
three can access both IDA and IBRD (Cameroon, Kenya and Nigeria) and three can access only IBRD loan-term resources (Guatemala, Indonesia, Vietnam).

PART 1: COUNTRIES IN IMPLEMENTATION PHASE (INITIAL 16 COUNTRIES)

GFF Investment Cases

The iterative manner in which the GFF process was developed, with the four front-runner countries (DRC, Ethiopia, Kenya and Tanzania) leading the way in defining the process, has meant that somewhat different approaches have been adopted by countries with regard to their GFF planning process, including the Investment Case. Five countries, i.e., Bangladesh, Ethiopia, Guatemala, Myanmar, and Vietnam, decided not to develop separate GFF Investment Cases, opting instead to use their existing health or RMNCAH-N plans (Figure 2). The remaining countries have almost all completed their Investment Cases, except for Senegal and Sierra Leone, both of which are at advanced stages of development.

Figure 2. Status of Investment Case Development (16 Initial Countries)



A number of lessons relating to the Investment Cases have emerged from the experience in the 11 countries from this first phase of GFF engagement, notably:

- Strong government leadership and ownership is essential for the successful development and implementation of an Investment Case.
- A strong involvement from financiers in the early design process is essential for full ownership and subsequent allocation decisions. In nine of the 16 initial countries there are more than three complimentary financiers to the Investment Case.
- A clearly articulated “roadmap” which outlines the process and the roles of each partner in developing the Investment Case has proven to be a useful approach to create a common vision and to create efficiency and ownership for the Investment Case. It also enables those partners

who do not have a country presence to plan their missions to coincide with key milestones in the Investment Case development process.

- Most of the results frameworks and monitoring systems to support the implementation of the Investment Cases require additional work.
- Different approaches were used to “set the boundaries” of the Investment Cases. In some cases, a large financing gap was identified (indicating either insufficient engagement of financiers or the need for additional prioritization). In other cases, it was difficult to set clear boundaries as to which financiers are included or not in the Investment Case resource mapping, indicating that more clarity would be required as to what constitutes a contribution to the Investment Case priorities.
- The initial set of Investment Cases had limited success in harnessing of private sector capacity, the notable exception being the role of private providers in service delivery under performance-based financing schemes.

These lessons and others led to the further articulation of the concept of a quality Investment Case which is a key starting point for the new countries and which will form the basis of revised GFF Investment Case Guidelines which will be developed by the end of June 2018.

A “quality” GFF Investment Case is:

1. Centered on a clear set of **results**
2. Based on local **data** about RMNCAH-N combined with global **evidence** about what works:
 - Should be attentive to **multi-sectoral** contributors to RMNCAH-N and to **structural shifts** (macro trends such as urbanization, demographic changes, and climate change)
3. Reflective of an **equity** perspective
4. Well **prioritized**:
 - Focused on **evidence-based, high impact** approaches
 - Addresses key bottlenecks/constraints and strategic shifts required to address them
 - Grounded in a **realistic assessment** of resources available/likely to be available
 - Geographic and socio-economic equity
5. Reflective of a **mixed health systems** perspective, and taking into account the full range of stakeholders, including private sector
6. Focused on the sustainability of results/ required “structural” changes (systems strengthening, behavior change)
7. Developed in an inclusive and transparent manner
8. Reflective of needs to ensure **smart, scaled and sustainable financing**:
 - Identifies ways to achieve efficiency gains
 - Discusses options to ensure the sustainability of the investments, including strengthening domestic resource mobilization

The GFF Secretariat has taken steps over the last few months to support the next round of 10 new countries to develop stronger Investment Cases and to enable the initial 16 countries to further strengthen theirs. These measures include:

- Country Workshop: the Investment Case was a key subject of the workshop held in February 2018 to guide the 10 new countries which have joined the GFF.
- Investment Case guidelines: Revised guidelines are under preparation and will be completed by end of June 2018.
- The GFF Secretariat has strengthened its capacity to advise countries on their results frameworks and monitoring systems as well as developed deeper partnerships with Investors Group members in this area.
- The Investment Case is one of the core topics that were discussed in all countries during the GFF Initiation missions (February to April 2018).
- The GFF Secretariat is currently in the process of hiring Liaison Officers in all countries; one of the tasks of these officers will be to support the government in the development and/or refinement of their Investment Cases. It is anticipated that, since the Investment Case is a “living” document, some countries will be updating and refining them in the months to come, notably to strengthen their results frameworks and monitoring systems.

GFF Country Platforms

All 16 countries have platforms that served to coordinate the engagement for the development of GFF Investment Cases. Most of these platforms are an extension or modification of an existing country platform, often with more focus on participation of civil society. It has been challenging in some countries to have meaningful participation of the private sector because the private sector is often not federated in a way that would enable a few private sector representatives in the GFF platform to speak on behalf of the range of private sector interests. Some countries (e.g. Nigeria) have seized the opportunity to engage with a federation of private sector actors for health.

While the GFF country platforms have been active during the preparation of the Investment Cases, their involvement during implementation has been less regular in some countries. In the case of Ethiopia, Mozambique, and Bangladesh, the platform meets on a regular basis to oversee health sector activities, including the implementation of the GFF Investment Case, but there is not the same momentum in some of the other GFF countries. Given that the incentive to participate in the GFF country platform is greater when there is a clear goal (e.g., developing the Investment Case), a similar purpose for the country platform needs to be identified during the implementation phase. The effective use of GFF country platforms during implementation will depend on the engagement of the various GFF in-country partners, but will be facilitated through the recruitment of a GFF Liaison Officer over the next six months. The Liaison Officer will focus on strengthening the results frameworks, building upon existing systems to improve data quality, access and use, as well as developing (where needed) analytic dashboards aligned with the IC to support data use into programmatic action.

In contrast to the traditional monitoring of development assistance (i.e., tracking each donor’s specific contributions), the GFF model allows the country to monitor the implementation of their IC as a whole. The GFF monitoring approach focuses on the country’s ability to monitor the Investment Case with their financiers and implementers from various sectors. Additionally, the results framework often focuses on multi-sectorial, multi-donor stakeholder engagement, allowing the integration of data focusing on financial resources, human resources, commodities, scale-up performance data (including quality of care) and the eventual impact. The advantages of this process are immense and mean that the country can truly focus on building and strengthening their own data systems, do not have to create any parallel systems, and are not burdened with heavy donor-driven reporting requirements.

However, the process leads to some hurdles that the GFF is working to overcome. The first is that each country has its own monitoring framework, with different indicators aligned to their IC, making it impossible for the GFF to design one standard analytic tool or dashboard that can be rolled out to each country. Instead, the GFF supports strengthening existing routine health systems and available dashboards in-country. The GFF Secretariat is presently working with countries and partners to enable countries to have dashboards for this purpose with a focus mainly on strengthening existing dashboards.

In Tanzania and Kenya, existing dashboards are being consolidated and used for this purpose. To help achieve Tanzania's priority to reduce the high maternal mortality ratio and improve maternal, child, and newborn health, the Vice President's office will launch an RMNCAH scorecard. The GFF supports the government in aligning this scorecard with Tanzania's RMNCAH IC (One Plan II) results framework as a means of monitoring its implementation. With GFF support, the government is merging this district-level scorecard with the new RMNCAH scorecard, which will be used to hold the regional level governors accountable for RMNCAH results. However, the use of the scorecard and other forms of data can be improved at the facility, district, and regional levels. The GFF plans to support strengthened data for decision making, including analysis of data quality bottlenecks and development of a data visualization platform.

In Kenya, in 2014, the Division of Family Health (DFH) introduced an RMNCAH County Scorecard as a quarterly management, advocacy and accountability tool which monitors 27 indicators across six categories that span the care continuum. The scorecard was paper-based and proved cumbersome to prepare every quarter. With technical support from The Africa Leaders Malaria Alliance (ALMA) and UNICEF, the DFH in 2017 developed a digitalized scorecard which is linked directly to DHIS2 through an API which pulls data every quarter. Starting in December 2017, the DFH and six county governments piloted the digital scorecard. The scorecard will be launched during the 2018 Devolution Conference to ensure high level buy-in at both national and county levels. Once the scorecard is generated, the DFH envisages that the scorecard will be used during quarterly review meetings at county level. With support from the RMNCAH TA MDTF, the DFH plans to roll out the digital scorecard in the remaining counties.

The second hurdle in monitoring the Investment Case using existing systems is the challenges relating to data quality, data access, and data use. Therefore, the GFF encourages countries to carry out an assessment (during IC development or afterwards) to evaluate in-country capacity to monitor the results framework. The GFF Secretariat has developed a stepwise process that can assist with this and has technical assistance available along with partners who can help support this endeavor. If assessments of data systems, data quality and use have been conducted recently, these should be used so as to not duplicate efforts. For example, in both Tanzania and Cameroon, the GFF will support the health data collaborative work in which assessments were done to determine gaps in the routine health information systems; this will allow the GFF country team to focus resources on supporting monitoring of the IC, on improving data quality, as well as on data management and access and data use.

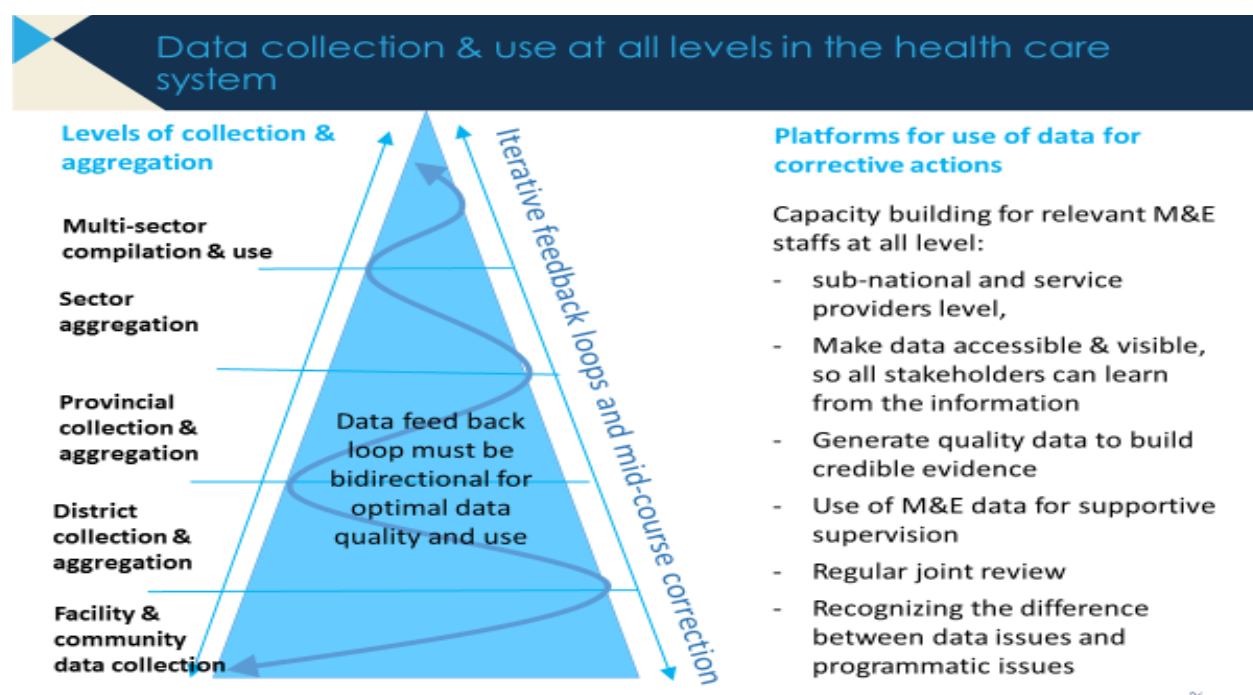
Another challenge has been the engagement of the country platforms to monitor the IC results. It is envisaged that country platforms are responsible to develop the IC-aligned results framework, and to ensure that the results framework is fit for purpose to monitor the specific objectives of the Investment Case. The GFF country platform should ensure that the results framework captures the following: 1) the best indicators to measure inputs, outputs, health and nutrition quality of care, outcomes and eventual impact; 2) the theory of change behind each objective and linked interventions; 3) monitoring of resources / financial tracking to ensure that service delivery areas are receiving the resources needed to anticipate

change; and finally, 4) a mapping of these needs to the available resources and existing health information systems in country.

In addition to the national country platform, it is also imperative for the implementation of the IC and real-time course correction, that there are entities within the healthcare system at provincial, district, local government or other level that are responsible for data analysis. The GFF is encouraging that these teams be well informed and have a strong understanding of the targets for which they are responsible. For these teams, the data need to be accessible, analyzed for their geographic level and actionable, so this can translate into advocacy for policy changes or implementation changes. This level of data use is also needed to ensure improvement of data quality.

This, as expected, differs in each country. Some country platforms are focused at the national level and meet frequently to review available data (for example, Ethiopia); however, in many countries the level of engagement of the national country platform differs in both the frequency with which they meet, the ability to review available data, and the comprehensive make-up of their members. Additionally, very few countries have been able to make data truly actionable at the subnational levels and have a country platform designated at the lower levels of the healthcare system. Building on this is imperative for data use to be translated into actionable change at the service delivery area.

Figure 3. Data Collection and Use at All Levels



Finally, one of the comparative advantages of the GFF model is the focus not only on health outcomes, but also on health financing reforms, working toward financial sustainability through efficiencies in both the short- and long-term. As well as the focus on equity, the GFF aims to ensure that it is supporting the most vulnerable populations. To be able to sustain these agendas, it is very important that policy makers, planners and clinicians can review data concerning performance, results and outcomes, as well as financial data. This is an important part of the GFF model, to ensure that financial disbursements map to the Investment Cases. To do this, the GFF is strengthening resource tracking tools to service delivery areas

and helping to ensure that data users can access and review their performance and financial data in the same visuals, and that definitions are harmonized where possible. This investment will be an important one for each country to truly understand their performance, potential efficiencies gained and the equity agenda.

For example, in Mozambique, health expenditure tracking and strengthening of the public financial management system was prioritized in the IC. The IC process emphasized understanding how health expenditures are being used, what information is currently available in the public financial management (PFM) system and how it can be strengthened. Expenditure analysis was conducted during the IC process to get a better understanding of how the existing resources in the health sector are being used. This work was essential to formulate relevant targets for Disbursement Linked Indicators (DLIsⁱ), tied to IC priorities as well as to understanding better the weaknesses in the existing PFM system. During implementation, the GFF supports the Government through capacity building, awareness raising and on-demand studies to improve PFM systems, and to recommend required reforms to track expenditures in a more meaningful way. This line of work will contribute to strengthen PFM systems and improve the monitoring of expenditure shifts over time according to the identified IC priorities.

Domestic Resource Mobilization

An important element of the GFF value proposition is to use the GFF Trust Fund resources to catalyze investment in RMNCAH-N and the underlying systems strengthening from the following four sources: domestic resources, the World Bank, aligned donor financing, and the private sector. The World Bank commitments and examples of aligned financing are outlined in the section below. Another paper prepared for this Investors Group meeting focuses on the private sector (GFF/IG7/6).

In the first 16 countries, GFF support to domestic resource mobilization has focused on three areas: (i) identifying potential additional sources of sustainable resources for health; (ii) increasing the prioritization of health in the budget (i.e. increasing the share of health in the government budget) and; (iii) increasing health-specific revenues, mainly from sin taxes. In support of this agenda, the GFF Secretariat is also working with different partners to intensify collaboration.

Identifying additional potential sources sustainable resources for health -- In addition to supporting countries to develop or strengthen an existing health financing strategy (e.g. Ethiopia, Myanmar, Senegal and Uganda), the GFF has provided technical assistance to evaluate fiscal space for health in beneficiary countries (e.g. Cameroon and DRC) and support more effective dialogue between the Ministry of Health and the Ministry of Finance. This is an important step for countries that want to identify and mobilize sources of additional public domestic funds for the sector.

Increasing the prioritization of health in the budget -- The GFF platform also has directly supported the prioritization of health in the budget, increasing the share of health in the government's budget, through the country Investment Case (IC) for RMNCAH-N and health financing strategies. This has been reflected in the [IDA/IBRD](#)/GFF operations, as shown in the following examples:

ⁱ DLIs: In IDA/IBRD Program-for-Results operations or in investment project financing with results-based activities, financing or loan/credit proceeds to the borrowers (governments) are only disbursed after targets of the pre-agreed DLIs are achieved.

- **Mozambique:** The national program that is financing the IC (supported by IDA, GFF, Canada, the Netherlands and USAID) has agreed with the government on DLIs including to maintain and later increase the percentage of total domestic government expenditure allocated to health.
- **Tanzania:** The IDA/GFF operation disburses against agreed on results, using DLIs. One of the DLIs focuses on institutional strengthening at all levels, which has six results against it, including at national level increasing the share of health in total government budget.
- **Kenya:** Given the decentralized nature of service delivery in Kenya, the investment framework identified the need to increase the share of resources going to health in the counties—the level of government responsible for the provision of primary health care—to help improve RMNCAH-N outcomes. Through the GFF engagement, county governments are encouraged to allocate at least 20 percent of their budget to health on an increasing scale.

To strengthen the dialogue with the Ministry of Finance and advocate for a higher prioritization of the health sector in the government budget, it is important for the sector to demonstrate better use of resources. In this regard, the GFF has supported countries in improving efficiency in health spending and increasing the focus on results through the IC. In all countries, the IC identifies priority high-impact interventions to improve RMNCAH-N outcomes and thus improve allocative efficiency. Additional efforts to improve efficiency vary across countries: some are taking measures to ensure a higher proportion of health expenditure going to frontline providers, whereas others are aiming to improve public financial management (PFM).

Increasing health-specific revenues -- The GFF, jointly with the World Bank, is supporting efforts to increase sector-specific revenues, by providing technical assistance in the design and/or implementation of these taxes, particularly sin taxes:

- Alcohol (**Liberia**)
- Tobacco (**Mozambique, Sierra Leone** [enacted] and **Senegal**)
- Evaluation of feasibility of earmarking taxes for health (**Uganda, DRC**)
- Technical assistance to develop proposal for leveraging third-party motor vehicle insurance for health (**Uganda**)

Several GFF countries are trying to develop or strengthen a social health insurance scheme. The GFF is providing technical assistance to ensure that these efforts lead to a more equitable way of financing health care. This type of support is being provided in **Sierra Leone** (e.g. integration of a performance-based financing scheme within the social health insurance scheme), **DRC** (feasibility study for the creation of a new social health insurance scheme), and is likely to be also provided in **Burkina Faso**, which recently became a GFF-supported country.

Complementary Financing

The alignment of complementary financing to the GFF Investment Case is essential not only to increase the volume of resources available for RMNCAH-N but also to generate efficiencies by reducing duplication and avoiding unnecessary burden to national governments from working with parallel requirements of each donor. The alignment of donor resources is an ongoing goal in the initial 16 countries. Countries typically have carried out a resource mapping exercise when the Investment Case was developed to assess potential sources of financing. This resource mapping is currently being updated in the initial 16 countries and the results of the eight countries where it has been completed (see Annex 1) show the following trends:

- Overall, there is a positive trend toward more financiers deciding to join the GFF Investment Cases, but the picture remains highly variable by country and countries could benefit from greater commitment from donors to align to their GFF Investment Cases.
- It seems that involving donors from an early stage in the development of the Investment Case increases the likelihood that they would align their resources to the Investment Case. The early and active engagement of donors may not have taken place in some countries.
- While there are some countries where a high proportion of the aligned financing is pooled (e.g. Bangladesh, Ethiopia), it is more typically the case that some financing is pooled through a World Bank Trust Fund and the remaining funds are aligned through the GFF Investment Case results framework. The proportion of the aligned financing that is on-budget and/or which makes use of government systems varies considerably across countries. The GFF approach offers the flexibility to reap benefits of alignment without necessarily needing to pool resources or use government systems; this should enable a greater number of financiers to align.
- The resources of most of the H6 partners, while more limited in scale, are almost always aligned to the Investment Cases.
- Some partners (e.g. Global Fund, GAVI, Sweden, DFID, EU) are aligned in a few countries.
- Other (smaller) bilateral partners may not have as wide a country presence or may focus on other sectors than health and so they do not feature as frequently in the aligned financing.
- Where bilateral agencies have had strong coordination of their GFF engagement at the central level and a clear commitment to the GFF, it has tended to result in their financing being aligned in a larger number of countries.
- There is virtually no alignment to date of the financing from regional development banks. Greater engagement with them is planned over the next six months.
- In fragile states where there is a strong presence of humanitarian actors (e.g. DRC, Central African Republic, Afghanistan), the financing from humanitarian partners, some of which originates in bilateral donors but a considerable portion of which comes from individual donors, is substantial (in some cases far greater than bilateral financing) and is not currently reflected in the resource mapping.

Engaging with donors to align their financing is an ongoing process that will continue as the Investment Cases in the 16 countries continue to be implemented. As the financing cycle for existing donor commitments come to an end, it is anticipated that the Investment Cases, which are living documents, will be updated and that a larger number of financing partners will join the GFF in-country.

GFF Trust Fund Commitments

The GFF Trust Fund continues to leverage World Bank financing in an increasing number of countries. As Figure 4 shows, there are currently 13 countries in which the GFF Trust Fund has co-financed World Bank resources (all of them IDA except for Guatemala which is IBRD). This amounts to a total GFF Trust Fund commitment of \$387 million to co-finance \$2.6 billion of IDA/IBRD resources. In two countries – Bangladesh and DRC – the GFF Trust Fund is co-financing two IDA projects.

All of the GFF co-financing in the active portfolio is for health sector projects, except for one in Bangladesh which focuses on adolescent boys and girls through the education sector. As outlined in the section below on the 10 new countries, the second wave of countries have taken a wider, more multi-sectoral approach than was the case in the initial 16 countries and it is anticipated that the GFF Trust Fund will co-finance a greater number of non-health sector related projects.

Figure 4. GFF Co-Financing of World Bank Projects as at March 28, 2018

Country	Board Date	GFF Approved amount	IDA amount	IBRD
Tanzania	5/28/2015	\$40	\$200	
DRC (AF-CRVS)	3/29/2016	\$10	\$30	
Cameroon	5/3/2016	\$27	\$100	
Nigeria (AF)	6/7/2016	\$20	\$125	
Kenya	6/15/2016	\$40	\$150	
Uganda	8/4/2016	\$30	\$110	
Liberia (AF)*	2/23/2017	\$16	\$16	
Guatemala	3/24/2017	\$9		\$100
DRC (AF)	3/31/2017	\$40	\$320	
Ethiopia	5/8/2017	\$60	\$150	
Bangladesh	7/28/2017	\$15	\$500	
Bangladesh - Education	12/18/2017	\$10	\$510	
Mozambique	12/20/2017	\$25	\$80	
Rwanda (Health)	2/28/2018	\$10	\$25	
Afghanistan	3/28/2018	\$35	\$140	
Sub-total Board approved		\$387	\$2,456	\$100

The World Bank-GFF co-financed projects have all employed various results-based approaches to link financing to results at various levels in the system. Examples include:

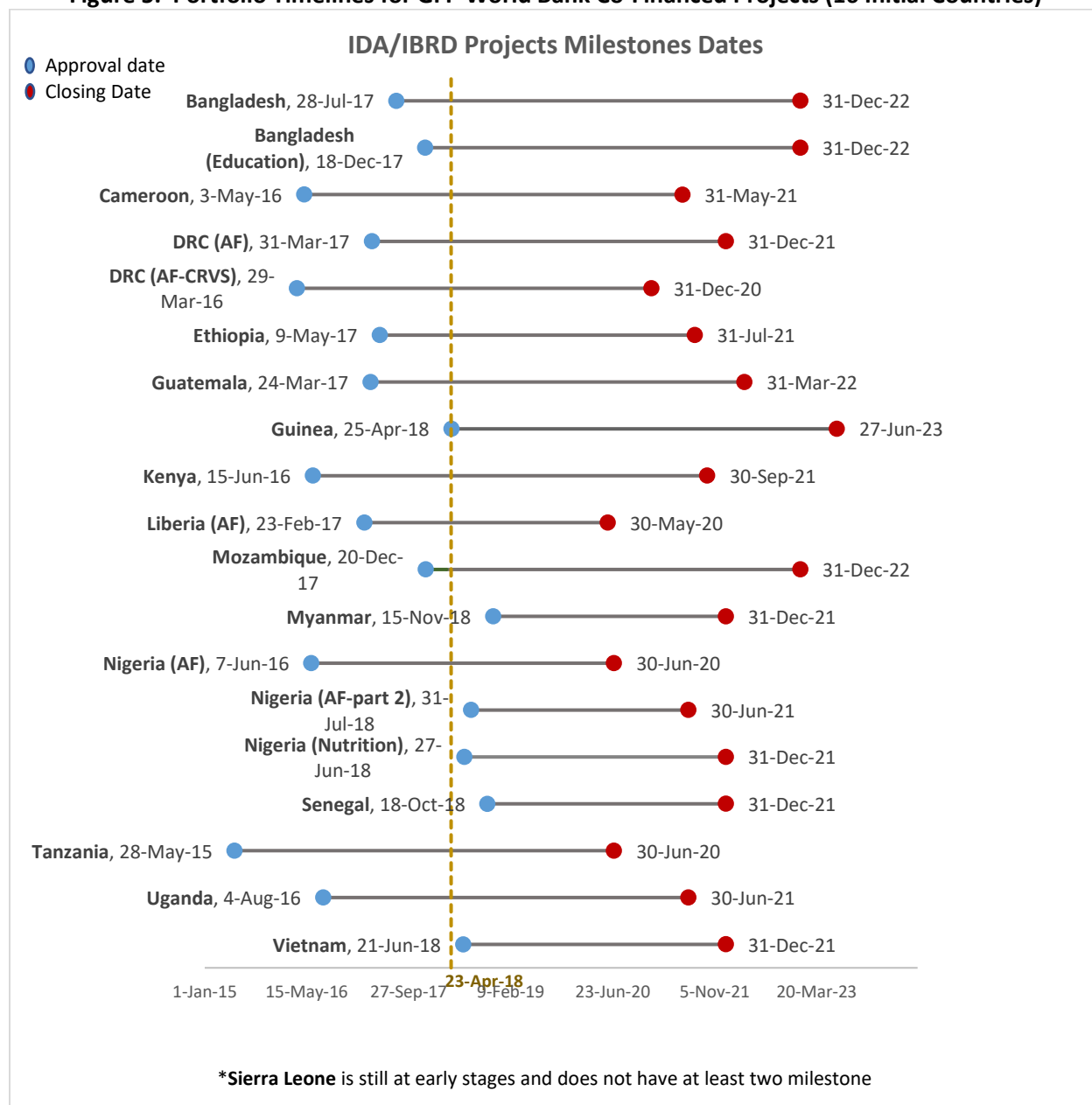
- **Buy-Down of IBRD terms (e.g., Guatemala)** – this enables the government to borrow IBRD resources at IDA terms and thus incentivizes the use of IBRD for social sector investment when IBRD is traditionally perceived by countries as a source of financing for infrastructure. In the case of Guatemala, the government has committed to re-investing the GFF grant into a conditional cash transfer.
- **Program for Results/Disbursement Linked Indicators (e.g., Ethiopia, Kenya, Tanzania, Mozambique, Indonesia, Nigeria [Nutrition])** – this approach reimburses the government based on results (policy objectives, service provision, etc.) which are independently verified. As noted earlier, in some cases, DLIs have been used in the GFF portfolio to incentivize the mobilization of domestic resources.
- **Performance Based Financing (e.g., Cameroon, DRC, Liberia, Nigeria [North East], Sierra Leone, Tanzania, Uganda)** – this approach focuses on service delivery, reimbursing health facilities for quantity and quality of services which are verified by the health system and counter-verified by civil society actors. The approach is widespread in the GFF portfolio, is one of the strongest ways

in which the GFF harnesses the capabilities of the private sector and constitutes a very practical way to engage with civil society around RMNCAH-N results.

- **Performance Based Contracting (Nigeria, Afghanistan)** – this approach involves the government contracting out the delivery of services to non-state actors. In Afghanistan these are both facility-based and community based services. In Nigeria, the GFF investment would be catalyzing the introduction of this approach for community-based services, initially for nutrition but could be expanded to other community-based services.

The GFF and World Bank co-financed projects in the initial 16 countries are all at different stages of preparation or implementation. As Figure 5 illustrates, by the end of June 2018 all countries except Myanmar, Senegal and Sierra Leone will have had their co-financed projects approved. The project and Guinea as well as two projects in Nigeria are expected to be approved by the end of June. The same figure also shows the variable periods that it has taken to move from approval to effectiveness, which is when the project can start making financial resources available to countries for activities. This delay can be long in some countries because the World Bank financed project usually require Parliamentary approvals and other reviews by the national legal systems before they can be declared effective.

Figure 5. Portfolio Timelines for GFF-World Bank Co-Financed Projects (16 Initial Countries)



PART 2: EXPANSION TO 10 NEW COUNTRIES

GFF Financial Engagement

In November 2017, the following 10 countries joined the GFF: Afghanistan, Burkina Faso, Cambodia, Central African Republic, Cote d'Ivoire, Haiti, Indonesia, Madagascar, Malawi and Rwanda. The actual amount of GFF and World Bank financing will continue to evolve in some countries as efforts are being made to further increase the leveraging effect of the GFF resources by increasing the size of the World Bank financial commitments to GFF priority areas.

GFF Workshop for New GFF Countries

With a view to sharing the lessons learned from the initial 16 GFF countries with this new set of countries, the GFF Secretariat organized, in collaboration with several of the Investors Group members, a four-day workshop in Accra, Ghana from January 28 to February 1, 2018. The workshop objective was to engage and energize the multi-sectoral country teams around a common vision and support the operationalization of country-specific GFF visions.

The GFF Country Workshop was attended by 10 country teams. Each country team included high-level decision-makers from the Ministry of Health (MOH) and the Ministry of Finance (MOF), a financier of the Investment Case, a technical partner, and a representative of civil society and/or the private sector. Country teams also comprised the World Bank Task Team Leader and the health financing focal point. In addition, many of the global technical partners were represented. In total, more than 150 people participated in the GFF Country Workshop.

The design of the workshop was developed through consultations to support the design, monitoring and implementation of GFF-supported Investment Cases and health financing work. As participating countries are at the initial stages of the GFF process, the workshop focused on elaborating on the GFF's vision, and exploring its underlying themes and processes. Workshop content also showcased how initial GFF countries are leveraging the GFF model to accelerate GFF results, highlighting challenges faced, lessons learned and potential next steps.

The GFF Country Workshop adopted an approach that combined plenary sessions and country group work to elaborate on the GFF's vision, contextualize presentations, encourage discussions and support the development of a tentative roadmap. This methodology was informed by feedback provided after the first Country Learning Workshop held in Kenya in 2015 and the second GFF Country Workshop held in the United States in 2017.

The workshop was structured along the following sessions:

- Introduction to the GFF and Lessons Learned
- The GFF Investment Case
- Financing and Implementing Priorities of Investment Cases in a Coordinated Manner
- More Value for Money and More Money for Health: Ensuring Smart, Scaled and Sustainable Financing
- Efficiency
- Working Multi-sectorally
- Private Sector
- Operationalizing the GFF at Country Level
- Monitoring GFF Implementation: RMNCAH-N Results and Health Financing Reforms

On the last day, several parallel technical sessions were offered on the following topics: Domestic Resource Mobilization (DRM); World Health Organization Guidelines for Maternal and Newborn Health; Lifesaving Commodities and Supply Chains; Adolescent Sexual and Reproductive Health (ASRH); Civil Registration and Vital Statistics (CRVS); and Nutrition.

Country teams were asked to provide their initial thinking on (i) key priorities across the GFF value proposition, (ii) proposed next steps and (iii) the type of GFF support needed to move the agenda forward. These reflections were presented by countries at the end of the workshop and countries were encouraged

to take this presentation, and all the presentations provided during the workshop, back to their country for further consultation and awareness-raising of stakeholders who were not able to attend the workshop.

GFF Initiation Missions

In February, March and April 2018, a GFF Initiation mission took place in each of the 10 new GFF countries. This mission is a new step in the initial GFF engagement in a country and has served to explain to a broader set of stakeholders than those who could participate in the workshop in Ghana what the GFF model is and how each stakeholder can contribute. In many cases the missions also served as an opportunity to start stakeholder engagement on the prioritization process for the Investment Case.

The missions were led by the GFF Secretariat Focal Point for that country and presented an opportunity to start a discussion with the potential financiers on the likelihood that they could align investments in RMNCAH-N to the Investment Case. Special efforts were made to reach out to representatives from the private sector as well as to members of civil society. The mission also typically discussed the form which the GFF platform will take in the country. In some countries a draft roadmap for developing the Investment Case was discussed as was an initial set of priorities. Some governments chose to use the mission to officially launch the GFF process in the country and to draw attention to it through mass media.

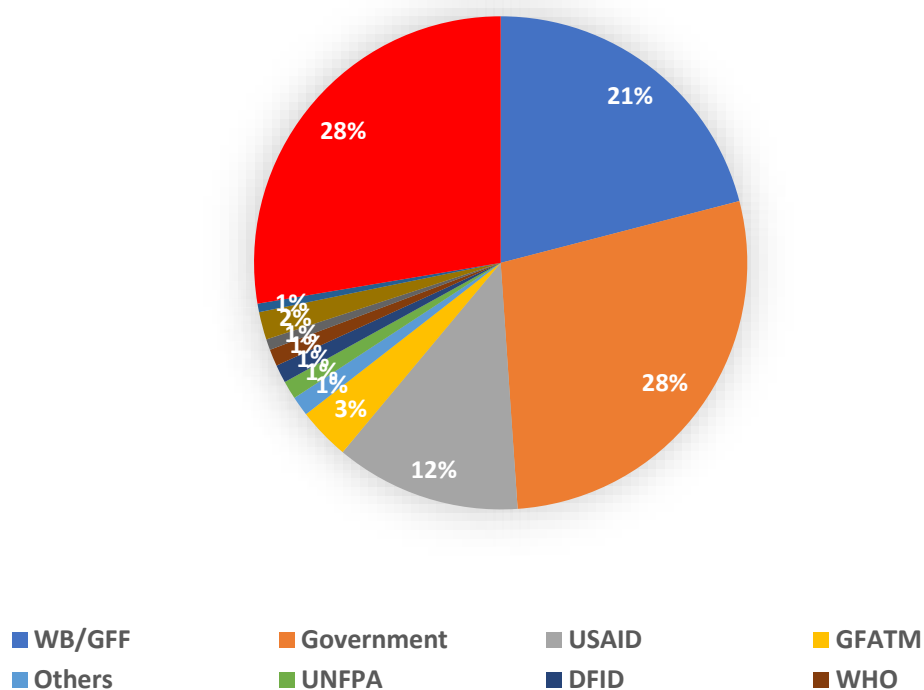
Next Steps in the 10 New Countries

The immediate next step in each country is to start the process of developing the Investment Case. This will involve developing roadmaps and seeking commitment from key partners to support specific steps in the roadmap. Where that has not yet been completed, the national governments will name the GFF Country Focal Point and will clarify what structure will serve as the platform for the GFF.

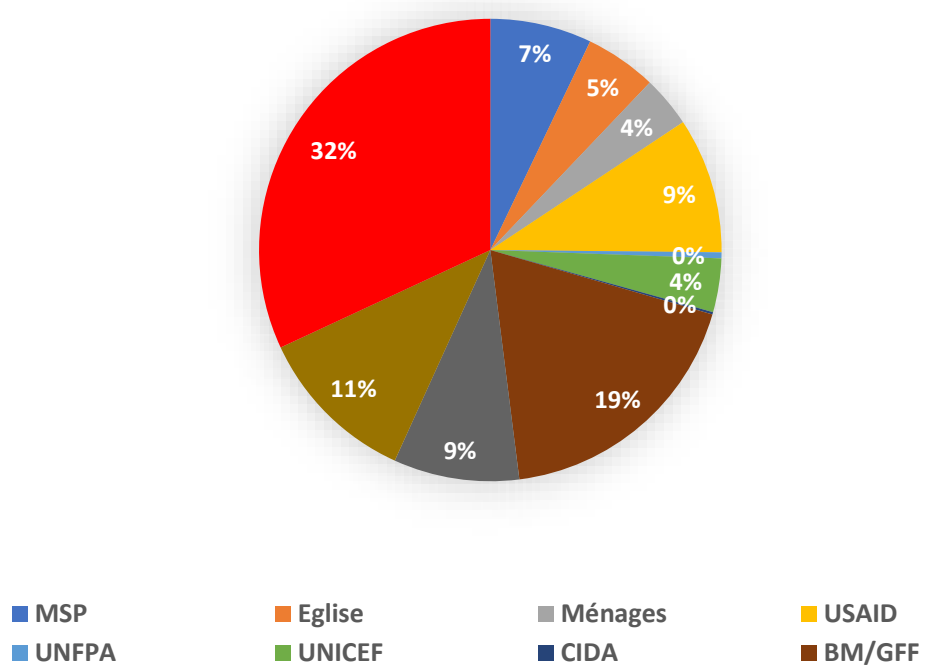
The GFF Secretariat is also planning to hold a workshop in late Summer 2018 for all 26 countries to support them in the development of their results frameworks and results monitoring systems. This workshop is expected to not only help the 10 new countries but also to enable the initial 16 countries to sharpen the results focus of their Investment Cases.

ANNEX 1. COMPLEMENTARY FINANCING AS OF MARCH 2018

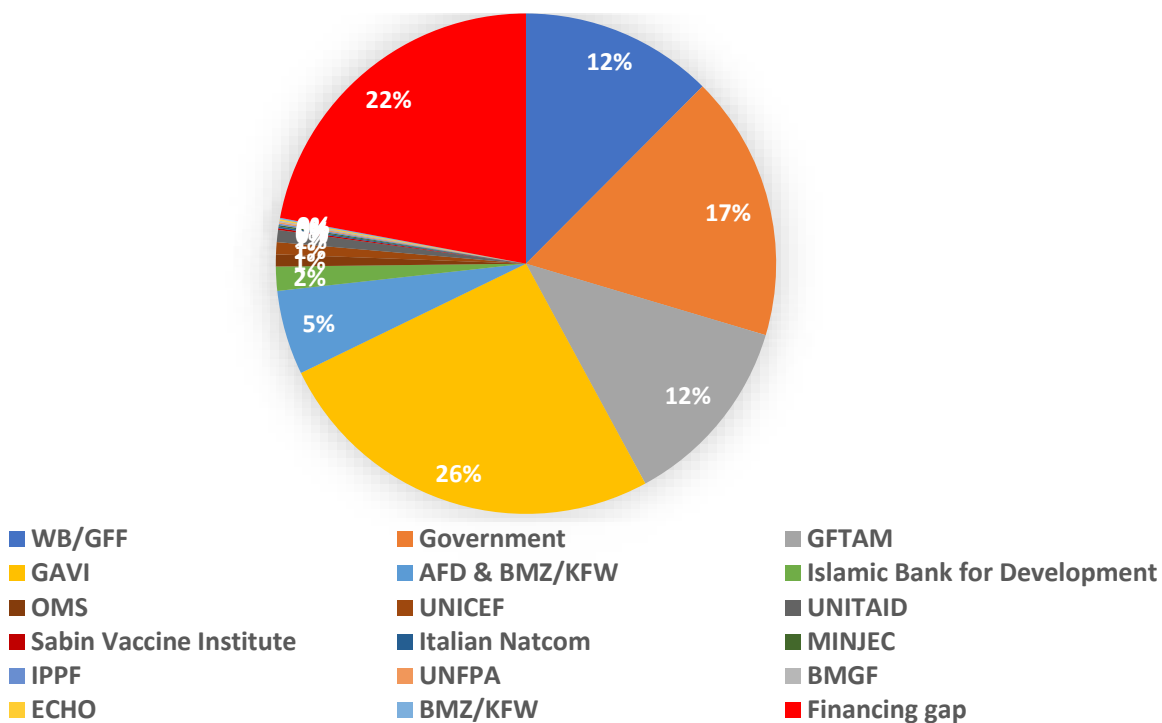
Liberia Resource Mapping



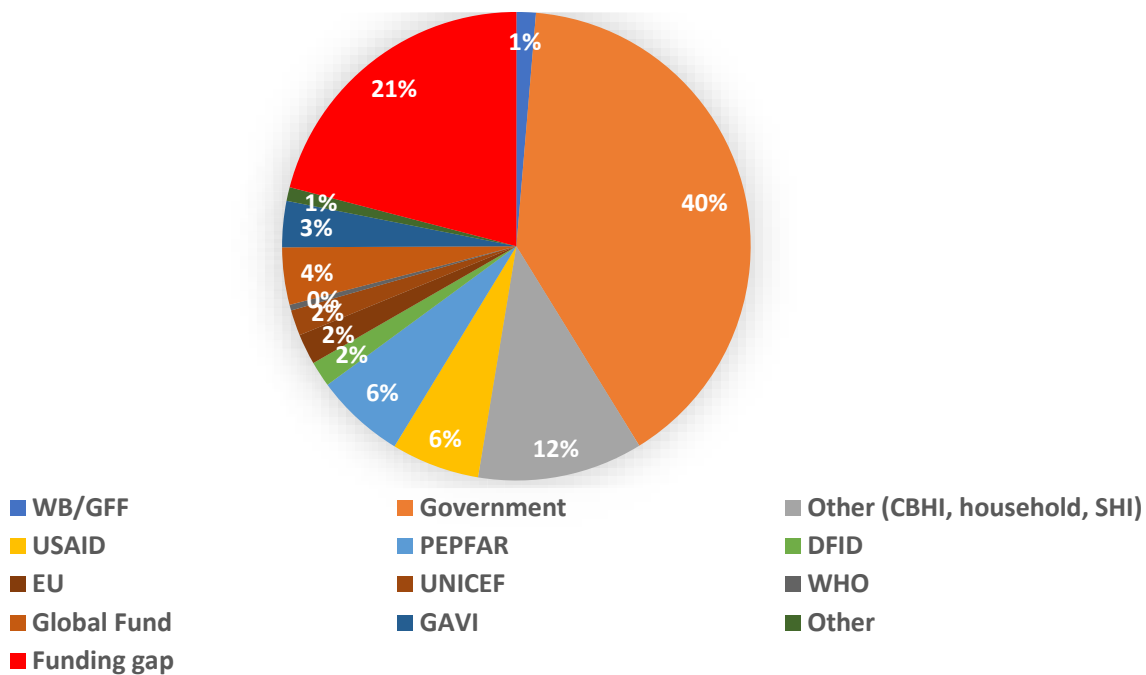
Democratic Republic of Congo Resource Mapping



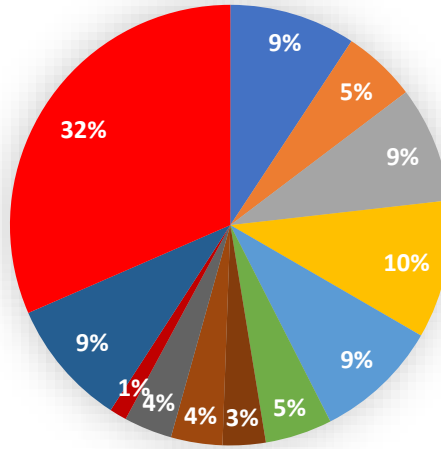
Cameroon Resource Mapping



Ethiopia Resource Mapping



Uganda Resource Mapping

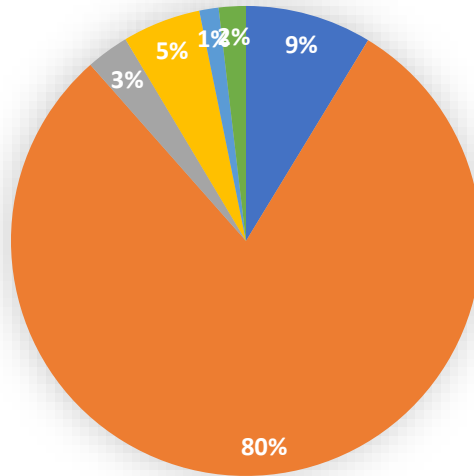


■ WB/GFF
■ UNFPA

■ Government
■ DFID

■ USAID
■ GAVI

Mozambique Resource Mapping



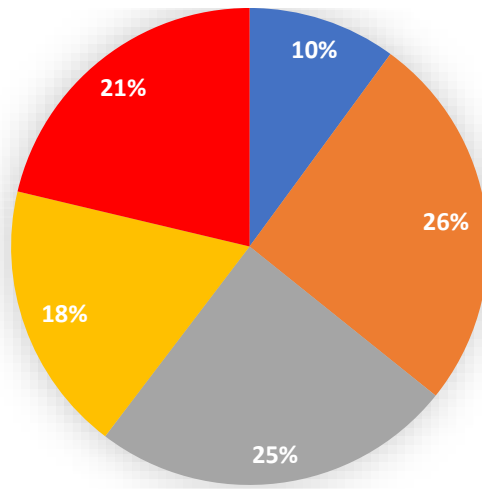
■ WB/GFF

■ Government

■ Multi-Donor Trust Fund (Netherlands)

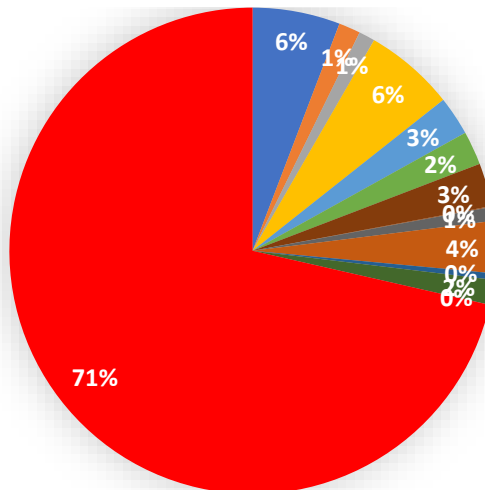
■ Multi-Donor Trust Fund (Canada)

Kenya Resource Mapping



■ Government ■ Development partners ■ Counties ■ Households ■ Funding gap

Guinea Resource Mapping



■ WB/GFF ■ Government (budget) ■ WHO ■ Global Fund
 ■ GAVI ■ USAID ■ EU ■ France
 ■ AFD ■ JICA ■ Japan ■ GiZ
 ■ UNAIDS ■ Funding gap

ANNEX 2. COUNTRY PROFILES AND PROGRESS UPDATES

BANGLADESH

IC period	Health, Nutrition and Population Strategic Investment Plan (HNPSIP) – 2016 to 2021
IC Financiers include	Government of Bangladesh, GFF, IDA, Netherlands, Sweden
Key technical areas	full sector program, including RMNCAH-N

1. RMNCAH-N situation

With a population of 160 million and gross national income per capita of US\$1,409 (2016), Bangladesh has achieved several Millennium Development Goal (MDG) targets for health, nutrition and population (HNP) outcomes. Child and maternal mortality, as well as fertility rates, have continued to decrease over the past decade, although progress on child undernutrition has been slower. Bangladesh has embraced the SDGs, including SDG 3, objectives for which include reducing maternal, under-five and neonatal mortality, reducing malnutrition, ensuring universal access to sexual and reproductive health services, and achieving universal health coverage.

Trends in HNP outcome indicators

	2007	2011	2014-16
Infant mortality rate (per 1,000 live births)	45.8	37.0	28.2
Under 5 mortality rate (per 1,000 live births)	59.3	46.5	34.2
Total fertility rate (births per woman)	2.5	2.3	2.1
Maternal mortality ratio (per 100,000 live births)	288	228	176
Prevalence of stunting among children under 5 (percentage)	43.2	41.4	36.4

Source: World Bank Databank

The country faces several challenges to achieving these objectives. First, there are important financing, governance, and system management gaps that need to be addressed to set the foundation for effective use of the increased public spending on health that will be necessary. Although government health spending has increased from US\$6 to US\$14 per capita between 2008 and 2017, as a share of the overall economy, it remains very low by international standards, at less than one percent of gross domestic product. This level of investment will come to be increasingly at odds with the population's aspirations for services in an emerging middle-income country, as well as with the country's commitment to achieve the SDGs. Second, there are significant parts of the MDG agenda that present ongoing challenges. While many service utilization indicators, such as immunization coverage, have reached high levels, it is necessary to maintain those gains, achieve still higher coverage, improve quality, and reduce socio-economic and geographic inequalities. Third, the country faces a number of emerging challenges in areas such as urban health, climate change and adolescent health.

2. Value-added of the GFF / Investment Case priorities

The GFF is supporting Bangladesh in aligning financing and technical support to meet these challenges with a focus on improving reproductive, maternal, newborn, child, and adolescent health and nutrition (RMNCAH-N) outcomes. Through support to the government's programs in both the HNP and education sectors, GFF is catalyzing coordinated impact of international financing of over US\$1 billion and

influencing domestic government spending of US\$30 billion in the two sectors over five years. The Health Sector Support Project (HSSP), co-financed by US\$15 million from the GFF, US\$500 million from IDA, US\$23 million from Sweden, US\$13 million from the Netherlands (and proposed co-financing from other partners), contributes to the government's Fourth HNP Sector Program through a results-based strategy. The project supports development of health system governance, management and service delivery capacities, implementation of an Essential Services Package that includes key RMNCAH-N services, and a focus on lagging regions, particularly Sylhet and Chittagong Divisions.

Among the factors thought to have contributed to improvements in HNP outcomes in Bangladesh despite very low public spending on health services are female education and labor force participation which have contributed to empowering women and girls to delay marriage, reduce fertility, and take more control over their own and their children's health and nutrition. However, there has been insufficient attention paid to adolescent health, while retention of girls in secondary education has been identified as a key challenge. The Transforming Secondary Education for Results Program is co-financed by US\$10 million from GFF and US\$510 million from IDA, as well as parallel financing of US\$225 million from the Asian Development Bank. The GFF is catalyzing collaboration between the HNP and education sectors to develop and implement school-based services to improve adolescent health. The GFF is supporting technical work and policy development to shape the efficiency and impact of the government programs in the HNP and education sectors. This includes work on health financing, strategies and interventions for adolescent health, civil registration and vital statistics, equity and the health of tribal and hill populations, and climate change and health.

As part of setting the foundation for increased government health spending, the GFF, through HSSP, supports improvements in budget planning and allocation, as well as increased efficiency in spending using results-based financing and development of core management systems, including financial management, procurement and human resource management. The GFF is improving the knowledge base for implementation of Bangladesh's Health Care Financing Strategy for 2012-32, including analysis of health equity and financial protection, diagnosis of public financial management bottlenecks, engagement with the private sector, and dialogue on domestic resource mobilization.

3. Achievements in the last six months

In accordance with Bangladesh's Sector Wide Approach (SWAp), the government has aligned domestic and international public financing in support of its US\$14.7 billion Fourth HNP Sector Program for 2017-22. The program, developed on the basis of wide stakeholder consultation, has been adopted through detailed plans and budgets for specific technical objectives and programs. The government's sector program includes activities and budgets necessary to achieve RMNCAH-N results supported by GFF through HSSP. The program, under implementation since January 2017, has achieved its first planned results in planning, budgeting and system development, as well as improved service coverage in Sylhet and Chittagong Divisions. These include adoption of plans and budgets focused on improved RMNCAH+N services, implementation of online procurement and asset management systems to improve the efficiency of public funding, recruitment of almost 3,000 midwives to improve maternal and neonatal care, and completion of needs assessments, planning, technical standards and service improvements for post-partum family planning services, emergency obstetric care, immunization, and maternal and child nutrition interventions.

In addition, the GFF has catalyzed cooperation between the HNP and education sectors on development of technical strategies and interventions to maximize secondary schools as platforms to improve

adolescent health services and outcomes. With support from GFF, the Ministries of Education and Health and Family Welfare have formed a working group to jointly develop an Adolescent Students' Program (ASP). The ASP includes incentives for poor girls to stay in school, investment in separate functional toilets for girls, promotion of facilities for menstrual hygiene, inclusion of adolescent health in the curriculum, teacher training, counseling of girls and boys, and awareness-raising on gender-based violence. GFF, through its support to both sectors, will contribute to introduction and scale-up of these interventions as program implementation moves forward.

4. Anticipated results in the next six months

The government will continue implementation of its Fourth HNP Sector Program, including activities that will contribute to the results to be supported by GFF, through HSSP, during the government's 2018 fiscal year (ending June 2018). Planned results include assessments and planning for the Ministry of Health and Family Welfare's grievance redressal system and reform of financial management and procurement systems. Other planned system improvements include improved budget allocations to the facility level, asset management by District Hospitals, and information management by Community Clinics. Planned service delivery improvements include technical work on improving post-partum family planning emergency obstetric care, as well as expansion of delivery care, immunization and nutrition services in Sylhet and Chittagong Divisions.

Under the SWAp, the Ministry of Health and Family Welfare will form Task Groups on specific technical issues that will bring together the ministry and Development Partners to monitor the Sector Program, as well as provide a dialogue on policy and program issues. The Task Groups will be used to mobilize and coordinate analytical, technical and financial support to the government to advance its program. Technical work and dialogue to be supported by the GFF on adolescent health will continue, bringing together the Ministries of Education and Health and Family Welfare, and will be initiated on health financing and equity issues.

CAMEROUN

IC period	2017 to 2020
IC Financiers include	Government of Cameroon, Gavi, Global Fund, World Bank IDA, GFF-TF, UNFPA, UNICEF, BMZ/KfW, AFD, Islamic Development Bank, UNITAID, WHO, BMGF, ECHO
Key technical areas	Results-based financing; adolescent SRHR; family planning; MNCH with a focus on ANC, skilled birth attendance, KMC, PMTCT, and malaria Rx for under 5s, MMR vaccination

1. RMNCAH-N situation

Cameroon is a country of 22.8 million (2014) and has an annual population growth rate of 2.7 with 41 percent of the population under 15 years old. Categorized as a pre-fertility transition country, total fertility rate in Cameroon is high at 4.9 and has declined by less than 1 birth per woman in the past 25 years.

Cameroon is a low-middle-income country with a GDP per capita of \$2,400 (2013) and annual growth rates that have held between 3.3 percent (2010) and 5.9 percent (2014). Despite its income level, Cameroon was ranked 153rd out of the 188 countries tracked in the Human Development Index (HDI 2014) and is one of a group of countries whose HDI scores have deteriorated in the past two decades.

Contributing to this deterioration are poor health outcomes. While child mortality declined 21 percent between 1991 and 2014, progress on a range of key RMNCAH-N indicators has not matched Cameroon's economic status or relatively high per capita health spending (\$138 in 2014). Cameroon has the unique distinction of being one of the only countries in the world to see no decline in maternal mortality rate between 1990 and 2015. Between 1994 and 2011, under-5 stunting increased from 24.4 percent to 33 percent.

Additionally, there are stark regional disparities, with the three northern regions and the East region having considerably worse health indicators. For example, the proportion of 15-19-year-old girls who have begun child bearing is 44.2 percent in the East and 23.4 percent in the Far North while in the capital, Yaoundé, the rate is only 7.6 percent. Similarly, four regions are affected by high rates of under-5 stunting, with 44 percent in the Far North, 40 percent in both the North and Adamawa, and 38 percent in the East.

2. Value-added of the GFF / Investment Case priorities

There are three themes for GFF efforts in Cameroon that run through the Investment Case. These include a focus on allocative efficiency, multi-sectoral focus on addressing adolescent health and fertility, and private sector engagement. The allocative efficiency efforts are multi-layered and focus on two dimensions: rebalancing of public health expenditure between tertiary level and primary/secondary levels (RMNCAH-N service prioritization being part of this effort) and shifting the regional allocation to increase resources to high-burden and low resource parts of the country, namely Adamawa, the Eastern Region, the Northern Region, and the Far North Region.

The adolescent health focus of the Investment Case seeks to directly address high rates of adolescent fertility (particularly in focus regions) by expanding access to sexual and reproductive health information, access to contraception, and improving educational opportunities for girls. While adolescent fertility is the primary outcome of interest, early and mistimed pregnancies and low social service utilization by

adolescent mothers are implicated in maternal, neonatal, child-health, and nutritional outcomes. Indirectly, this strategy is linked to the longer-term opportunity that a rapid fertility decline and transition could present through changes to the population-age structure, reducing dependency ratios, and ultimately the economic gains from a demographic dividend.

Finally, the Investment Case also has a focus on engagement with the private sector to expand access to services through a mixed model for health service delivery made possible by a results-based financing purchasing system and to mobilize private resources through both tradition (corporate social responsibility) and innovate ways (development impact bond for new-born health).

3. Achievements in the last six months

Nationally, RBF coverage reached 47 percent across the 10 regions of Cameroon by the end of 2017. This includes complete coverage in three regions, partial coverage in four regions, and three regions that have not yet initiated.

In addition, RBF has been extended to the central level, with performance contracts renewed with five directorates within the Ministry of Health. It is anticipated that a further 3-4 directorates will also enter into similar contracts. The design of the CRVS performance based financing pilot has been finalized in a workshop in Douala. The Bureau National de l'État Civil (BUNEC) has also created posts in each of the regions to coordinate implementation.

There has also been further alignment of IDA financing (without a GFF-TF linked investment) to the Investment Case through a development policy lending operation approved by the World Bank board in December 2017. While the scope of the overall budget support cuts across sectors, there are specific disbursement triggers related to improving tax efficiency, shifting the allocation of public health expenditure between tertiary and primary/secondary levels, and the implementation of the performance-based financing model in the health sector.

4. Anticipated results in the next six months

The country platform is planning an annual review of the Investment Case and performance in April 2018. By the end of the year, it is anticipated that there will be seven regions that have full coverage of results-based financing and that the final three regions will have begun the rollout.

DEMOCRATIC REPUBLIC of CONGO

IC period	2017-2021
IC Financiers include	USAID, WB, GAVI, Global Fund, Canada, UNFPA, UNICEF
Key technical areas	RMNCAH-N package; Medical and Counselling interventions against SGBV; Health Systems Strengthening including RBF; CRVS; WASH

1. RMNCAH-N situation

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 (MMR) of 846 per 100,000 live births is among the highest in the world. In addition, the very low use of contraceptives and a high adolescent pregnancy rate, are key determinants of the high MMR. Only 33 percent of health zones are covered by functional FP services and adolescent fertility rate is high with 21 percent of adolescent females (15-19 years) having given birth in 2014. The high MMR is also directly correlated with low quality of care and inadequate preparedness for obstetric emergencies. Furthermore, women are among the most vulnerable groups in the DRC with 42 percent affected by both domestic violence and inadequate control over their health.

Limited supply chain and inefficient human resources hamper quality of RMNCAH-N services. On average, 23 percent and 29 percent of health facilities carry the 15 essential medicines for maternal and child health, respectively (Sara, 2014, p.92-93). When drugs are available, 64 percent of the population cannot afford them. Overstaffing of health facilities for certain types of staff is common in both rural and urban areas, while 70 percent of the health workforce does not receive a salary (WB PAD, 2016).

The Government has launched many reforms to strengthen the fiduciary and technical aspects of the Government, but public financial management (PFM) remains weak (e.g. slow procurement process causes delay in budget preparation and low budget execution). Additionally, low level of public health financing is contributing to distressing health outcomes. The health spending per capita in the DRC was US\$ 22 in 2015 (NHA, 2015), which is one-sixth of the Sub-Saharan Africa average and one-fourth of the amount necessary to provide basic health services to the population (McIntyre and Meheus, 2014). Additionally, almost one fifth of the DRC population encounters catastrophic expenditures.

Limited RMNCAH-N data availability and quality impede the monitoring of RMNCAH-N outputs and outcomes. The Civil Registration and Vital Statistics (CRVS) system is almost inexistent in DRC with only one in four children being registered at birth (DHS 2013-14).

2. Value-added of the GFF / Investment Case priorities

The GFF provides added-value to DRC by:

1. Supporting the expansion of the RMNCAH-N package in the 14 provinces prioritized in the IC (*Priority 1 of the IC*)
2. Funding medical and psychosocial services to support individuals affected by sexual- and gender-based violence (*Priority 1 of the IC*)
3. Improving DRM, with a strong focus on efficiency reforms (*Priority 1 to 9 of the IC*)
 - Efficiency reforms are the focus of GFF in the short to midterm and include: a) PBF; b) Cost-effective RMNCAH-N interventions; c) Implementing the RMNCAH-N through community and multi-sector approaches; d) Scaling-up a single contract approach; e) Efficient HR reforms; f)

- Efficiency of supply chain; g) Leveraging the private sector to improve effective coverage and efficiency
- Supporting several analytics related to DRM as part of the IC and HFS to attempt to raise additional revenue for health in the mid to long-terms
- Overall, linking the IC to the health financing strategy and providing policy options to generate new resources for health as well as freeing existing resources for the implementation of the RMNCAH-N package
- 4. Improving Governance of the health sector and data use to better monitor RNMNAH-N outcomes. This implies modernizing the CRVS system to improve vital registration and information on causes of deaths in a multi-sector and sustainable manner. *(Priority 10-12 of the IC)*

3. Achievements in the last six months

Overall, the quality scores of health facilities have improved in all health zones, attaining 50 percent in the second trimester (year 2017), compared to 29 percent in the first trimester (year 2016). The provinces (DPS) where PBF was implemented have seen significant increase in utilization of health care services in the last six months. The health services utilization rate increased from 0.31 number of cases in the 1st trimester 2017 to 0.43 number of cases in the fourth trimester 2017. Percentage of children ages six to 23 months who received nutritional services increased from 23 percent to 32 percent in 2017. In addition, the percentage of children fully vaccinated reached 74 percent end of 2017, which is considerably above the initial target of 58 percent. Finally, the percentage of pregnant women receiving HIV counseling and diagnosis (PMTCT) is estimated at an average of 35 percent, surpassing the initial target.

The Single Contracts were implemented in DRC as a vehicle to improve performance of health facilities through better management of financial resources at the provincial level. In October 2017, it was agreed that single contracts for year 2018 for eight second round DPS should be prepared by January 2018, leading to a total of 16 DPS with single contracts implemented. However, a follow-up World Bank mission in January-February 2018 revealed that only two provinces had signed their Single Contract.

The Minister of Health called for a high-level retreat to revise the 2016-2020 PNDS which will be the object of a mid-term review in July 2018. The objective of the retreat is to provide a conceptual framework to prioritize the existing PNDS and ensure it is operationalized at provincial level and does not have any funding gaps.

The WB/GFF developed TOR for three health financing studies following based on the health financing strategy: 1) fiscal space analysis; 2) resource mobilization at provincial and national level (including reviewing the feasibility of earmarked tax at central and decentralized levels); 3) study case on vaccination). The firm will be hired before June 2018. The GFF is also discussing with MOH the possibility of conducting regular resource mappings of external resources, in order to address inefficiencies in the health sector.

4. Anticipated results in the next six months

- A follow-up WB mission is planned for June 2018 to review the progress of the RBF results
- We anticipate the implementation of the Single Contract in all second round DPS.
- Improved health service coverage in some key provinces of the GFF investment through RNF
- Implementation of the health financing studies
- Support draft of the next PNDS, including its monitoring and evaluation framework.

- Update of the GFF IC resource mapping
- Operationalize the Investment Case in one or two provinces by integrating the IC workplan with existing mechanisms (national health plan and single contract)

ETHIOPIA

IC period	Health Sector Transformation Plan – 2015/16 to 2019/20
IC Financiers include	Government, WB/GFF, USAID, PEPFAR, DFID, EU, UNICEF, WHO, Global Fund, Gavi and other (CBHI, Households and SHI)
Key technical areas	RMNCAH programs and Health System Strengthening (Governance/Regulatory system, health infrastructure, health financing, supply chain and logistics management, Quality of Care, HMIS and CRVS)

1. RMNCAH-N situation

Overtime, Ethiopia has made remarkable progress in improving reproductive, maternal, child, and adolescent health and nutrition (RMNCAH+N). Since 1990, under-five and maternal mortality fell by 67 and 69 percent, respectively. According to the Ethiopia Demographic and Health Survey (EDHS) in 2016, the prevalence of stunting has decreased from 58 percent in 2000 to 38 percent, ranging from 15 percent in Addis Ababa to 46 percent in Amhara region. Between 2000 and 2016, the contraceptive prevalence rate of married women (any method) increased from 8 to 36 percent; the total fertility rate declined from 5.5 to 4.6 children per woman; and births attended by skilled attendants increased from 6 to 28 percent. This progress has been facilitated, in part, by the flagship Health Extension Program which enabled the delivery of high-impact, cost-effective basic services to all Ethiopians, particularly reproductive-aged women and children.

Another major stride in the health sector is the improvement in health service utilization by the lowest wealth quintile. The DHS 2005 shows that coverage of modern contraceptives among highest wealth quintile was more than eight times higher than that of the lowest quintile (33.7 vs. 4.0 percent) while the DHS 2016 shows that it is now about two times higher (45.7 vs. 21.9 percent). The flagship HEWP by targeting community has been acting as a pro-poor program contributing to reduce inequalities in the health system.

Despite these gains, challenges remain in ensuring access to quality essential RMNCAH+N services. For instance, although neonatal mortality is declining over time, the decline is at a slower rate than child mortality and continues to constitute a challenge. The per capita health expenditure increased from US\$5.6 to US\$28.4 between 1999/2000 and 2013/2014, potentially increasing domestic resources for health. However, out-of-pocket payments are higher (at 34 percent) than most other countries in the region and the proportion of the population enrolled in insurance schemes remains low such that impoverishing and catastrophic expenditures remain barriers to the use of essential RMNCAH+N care.

2. Value-added of the GFF / Investment Case priorities

Fostering donor coordination and alignment to the HSTP. The GFF platform exists in the current governance structures with the Joint Consultative Forum (JCF) and Joint Core Coordinating Committee (JCCC). The JCCC serves as the technical arm of the JCF. Technical Working Groups created by the JCF support the implementation of the Sector Strategy as well as sub-sectors including the RMNCAH sub-sector strategy. The GFF uses this existing governance and provide an additional opportunity to discuss results of the Health Systems Transformation Plan (HSTP-2015-2020, which serves as the Investment Case) and ensure the funding gap acknowledged in the HSTP is reduced.

Contributing to improve RMNCAH coverage as stated in the HSTP through DLI. GFF Trust Fund will purchase results for a set of RMNCAH achievements, including assisted deliveries, antenatal care, immunization, contraceptives, adolescent health services, and nutrition services. 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 HSTP-2015-2020. A cornerstone of the HSTP is the focus on 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. Certain DLIs purchase results for low-performing regions (Emerging Regions), putting an accent on equity concerns. 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.

Improving health information systems and data use, including civil registration and vital statistics (CRVS). The emphasis that GFF places on strengthening data systems to monitor and improve RMNCAH-N outcomes and facilitate access to and coverage of civil registration services led to support for the Federal Vital Events Registration Agency (FVERA). 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 in 2013. An improved CRVS system, together with DLIs related to HMIS reinforcement, will contribute to M&E of the HSTP.

Contributing to incremental changes in Health Financing: WB/GFF will support the health sector in setting the stage for long-term domestic resource mobilization (DRM) reforms. DLI on public financial management reform may enhance efficiency and free additional resources to close the HTSP funding gap. Financing-related DLIs include transparency of procurement process, timely financial audits reports and automation of the financial management system of the pharmaceuticals agency. Additionally, the WB/GFF is incentivizing the government in improving the functionality of CBHI and the expansion of its coverage through DLI. CBHI is another stepping-stone reform toward DRM.

3. Achievements in the last six months

In the first few months of implementation, Pfor disbursements have been achieved for DLIs related to institutional deliveries and community-based health insurance outcomes. Significant investments in nutrition and reproductive health are currently being made to meet the 2018 DLI targets for RMNCAH. With GFF support, Ethiopia is moving rapidly to scale-up and strengthen the (CRVS) system and support a Multi-sectoral nutrition program. This includes overall support to FVERA, transitioning 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 information technology strategy, system design, and procurement of required information and communication technology equipment is underway. A procurement implementation manual is being developed, with the technical support of the program.

In addition, the GFF is supporting a diverse and ambitious health financing portfolio in Ethiopia. Significant analytical work, training and capacity building is underway to support the government in the implementation of their new health financing strategy for UHC. Progress has also been made on private sector engagement in the health sector. A recent workshop, organized jointly with the Ministry of Health, brought more than 60 representatives from private sector, nongovernmental organizations, 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.

Key RMNCAH directives and strategies have been endorsed, including: quality standard for the PHCU facilities, postnatal care directive, and adolescent and youth health strategy. These key documents will serve as guidelines for the healthcare professionals and frontline workers, enabling implementation of programs meeting quality standards at all levels.

4. Anticipated results in the next six months

The Mid Term Review (MTR) of the HSTP will be conducted with the technical support of development partners including MDGP contributors and GFF. The main objective of this MTR is to assess the level of performance against the progress towards the expected results of HSTP; to draw best lessons from the accomplishments and challenges; and to guide and accelerate the progress of the health sector with the aim of achieving targets of HSTP 2020.

The second Public Private Partnership Dialogue will be held in April 2018 to enhance the dialogue between government and health private sector; and discuss how to improve the role of private sector in the health transformational plan and complement the government's effort.

The Standard Package of health services for schools will be finalized. This initiative is expected to complement the ongoing efforts to address Ethiopia's large bottleneck in primary health care by addressing reproductive and adolescent health, nutrition, and the WASH agenda.

A draft costed CRVS information technology strategy and system design will be finalized; procurement of key inputs will be initiated; and a fully functional Project Implementation Unit with 4 technical advisors will be in place.

GUATEMALA

IC period	National Strategy for Prevention of Chronic Malnutrition – 2016 to 2020
IC Financiers include	Not applicable (please see below)
Key technical areas	Multi-sectorial interventions to improve nutrition

1. RMNCAH-N situation

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. 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. Major drivers of maternal and child mortality include access to quality health services as well as access to safe water and sanitation. Slightly more than half of the population has access to primary health services, mainly due to the discontinuation of the Expansion of Coverage Program (Programa de Extensión de Cobertura, PEC) and only 63.9 percent of the population have access to improved sanitation facilities. Thus, poor sanitation remains a major driver of a high prevalence of diarrheal diseases and associated loss of nutrients.

The share of the government budget allocated to health (18 percent) in 2014 substantially exceeds the LMIC median (8.4 percent). However, the main challenge in Guatemala is that the country suffers from a particularly weak tax collection system; the General Government Expenditure/GDP ratio is the second lowest in the entire group of LLMIC. Thus, even if public health expenditures increased from 1.8 percent of GDP in 2007 to 2.2 percent in 2014, it is still insufficient and lower than the LAC average of 3.8 percent. Insufficient spending levels and funding flow bottlenecks, and low budget execution rates limit the coverage and quality of services and social programs in Guatemala.

2. Value-added of the GFF / Investment Case priorities

The Government already had a prioritized strategy to address key challenges related to RMNCAH-N when the GFF started to work in the country. Furthermore, the World Bank financed project, to which GFF's first buy-down is linked, supports the implementation of a prioritized National Strategy to Prevent Chronic Malnutrition 2016–2020 (NSPCM), which is an ambitious multisectorial strategy which seeks to reduce chronic malnutrition. Given this, it was agreed, that the NSPCM will serve as Guatemala's Investment Case.

The NSPCM 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 Government has requested support from the GFF to develop effective governance mechanisms to promote inter-sectoral and interagency coordination given the large number of line ministries and stakeholders involved. They have also requested targeted TA to (a) improve the governance of the water and sanitation sector by developing a series of instruments to strengthen water, sanitation and health sector coordination and (b) contribute to the operational design of the Ministry of Health's new Model of Care. This support is critical to ensure that the poorest segments of the people receive needed nutrition

and health services essential to achieve RMNCAH indicators. It will also be important to make sure that the trigger indicators for the GFF buy-down are achieved.

3. Achievements in the last six months

Although the IBRD/GFF Trust Fund-supported project was approved in FY17, implementation is currently on hold awaiting congressional approval, which was further delayed by changes in several Government officials including the Minister of Health. A new Minister of Health, Dr. Carlos Soto, was appointed in September 2017. In the past six months, the main achievement has been to redefine the GFF supported technical assistance program together with the new MOH team as well as GFF Partners. The program will focus on four key areas: (1) increasing efficiency and transparency in public spending by contributing to piloting a fiscal observatory in the health sector, improving drug procurement practices and building public financial management capacity to improve budget execution rates; (2) contributing to strengthening information systems and evidence-based policy making, by allowing effective tracking of health co-responsibilities in the conditional-cash transfer program and by starting to measure service delivery performance and quality of care at the health facility level; 3) strengthening all partners and government's efforts to improve integrated service delivery networks to contribute to the proper functioning of referral and counter-referral system across levels of care; 4) developing options for implementing universal health coverage through the development of a health financing strategy.

4. Anticipated results in the next six months

It is expected that teams from the Ministry of Health and partners are set up to work on three first focus areas of the TA program (focus area four will be implemented in years 2-3). Furthermore, although beyond the control of the GFF and the World Bank, congressional approval of the Project is expected for implementation to start.

GUINEA

IC period	2017 to 2020
Key technical areas	Health financing, community health

1. RMNCAH-N situation

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.

2. Value-added of the GFF / Investment Case priorities

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.

GFF support can add value in Guinea through: 1) Prioritizing and coordinating investments in RMNCAH service delivery; 2) Institutional strengthening in health care financing and planning; 3) Improving evidence-based decision making; and 4) Supporting WB/GFF project design and fast implementation. Strengthening institutional capacity in health care financing includes: i) building capacity, both through training of existing staff and the appointment of new staff in the Bureau of Strategy and Development (BSD); ii) strengthening public financial management together with development partners; and ii) developing a health financing strategy with all relevant partners. Initial steps with GFF support include undertaking a Health Financing System Assessment to inform a health financing workshop in 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.

3. Achievements in the last six months

- The BSD has successfully completed a first resource mapping exercise with support from the GFF. The results, as well as its continuation and institutionalization, were discussed in a three day workshop organized by the MoH March 21-23. The next step will be to provide a more detailed assessment of how all partners contribute and align to the government's Community Health Strategy. GF will also be supporting this effort going forward.
- A feasibility study has been finalized (with support from GAVI and GFF) on the options for establishing a joint implementation unit to better align external resources.
- The GFF co-financed IDA project is finalized and is expected to be approved in April 2018.
- The Government has drafted and budgeted the Community Health Strategy (supported by Global Fund and GFF). It lays out a practical vision for increasing the number of qualified community health workers, remunerating them and ensuring quality of the services being delivered. The Resource Mapping exercise highlights the variation in the approaches taken by the partners with respect to community health and can serve as a tool to increase alignment.

4. Anticipated results in the next six months

The following are expected in the next six months:

- Establishment of the joint implementation unit
- ToR for the Health Financing strengthening (\$2 million GFF financed) finalized, and closely aligned with EU's planned support to BSD
- Health Financing System Assessment completed
- Improved alignment of partners around the Community Health Strategy

KENYA

IC period	2014 – 2020
Key technical areas	Health financing, community health

1. RMNCAH-N situation

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. Neonatal mortality experienced a slow rate of decline in the last decade (33 percent), with more than 42 percent of deaths under five years of age occurring in the first month of life. In addition, more than one in four children under five are still stunted. The total fertility rate reduced to 3.9 births per woman after a decade of stagnation, but the maternal mortality ratio remains unacceptably high at 362 per 100,000 live births in 2014. Also, teenage pregnancy remains high with 18 percent of girls between the ages of 15 and 19 having begun childbearing. Moreover, there is considerable variation in health status by geographic and socioeconomic factors.

Both demand- and supply-side barriers hamper utilization and coverage of essential RMNCAH+N services. On the demand side key barriers include socio-cultural beliefs and practices, low status of women, high cost of services, and long distance to health facilities. Key supply side health system barriers include weak stewardship and evolving governance structures, weak management of human resources for health, and insufficient essential medicines and medical supplies. Weak health information and CRVS systems limit evidence-based decision making. In 2015, 65 percent of births and 45 percent of deaths were registered within six months of occurrence, with only 2 percent of deaths having information on causes of death certified according to International Classification of Diseases-10th (ICD-10) revision. Moreover, data from various HIS are not linked and platforms to inform evidence-based decision making are still limited.

In Kenya, Public expenditure for health accounted for only 2 percent of the GDP in FY 2013. Countries that have made progress to universal health coverage (UHC) spend public funds at around 5 percent of GDP, which is more than double the current levels of spending in Kenya. Out-of-pocket (OOP) payments remain the main source of health funding and push about 1.5 million Kenyans into poverty each year.

2. Value-added of the GFF / Investment Framework priorities

As one of the four GFF front-runner countries, Kenya has moved from the early phases of the GFF process to operationalization of the RMNCAH Investment Framework which identifies 20 priority counties. This includes implementation of prioritized interventions aligned to the RMNCAH 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 (THS-UCP) and Danida UHC Program. Key project activities underway in the last six months comprise the procurement of family planning commodities, the training of nurse midwives and preparation of integrated county annual work plans incorporating on-budget partner financing including THS-UCP and Danida resources.

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: (i) strengthen planning and budgeting for health at the county level;

(ii) provide support for sector resource mapping; and (iii) provide technical assistance and capacity building for new county teams following the recent election.

3. Achievements in the last six months

RMNCAH Technical Assistance multi-donor Trust Fund (TA MDTF): An exciting recent development is the establishment of a multi-donor Trust Fund for RMNCAH TA in Kenya. U.S. Agency for International Development has signed the agreement and discussions are underway with United Kingdom Department for International Development and Danish International Development Agency. The Trust Fund will provide timely, high quality technical assistance for county and national capacity building in support of the implementation of the RMNCAH investment framework.

RMNCAH Scorecard: MOH Division of Family Health, working closely with UNICEF and other technical partners, has now updated their RMNCAH Scorecard which aligns to the RMNCAH investment framework and is linked to DHIS2. The Scorecard will be used to monitor RMNCAH investment framework results. The new Scorecard was piloted in six counties (Homa Bay, Kakamega, Nairobi, Garissa, Turkana, Siaya) and all 47 counties were introduced and oriented to the Scorecard in December 2017. The Scorecard will be officially launched at the upcoming annual Kenya Health Forum in March, and at the Council of Governors Health Conference in April to generate high-level political interest and support for achieving RMNCAH results. With support from the RMNCAH TA MDTF, the MOH will undertake a full roll-out and training of key county-level officers on use of the Scorecard and use of RMNCAH data for decision-making beginning in May 2018.

Health Sector Resource Mapping and Tracking: MOH is now working with Clinton Health Access Initiative (CHAI) to develop an institutionalized health sector resource mapping and tracking system. The MOH Resource Mapping technical working group has been revived, and a one to two-day workshop is planned for mid-late March to define parameters and chart a way forward. THS-UCP will provide support for the hosting of a resource tracking dashboard on the MoH website.

Building county capacity for planning and budgeting: MOH and County Departments of Health (CDOHs) are in the process of developing annual workplans and medium-term (five year) plans for inclusion in County Integrated Development Plans (CIDPs). There is a wide disparity in the quality and content of county health plans and an urgent need to develop common guidelines and formats and to build skills at county level for health sector planning and budgeting processes. A number of related but disconnected initiatives are already underway supported by various partners working with CDOHs in different counties and these experiences and lessons learnt need to be pulled together to create a common framework. The RMNCAH TA MDTF will provide technical support to MOH and COG to take this process forward with sector partners and the Planning Working Group will be revived in March to begin discussions. The MDTF will also provide hands on TA to county governments which request support in planning and budgeting.

4. Anticipated results in the next six months

- RMNCAH Scorecard rolled out to all counties and being used to monitor progress against RMNCAH indicators and to inform decision-making on key actions at county management and service delivery levels.
- MOH Health Sector Resource Mapping and Tracking system in place and used in a first round to capture resources available for FY 2018-19 (and projected resources for three year MTEF timeframe), actual

expenditures for FY 2017-18, and, in the longer term, analysis of resource allocations against priorities to identify critical imbalances and gaps.

- Planning and Budgeting: new common guidelines and formats for counties to be in place by Aug/Sep 2018 for use in the planning and budgeting cycle for FY 2019/20.

LIBERIA

IC period	2016-2020
IC Financiers include	World Bank/GFF Trust Fund, USAID, Global Fund, UNICEF, WHO, UNFPA, Bill and Melinda Gates Foundation, Sweden, Government of Japan, GAVI
Key technical areas	Emergency obstetric and neonatal care (EmONC); Civil registration and vital statistics (CRVS); adolescent health; emergency preparedness, surveillance, and response; community engagement; leadership and governance

1. RMNCAH-N situation

Although Liberia achieved the Millennium Development Goal for child mortality, the under-five mortality rate is still high at 94 per 1,000 live births (2013), as is infant mortality (54 per 1,000 live births, 2013). Liberia's maternal mortality rate is among the highest in the world at 1,072 per 100,000 live births in 2013. Adolescents are a large part of the population and the high teenage pregnancy rate of 31 percent is a deep concern, while 55 percent of neonatal mortality occurs amongst infants born to mothers who are under 15 years. Many of Liberia's maternal and newborn deaths are caused by preventable and treatable conditions. However, there are critical shortages of skilled health workers, with Liberia having the lowest density of physicians in the world (14 MDs/1,000,000 population) partially due to an estimated loss of 8 percent of its health workforce during the Ebola crisis. In addition, Liberia experiences infrastructure gaps, equipment shortages, and frequent stock-outs of essential drugs and medical supplies. Finally, there are large geographical disparities in the coverage of quality health services that translate into significant regional variations in health indicators.

To improve population health and health equity, the Government of Liberia (GOL) is working towards Universal Health Coverage (UHC). The GOL is conducting further analysis on efficiency improvements, establishing a joint coordination unit in the Ministry of Health, and development of revolving drug fund. To facilitate further efficiency gains, the Ministry of Health plans to implement a population and needs-based resource allocation formula for distributing resources across counties. In addition, RBF, which is being implemented in priority counties, is a means to help develop strategic purchasing mechanisms.

Liberia has made remarkable strides in mobilizing domestic resources over the last decade to reach the Abuja target. In 2016/17, the country allocated 14.6 percent of its budget to health, which is likely to reach 15 percent in the coming years. However, allocation of health resources is not optimal as there is currently no correlation between the county's share of country population or health needs and per capita funding received from the MoH. Additionally, 50 percent of resources are allocated to hospitals and three quarter to curative care while the causes of deaths (diarrhea, ARI, TB, Malaria) could be addressed at preventive, community and Primary Healthcare levels. Finally, the average per capita income is only \$455 (2016) which severely constrains domestic resources for health, 45 percent of all health expenditures are borne by households, 47 percent of the population is unable to afford health services, and 40 percent of people are unable to access care because of distance.

2. Value-added of the GFF / Investment Case priorities

With Liberia's strong commitment to improving reproductive, maternal, newborn, child and adolescent health (RMNCAH), its health ministry welcomed the Global Financing Facility's (GFF) pragmatic, results-focused process, to prioritize high-return investments and actions, building on existing national plans. Aligned with the National Health Policy and Plan (2011-2021) goal of improved health status of the

population of Liberia on an equitable basis, Liberia's Investment Case (IC) accelerates strategies to improve essential health services in six remote counties with comparatively worse RMNCAH indicators and fewer resources. IC priority areas are: (i) quality EmONC including antenatal and postnatal care and child health; (ii) strengthening the civil registration and vital statistics (CRVS) system; (iii) adolescent health interventions to prevent mortality and morbidity during antenatal, childbirth, and postpartum periods, unsafe abortion, early and unintended pregnancy and sexually transmitted infections, and gender-based violence; (iv) emergency preparedness, surveillance and response, especially maternal and neonatal deaths surveillance and response (MNDSR); (v) sustainable community engagement; and (vi) leadership, governance and management at all levels. The Investment Case uses results based financing (RBF) as a primary means to achieve these priorities.

As implementation of the Investment Case has commenced, the GFF specifically adds value in Liberia by: i) Improving service delivery quality, and facility/county functionality and efficiency, through primary and hospital level RBF; ii) Improving data and analyses for decision making to help government and partners to prioritize, implement, and course correct; iii) Contributing to the development of adolescent health services; iv) Building resilient health systems through Community Health Assistants and Emergency Preparedness and Response; and v) Stepping stones towards UHC and establishment of Liberian Health Insurance in the longer term.

The GFF in Liberia broadly contributes to building resilience, improving capacity, and establishing strengthened policies and systems. These broader health system impacts are particularly important given Liberia's fragile context.

3. Achievements in the last six months

The Government, under leadership of the director of the Ministry of Health's Family Health division, recently had a partner meeting to review progress on Investment Case implementation. The meeting showed progress in RMNCAH IC implementation particularly in implementing maternal and neonatal death reviews, emergency obstetric and neonatal care (EmONC) upgrading, and efforts to improve EmONC quality. However, not all partners participated in the meeting. In addition, there are gaps in IC implementation, with some priority investments and priority geographic areas not covered by current programs.

The Ministry of Health finalized performance based financing (PBF) indicators to operationalize the RMNCAH Investment Case, which aligns financial support from USAID as well as the World Bank/GFF. Recruitment for a Technical Assistance Agency to build capacity of the County Health Teams in three of the six priority counties (Gbarpolu, Rivercess and Sinoe) is currently ongoing. USAID has continued its support for PBF in three counties (including IC priority county Grand Bassa) where the Maternal Child Survival Program (MCSP) supports integrated management of childhood illness (IMCI), immunization, and RMNCAH services as well as supportive supervision, facility upgrading, and staff training. Contracting of secondary hospitals in 6 counties (including IC priority county Sinoe) has commenced to enhance quality of care with support from the World Bank.

The Ministry of Health has initiated hospital-level performance based financing in six hospitals to improve maternal, neonatal and child care. Hospital PBF focuses on improving key hospital level services, aligned with the RMNCAH IC, and is financed by IDA and the Health Results Innovation Trust Fund (HRITF).

The Ministry is furthermore recruiting an agency to carry out the baseline survey for the adolescent health pilot which will explore innovative approaches to improving adolescent health, a key priority in the RMNCAH Investment Case which has been underserved in Liberia.

In 2017, UNICEF completed the first phase of support to counties for the Community Health Assistant (CHA) program, under MoH leadership, with World Bank support throughout Grand Kru, Maryland, River Gee, and Sinoe counties and in four districts of Grand Gedeh County, which ran from July of 2016 to December of 2017. This program showed impressive results including an increase in the number of women referred to health facilities for deliveries by CHAs and trained traditional midwives (TTMs) from 1,489 to 12,387 and an associated increase percent of women delivering in health facilities from 33 percent at the 2015 baseline to 87 percent in December of 2017. Similarly, the program showed improvements in child health with an increase in post-natal care for newborns from 15 percent in 2015 to 43 percent in 2017 and an increase in the percent of children under five with suspected acute respiratory infections (ARI) treated with antibiotics at the community level from 13 percent to 22 percent. In four of the five counties, the program was managed by NGOs and in Grand Gedeh it was managed by the County Health Team (CHT). Strong results from Grand Gedeh show that CHT management of the CHA program can create health improvements through a sustainable CHA program. Going forward, the CHT-managed CHA model will be implemented in other counties. In late 2017, capacity assessments were conducted in Maryland, River Gee, Grand Kru and Sinoe to support the transition to CHT management of the CHA program.

Partners support and implement the CHA program as follows: GFTAM supports implementation by Plan International throughout Bomi County and in parts of Lofa County, Margibi County, and Nimba County; USAID supports implementation by PACS Project in parts of Bong County, Montserrado County, Bomi County, Grand Bassa County, Lofa County, Margibi County, and Nimba County. Last Mile Health implements and supports the CHA program throughout Rivercess County and in parts Grand Gedeh County and Grand Bassa County. Portions of four counties remain unfunded including three out of five districts in Gbarpolu County and four out of eight districts in Grand Bassa County, both IC priority counties.

Plan International, Maternal Child Survival Program, and Last Mile Health also support the CHA program in other counties with support from the Global Fund for Tuberculosis, AIDS, and Malaria (GFTAM) as well as USAID. Last mile health also supports the CHA program nationally, including support for CHA training.

USAID and the GFTAM have provided support for a single supply chain management warehouse as well as support for integrated drug distribution and strengthening of the supply chain system.

A number of other partners have provided support for specific aspects of the RMNCAH Investment Case. WHO has built six maternity waiting homes, four of which are in IC priority counties. The Public Health Initiative of Liberia supports antenatal and postnatal care referral as well as child health in two IC priority counties: Rivercess and Grand Bassa. The Liberian Board for nursing and midwifery provides support for EmONC nationally, including monitoring EmONC implementation and support for national EmONC guidelines.

The government has finalized its second round of resource mapping which reviewed commitments towards IC implementation. While resource mapping showed substantial commitments towards RMNCAH, it also found that 29 percent of donors' investments in RMNCAH are not aligned with the Investment Case along with financing gaps in key priority counties. In addition, 7 percent of financiers

and 51 percent of non-governmental organizations (NGOs) did not respond to the Government's resource mapping survey.

County Platform meetings involving the six participating counties have been held. This is a key step towards engaging priority counties in implementing the RMNCAH Investment Case as part of their planning process.

4. Anticipated results in the next six months

In recognition of the need to further support the role of the country platform to oversee Investment Case implementation, including data use for decision making, as well as support analytical work related to the health financing agenda, the GFF will support a liaison person in Country. The MoH is also intending to engage an M&E Officer to provide specific support for monitoring the RMNCAH Investment Case implementation.

Readiness funds will be provided in three of the six Investment Case priority counties (Rivercess, Gbarpolu, and Sinoe) to prepare for the PBF program which is expected to start in July 2018. The focus is on improving the quantity and quality of key RMNCAH services as well as the management capacity of the County Health Teams, which oversee the facilities, in these underserved counties. In addition, the GFF will provide support to operationalize the country's CRVS system in these underserved counties.

In January of 2018, an agreement between UNICEF and the MoH became effective for UNICEF to support CHT implementation of the CHA program in three southeastern counties: Grand Kru, Grand Gedeh and RiverGee. In addition, Consiel Sante, an NGO, is contracted to implement the CHA program in two additional counties, Gbarpolu and Grand Cape Mount, with World Bank support. Three of these six counties (Sinoe, Rivercess, and Gbarpolu) are priority counties from Liberia's RMNCAH Investment Case. Implementation of the CHA program in these counties is ongoing. USAID, Last Mile Health, and GFTAM's support for the CHA program will also continue.

MOZAMBIQUE

IC include	GOM, IDA/GFF, Multi donor TF (Netherlands & Canada), PROSAUDE (Switzerland, Ireland, UNICEF, UNFPA, Spain) and Single donor TF (USAID). In addition, several partners DFID and USA also channel money through e.g. NGOs or UN agencies.
Key technical areas	<p>Supply side: 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.</p> <p>Demand side: family practices and cultural norms that require a multi-sectoral approach and community-based interventions to address vulnerable groups (e.g. adolescents), considering inequalities of gender, geography, education, income, and other vectors.</p> <p>Health financing: increasing share of government budget to health, increase health expenditure in lagging behind districts and provinces</p>

1. RMNCAH-N situation

Over the past two decades, Mozambique has achieved mixed progress in improving health outcomes and expenditure efficiency. Advancements have resulted in improvements in access to health facilities and community-based interventions, as well as increased demand for care, and improvements in other health determinants. However, results have been uneven, particularly for those in rural areas and the poorest quintiles, and for women and children. Sixty-two percent of causes of death in 2015 were associated with communicable, maternal, neo-natal and nutritional diseases. Related indicators that compare poorly in the region and show little sign of improvement include: the percentage of women whose needs for modern contraceptives are met; neo-natal death rates; and the percentage of skilled attendants at birth. Similarly, Mozambique's high fertility rate is associated with poor pregnancy outcomes and over the last 2-3 decades, high levels of stunting have remained unchanged. High and increasing rates of adolescent fertility are correlated with increased risk of maternal death and other lasting complications such as fistulae. And on average, 43 percent of children under five are stunted, with higher concentrations in the northern and central regions. Its costs include poorer education outcomes, lower productivity and income, and higher health care expenses.

Furthermore, quality of and demand for care remain a challenge at the primary level. Provider competence is weak and adherence to clinical guidelines is low. High levels of dropout for DTP3 immunization show little continuity in care delivery over time. Thus, demand for care is affected by both low perceptions of quality and difficulties in access.

Mozambique's level of per capita health expenditure lags behind sub-regional and regional averages. Country comparisons in the Health Public Expenditure Review (PER 2015) highlight that Mozambique could achieve more with its current spending. In the current context of fiscal pressures, increasing efficiency and protecting pro-poor spending for human development are critical.

2. Value-added of the GFF / Investment Case priorities

The Investment Case prioritizes increasing the readiness and effectiveness of care providers (particularly at primary level and more specifically in 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 multi-sectoral 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 the US and the Netherlands, was approved on December 20, 2017 by the World Bank Group (WBG) Board will link disbursements to priorities in the Investment Case. Disbursements are linked to the achievements of a set of 11 Disbursement Linked Indicators (DLIs) established jointly with the Ministry of Health and its Health Partners as well as the Ministry of Economy and Finance. 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).

3. Achievements in the last six months

An important milestone was the WBG Board approval of the \$105 million equivalent in non-reimbursable grants for the *Primary Health Care Strengthening Program* in support of the Investment Case in December. Prior to approval, there was a major push to finalize the DLIs. Under the leadership of the GOM and supported by development partners, more than 100 people 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. Since the approval, activities are focusing on advancing implementation readiness of the Program to further advance the implementation of the Investment Case. These include mapping of technical assistance (TA) and staff needs to implement the IC, advancing in HP coordination by e.g. better coordinating existing and future TA and thereby reduce existing fragmentation and duplication, preparing decentralization plan for the IC (thinking through planning, budgeting, and incentivizing change at the provincial level) and finalization of the Program Operation Manual and prepare for verification of results and other processes and the hiring of the GFF Liaison Officer Work is also ongoing to determine if any adjustments are needed in the country platform and existing processes of dialogue to effectively monitor progress and implementation of the IC.

4. Anticipated results in the next six months

In the next six-month readiness of implementation will improve and we anticipate seeing increased activities in the provinces with resulting initial progress in achieving the first year DLI targets. At the central level, we foresee adjustments to the country platform and existing process of dialogue to create an even more inclusive (yet efficient) structure that has progress monitoring of the IC implementation at its core. Furthermore, the GFF will also support 1) the piloting of a **Fellowship program** to strengthen local capacity

in planning, health financing and policy evaluation by fostering stronger links between GOM and local as well as international universities, and 2) support the GOM to **improve the Public Financial Management (PFM) system**, and to recommend required reforms to track expenditures in a more meaningful way. This line of work will contribute to improve monitoring of expenditure shifts over time, e.g. towards primary care and in lagging districts, as recommended in the IC. Furthermore, GOM and partners are exploring 3) increasing **private sector involvement** to improve last-mile delivery of drugs. We expect increased activities in these three areas with clear work plans developed at the end of the six months period.

MYANMAR

IC period	National Health Plan 2017 to 2021
IC Financiers include	TBD
Key technical areas	TBD

1. RMNCAH-N situation

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 six months (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 and displacement, health financing, fragmentation in service delivery, human resources, the state of physical infrastructure, and lack of quality HMIS systems.

Myanmar is still in the initial phases of the GFF process. 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. In addition, Government of Myanmar has established a Sector Coordination Group on Nutrition, which will be the platform for the oversight of the development and implementation of a costed prioritized Multi-sectoral National Plan of Action for Nutrition. This Plan of Action is expected to be completed in June 2018.

The country has a complex operating environment with ongoing conflict and displacement in many parts of the country and with a history that continues to influence the situation today. Health financing in the country is fragmented, with a large majority of external support being off-budget. Additionally, the organization of the Ministry of Health and Sports (MOHS) is being reassessed.

2. Value-added of the GFF / Investment Case priorities

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, which 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 a GFF Liaison Officer to improve coordination and collaboration among the various programs (within MOHS and 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.

Furthermore, MOHS has committed to developing a village-based health workforce policy to address the challenges associated with a fragmented and externally financed community health volunteers. The need to extend RMNCAH+N services to women and children, particularly in remote and hard to reach areas, is vast and urgent. GFF would provide value-added in supporting MOHS to develop sustainable financing for an integration of community health workforce into primary health care.

3. Achievements in the last six months

A RMNCAH+N focal point has been named by the Government to enhance the support to the operationalization of the country-led platform. Some delays are being experienced in the timeline for the preparation of a proposed IDA-financed 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 being reviewed. In addition to the implementation of the National Health Plan, the proposed additional financing of IDA and GFF Trust Fund is intended to assist the medium and long-term health systems needs in conflict affected areas.

4. Anticipated results in the next six months

The following results are expected in the next six months:

- Approved workplan of the Country Led RMNCAH Platform.
- Findings on cross cutting issues and gaps in service delivery and financing from review of national plans and strategies to improve RMNCAH outcomes.
- Proposal on financing a sustainable and integrated community health workforce.

NIGERIA

IC period	2017 to 2030
Financiers include	Bill and Melinda Gates Foundation, World Bank, Dangote Foundation, Power of Nutrition
Key technical areas	Domestic resource mobilization, results-based financing in facilities for a package of RMNCAH-N services, community-based delivery of nutrition services, with a particular focus on adolescents and their children. Private sector engagement. Advocacy for RMNCAH+N financing

1. RMNCAH-N situation

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 lack of focus on high impact interventions for RMNCAH+N which addresses the bulk of disease burden means that health expenditures are largely for curative rather than preventive care. Health worker deployment, productivity, and inadequate knowledge contribute to poor performance. There are virtually no community-based health programs delivered by the government. This points to opportunities for improving efficiency and outcomes from better resource allocation, training, and provider incentives.

2. Value-added of the GFF / Investment Case priorities

The overarching GFF approach in Nigeria supports the mobilization of additional resources for health care at the front lines -- in primary health care centers and through community-based approaches; thus emphasizing a combination of domestic resource mobilization through the operationalization of the Basic Health Care Provision Fund (BHCPF) and seeking efficiencies in service delivery through results-based approaches in facilities and community-based delivery modalities. Furthermore, it mobilizes the Nigeria private health sector for financing and service delivery.

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. The GFF is facilitating the piloting (including evaluation) of the implementation of the BHCPF in 3 States in Nigeria, with a view to establishing the implementation arrangements for the BHCPF, as well as creating a financing mechanism to facilitate pooling of donor resources to match domestic resources, in order to scale up in the remaining states and creating a strong advocacy platform for the implementation of the BHCPF.

The efficiency agenda is being pursued on two related tracks: i) through a performance based financing approach to contracting largely private health facilities for the delivery of a prioritized package of RMNCAH-N services in the fragile areas of the North East that were affected by the Boko Haram insurgency; and ii) through performance-based contracting of non-state actors to deliver largely at community-level a basic package of nutrition services, with a particular focus on adolescents, in 12 high stunting burden states across the country. The Investment Case adopts a phased approach with a strong equity focus and giving priority to innovations, including a strong focus on harnessing the capacity of the private sector.

3. Achievements in the last six months

Over the past six months, with the Federal MOH in the lead, the RMNCAH+N Investment Case has been finalized and approved by the Federal Minister of Health in March 2018. The Investment Case 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).

Although the Investment Case was finalized only recently, implementation in the five northeast states began on an emergency basis in June 2017 with an initial \$20 Million of GFF Trust Fund resources co-financing a World Bank-financed operation. The delivery systems have been established and the approach has been gradually scaled up to an increasing number of local government areas.

A second tranche of \$21 Million of 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. 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 for World Bank approval by the end of August 2018. It is noteworthy that the BMGF has committed an additional \$2 Million to support the startup phase.

An additional tranche of \$10 Million of GFF Trust Fund resources has been committed to the Government of Nigeria's national nutrition project called "Accelerating Nutrition Results in Nigeria (ANRIN), which focuses on the delivery, largely through non-state actors, of a basic package of nutrition services at community level in 12 high burden states. The World Bank project is scheduled to be presented to the Board at the end of June 2018.

4. Anticipated results in the next six months

The next six months in Nigeria will be a critical period for the GFF engagement and for primary health care and nutrition more generally.

- i. The GFF TF resources have been positioned largely as a leverage to move Government into action to implement the Basic Healthcare Provision Fund which has been unfunded since it was signed into law in 2014. The articulation of the use of GFF resources for three states has spurred decision makers to implement the BHCPF – it is expected that at least half of the expected 55B Naira (approx. \$150 Million) will be appropriated for the BHCPF in the coming months.
- ii. It has been agreed that further work will be invested in refining the GFF Investment Case into a second version that will include financing from a wider group of donors and a more robust results framework and results monitoring system.
- iii. The projects that will finance the piloting of the BHCPF and the scaling up of community-based nutrition interventions are both expected to be approved in the next six-month period. A Trust

Fund to support the implementation of the nutrition project is expected to create a platform (with Bill and Melinda Gates Foundation and Dangote Foundation as founding donors) which other partners in nutrition are expected to join.

- iv. The investment in the North East is expected to continue to generate additional results over the next six-month period.
- v. Additional engagement with the private sector, including financing of the three innovations outlined in the Investment Case, is anticipated.
- vi. The work to broaden the financing base of the Investment Case should also help to strengthen the GFF platform.

This period will be marked by the lead up to the Presidential elections scheduled to take place in February 2019 – the launching of the BHCPF in the three states ahead of this time will allow for UHC to be high on the election agenda.

SENEGAL

IC period	2018 to 2022
IC Financiers include	WB, USAID, GAVI, Global Fund, JICA, UNICEF, AFD, UN agencies
Key technical areas	Demand-side Financing (community-based interventions, community based health insurance), human resources, supply chain, quality of care, Adolescent health, governance

1. RMNCAH-N situation

While Senegal has seen substantial progress in infant mortality over the last decade, more needs to be done to accelerate reductions in stunting and neonatal mortality. The country has made tremendous strides in diminishing infant and under five mortality rates, which respectively decreased from 61 to 33 and 121 to 54 deaths per 1000 live births from 2005 to 2015. Yet, nutrition progress is mixed: While Senegal has one of the lowest stunting rates in Africa (i.e., 17 percent in 2016), the prevalence of underweight children only decreased from 14.2 percent in 2005 to 12.6 percent in 2014 (DHS, 2005; 2014). Furthermore, the neonatal mortality rate has seen only a small decline, compared to the under-five and infant mortality rates, from 35 deaths per 1000 in 2005 to 21 in 2016, (DHS).

Improvements in maternal health are modest with malnutrition being a major risk factor in maternal mortality (over a fifth of all maternal deaths are associated with undernutrition). Similarly, the rate of births assisted by trained personnel remains low at 59 percent (DHS 2016) with large geographic and socioeconomic disparities: skilled birth attendance rate is 45 percent in rural areas versus 82 percent in urban areas. Modern contraceptive prevalence, however, showed marked improvement from 10 percent in 2010 (2005 DHS) to 23 percent in 2016 (2016 DHS), but not among the adolescent population: less than 2 percent of adolescents have access to modern contraception and 38 percent of adolescent girls marry before the age of 18 (DHS 2015).

Senegal has accomplished important strides in improving financial protection with the development of a prepayment system, which contributed to the gradual fall in OOP payments for health. Yet, national resources for the health sector have slowed down, threatening the achievement of Universal Health Coverage (UHC). Since 2005, the share of GGE spent on health has decreased from 12.1 percent to 8.0 percent in 2014. In 2014, the GGHE/GGE ratio was below the median of L-LMICs of 9.7 percent. 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.

2. Value-added of the GFF / Investment Case (IC) priorities

The GFF provides added-value in Senegal by:

- Supporting the expansion of demand-side financing mechanisms in the prioritized regions of the IC (Universal Health Insurance among others)
- Scaling-up high-impact interventions to improve efficiency and RMNCAH results through the IC;
- Piloting adolescent health interventions
- Fostering coordination among partners (governance) by: i) making the GFF Platform an effective donor coordination mechanism, ii) financing P4H Coordinator supporting the MOH overseeing health financing reforms in Senegal, iii) supporting the development of a unique work plan leading to a virtual pooling of external resources by the MOH to support the funding of the RMNCAH-N package on the long-term

- Providing innovative and sustainable funding to reach UHC by: i) Supporting the Civil Society in developing an advocacy note on DRM and feasibility study on DRM at decentralized/regional level; ii) Supporting a feasibility study on earmarked tax for health; and iii) Fostering efficiency (part of workplan of the Health Financing Strategy)
- Financing processes allowing interoperability between the DHIS2 and the CRVS system of Senegal

To improve the coverage of RMNCAH-N services to the population, the IC focuses on tackling the top three impediments to effective coverage which are clinical quality, financial access, and cultural acceptability. Factors such as weak performance of healthcare workers and unequal geographic distribution of the health workforce limit quality of care. Similarly, cultural norms negatively impact essential interventions such as family planning and anti-natal care. As a result, the IC focuses on the four priority areas: 1) Enhanced financial access to and socio-cultural acceptability of the RMNCAH package through demand side financing; 2) Improvement of adolescent health through multi-sectoral approaches; 3) Strengthening of health supply by scaling up high-impact human resource and supply chain interventions to address low RMNCAH service coverage; and 4) Strengthening of the health system governance.

3. Achievements in the last six months

Achievement in the last six months relate to processes aiming at finalizing the IC given that GFF Trust Fund cannot start operationalizing without the final IC. Final validation workshop of the IC is planned April 2018 after which the GFF TF will be able to start disbursing against priorities of the IC.

- **Finalized prioritization of the Investment Case and solidification of donor coordination:** The process of developing the Investment Case is very inclusive in that the GFF Platform, including civil society, donors, government representative and private sector have been meeting several times to review the workplan of the IC, including its costing and resource mapping. Financiers and UN organizations are particularly interested in yielding a detailed resource mapping in order to be able to fill out potential gaps in their next budget cycle. That process has solidified donor coordination and dialogue between ministries of finance and health.
- **Draft costing and resource mapping of the IC**
- **More structured civil society setting basis for monitoring the implementation of the IC:** a civil society GFF platform was formally constituted early 2018 to be a key partner for achieving objectives of the IC
- **The health financing strategy was finalized mid-2017 and was followed by a high-level forum on health financing in November 2017 (chaired by the President of Senegal).** The IC is aligned with the DRM and efficiency agenda of the HFS and HFS workplan.

4. Anticipated results in the next six months

In the next 15 months, \$5M from GFF TF will be disbursed as part of the restructuring of the current WB/IDA project (Health and Nutrition Financing) which will be allocated to some priority interventions identified in the GFF Investment Case such as : (i) support for Universal Health Insurance, especially for coverage of the poorest populations; (ii) strengthening health service delivery/supply side interventions, including supporting the transition of the IPM model (supply chain), as well as strengthening the availability of quality human resources for health and delivery of a comprehensive RMNCAH package with increased quality (training, supervision, inputs for reproductive health); (iii) implementation of pilot adolescent health interventions, and (iv) support to health financing reforms.

Preparation of a new WB/IDA operation will be accelerated (Board Q2 FY19) including \$10M GFF TF and will be based on the priority interventions and regions of the validated GFF IC.

SIERRA LEONE

IC period	2017 to 2021
IC Financiers include	Government of Sierra Leone, DFID UK, World Bank and GFF TF (pending), UNICEF, USAID, JICA, KFW, GFATM, GAVI, Italian Government, PIH
Key technical areas	Health system strengthening, antenatal care, emergency obstetric and newborn care, nutrition, family planning, health information systems, health financing (DRM, efficiency)

1. RMNCAH-N situation

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. In 2015, Sierra Leone had a maternal mortality ratio of 1,360 per 100,000 live births and an under-five mortality rate of 120 per 1,000 live births. Teenage pregnancies are common and adolescent deaths constitute nearly 25 percent of the total maternal deaths in the country (DHS 2013). As with maternal deaths, more than half of all childhood deaths are preventable with access to key interventions. Although coverage rates of some high-impact and cost-effective reproductive, maternal, newborn, child and adolescent health (RMNCAH) interventions are high, there are large geographical inequalities. Thus, in the 2013 Demographic and Health Survey, the prevalence of measles vaccination nationally was 79 percent, but ranged from 55 percent in the Western Urban Area District to 93 percent in Bonthe District. There are also persistent deficits in quality of care and efficiency of resource use in the health system. The 2013 Ebola outbreak further weakened the public health system and was associated with a 15- to 25-percent drop in RMNCAH service use.

Although total expenditure on health per capita in Sierra Leone (US\$ 96 in 2012) is one of the highest in West Africa, health outcomes do not compare favorably with other countries at similar levels of development. Out-of-pocket expenditures (OOP) are high (estimated to represent around 70 percent of total health expenditures, based on a 2012 household survey), however there is no reliable recent survey data to assess trends, distribution and determinants of out of pocket payments and catastrophic payments. Initial analysis shows OOP are mostly driven by hospitalizations and by drugs obtained from the private sector (drugs account for over 60 percent of outpatient spending per SLIHS 2011). Despite the Free Healthcare Initiative (FHCI), a government initiative that exempts pregnant and lactating women and children under five from paying for health services, monetary cost is still an important barrier for women, children and adolescents accessing treatment.

2. Value-add of the GFF / Investment Case priorities

In the fragile context of post-Ebola Sierra Leone, the country has developed an RMNCAH strategy to enhance investments and improve RMNCAH outcomes, including through multi-sectoral approaches. Extensive consultations and engagement with the government and development partners identified key areas to progress on RMNCAH+N. The RMNCAH Strategy developed by the Government of Sierra Leone includes the following four objectives: i) strengthening health systems, with a focus on improving human resources for health, supplies, infrastructure, emergency referral services, safe blood supply, and governance; ii) improving the quality of RMNCAH services delivered, particularly focused antenatal care, emergency obstetric and newborn care, integrated management of childhood illness, immunization, nutrition, family planning, prevention of teenage pregnancy, and promotion of safe water, sanitation, and hygiene; iii) strengthening community engagement, including integrated community case management; and iv) improving health information systems.

Global Financing Facility (GFF) support is particularly focusing on improving coordination and alignment between donors, ministries, and implementing partners in the health sector through the development of a prioritized and realistic implementation plan that accounts for available resources and capacity constraints. 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: i) the key drivers of inefficiencies in the health system (by rightsizing the public health service delivery system and by improving quality of care); and ii) enhancing access to services for the poor, specifically for medicines. With financial resources from Bloomberg Fund, support has also been provided on analytical work related to domestic resource mobilization for health (through tobacco taxes);

The GFF approach links discussions on RMNCAH+N service delivery to those on health financing, by supporting a redesign of the current performance-based financing program to address key determinants of inefficiencies and by trying to foster better integration of performance-based financing and the envisaged Sierra Leone Social Health Insurance (SLeSHI) scheme. The World Bank and the GFF team are supporting the government to develop a Health Financing Strategy which will guide a holistic vision of health financing for improved health outcomes.

3. Achievements in the last six months

The Ministry of Health, with support from the GFF Secretariat and partners such as WHO, have put together the first draft of the implementation plan for the RMNCAH Strategy. The information gathered thus far encompasses commitments from all the major funders of RMNCAH activities in Sierra Leone and gives a good picture of those activities from the RMNCAH Strategy which have been or will be carried out by partners. The implementation plan as such shows which of the highest priority activities have been committed to, and which have not, enabling discussions with possible financiers and implementing partners to support the currently uncovered priority activities.

One of the approaches to support implementation of the integrated RMNCAH quality services included in the Strategy is through a refined performance-based financing approach to commence in the two first phase districts of Kailahun and Koinadugu, with further roll out envisioned as part of the upcoming World Bank/GFF project. This approach will include support to Community Health Worker program as well as support to strengthening Emergency Obstetric Care in core facilities.

The World Bank and GFF Secretariat have also been supporting the government to develop a health financing strategy. The World Bank and GFF have catalyzed the development of the health financing strategy, playing a convening role to promote the involvement of the Ministry of Finance in this important process. This process is receiving attention from the highest levels of the Ministries of Health and Finance. The situation analysis, which will inform the priority reforms in the Health Financing Strategy is based on analysis done with support from the GFF Secretariat and other partners, such as WHO, during 2017. A draft terms of reference for the establishment of national steering and technical committees has been prepared. Stakeholder discussion of the draft terms of reference will take place when a new government is in place.

4. Anticipated results in the next six months

The implementation plan for the RMNCAH Strategy will be finalized in the near future. Activities within the implementation plan have already started. The next step is to develop a monitoring framework and

dashboard to track the progress of the implementation plan over time. The GFF Secretariat has offered to support this work, together with other partners in the country. Work will also be underway to develop the additional financing from the GFF TF and IDA which will increase the funding to implement the RMNCAH Strategy in Sierra Leone.

The Health Financing Strategy development and implementation constitute an important process. The Strategy will be developed over the next months. A completion time has not been set, however it is expected that this will be finished by the end of the calendar year, and the government stands ready to implement it as soon as it is ready.

Part of the vision for health financing and for service delivery is operationalizing performance-based financing in the two districts. The goal by the Ministry of Health is to complete the design by the end of May 2018, and to start implementation shortly thereafter.

TANZANIA

IC period	One Plan II – 2016 to 2020
IC Financiers include	Government of Tanzania, USAID, PEPFAR, World Bank IDA, GFF Trust Fund Canada, Power of Nutrition, DANIDA, Ireland, Switzerland, UNFPA, UNICEF, WHO
Key technical areas	quality of care, child health, emergency obstetric and neonatal care (EmONC), family planning, adolescent health

1. RMNCAH-N situation

Tanzania has made steady progress in reducing mortality among children, but still faces challenges in maternal health, family planning, and child nutrition. The infant mortality rate decreased from 51 per 1,000 live births in year 2010 to 43 in year 2015. Similarly, under-five mortality rate decreased from 81 per 1,000 live births to 67 between year 2010 and 2015. Stunting is persistently high (42 percent among children under five years of age), affecting over 3 million children (2010). The maternal mortality ratio (MMR) increased from 454 per 100,000 live births to 556 during the same period and total fertility rate (TFR) remains high, at 5.2 in 2015.

Poor maternal health indicators are partially a result of low maternal health service coverage: in 2015, only 51 percent of pregnant women had four or more ANC visits, and only 64 percent of births are attended by a skilled birth attendant. Sixty-five percent of Tanzania's maternal mortality is attributable to causes that could be prevented through facility births by a skilled provider. Addressing high maternal mortality is a national priority.

Other health system constraints include 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.

Although government expenditure for health as a percentage of general government budget is relatively high (12 percent), government expenditures as a percentage of total health expenditure is relatively low (21 percent). Despite strong GDP growth, revenue collection is low, limiting overall government resources for health. In addition, Tanzania is dependent on fragmented and largely off-budget external support for up to 48 percent of total health expenditures (THE). Household expenditures account for 27 percent Tanzania's THE.

The government of Tanzania developed a health financing strategy to further enhance the sustainability of the RMNCAH+N interventions as well as to mobilize and harness domestic resources and complementary financing. This strategy particularly emphasizes (1) the creation of a fiscal space through efficiency gains; (2) the alignment of partners around prioritized investments; (3) the leveraging of private sector resources; and (4) the expansion of performance-based financing to enhance quality, cost-effectiveness, and sustainability

2. Value-added of the GFF / Investment Case priorities

Tanzania's National Roadmap and Strategic Plan to Improve Reproductive, Maternal, Newborn, Child, & Adolescent Health (2016 – 2020) serves as the RMNCAH+N Investment Case. It aims to i) strengthen

service delivery for maternal health; ii) scale-up coverage of child health and nutrition services including infant and young child feeding interventions; and iii) address cross-cutting issues including community involvement in RMNCAH+N services. Service delivery reforms focus on improving performance, governance and accountability in primary health care; enhancing equity in skilled health worker distribution in nine regions with absolute shortages; improving essential commodity supply via governance, procurement and inventory reforms; and improving 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.

The GFF adds value in Tanzania by making key investments in RMNCAH priorities to significantly improve RMNCAH services in line with One Plan II. With implementation of One Plan II having started, the GFF aims to further contribute by: i) Strengthening systems for RMNCAH results measurement, including CRVS and RMNCAH scorecard, and use of data; ii) Strengthening the RMNCAH Technical Working Group to improve coordinated implementation and monitoring of One Plan II implementation; iii) Expanding opportunities to engage the private sector in the health system; iv) Strengthening health financing through strengthened links between the Ministry of Health and the Ministry of Finance as well as the development of sustainable health financing institutions; and v) Making key investments in RMNCAH priorities to significantly improve RMNCAH services in line with One Plan II.

The World Bank/GFF supported Primary healthcare for Results (PHCforR) program in Tanzania is fully aligned with One Plan II and was approved by the Board in May 2015 with \$200 million from IDA, \$40M from GFF TF, \$46M from USAID and \$20M from the Power of Nutrition Trust Fund. The program uses key performance indicators to track and disburse financing linked to results at all levels (national, regional, district and facility) related to improved quality RMNCAH service delivery as well as institutional strengthening. The Health Basket Fund (with financial support from Canada, Denmark, Ireland, Switzerland, UNFPA, UNICEF and World Bank) specifically focuses on financing district/local government level.

3. Achievements in the last six months

The Government (led by Ministry of Health and President's Office- Regional Administration and Local Government) recently invited partners to review progress in implementation and alignment of One Plan II. The share of health in total government budget has increased from 8 percent to 9 percent. One Plan II is not yet fully funded though- although gaps were found in information on partner activities supporting One Plan II. The GFF will support Government in partner resource mapping to improve alignment around Tanzania's Investment Case.

A review of key health indicators included in One Plan II's results framework found positive progress for most indicators: institutional deliveries increased from 64 percent to almost 70 percent and women attending ANC receiving at least two doses of intermittent preventative treatment (IPT2) for Malaria increased from 34 percent to 60 percent. However, not all indicators are progressing as expected: the percentage of women who attend at least four antenatal care visits is currently at 41.8 percent compared to 35 percent in 2015. Government is exploring, through further analysis and field level exploration, the need for any corrective actions to attain the results envisioned. This analysis and review is supported by the GFF and World Bank as part of the mid-term review for the PHCforR program.

In addition, the Vice President's office is in the process of launching an RMNCAH scorecard to help achieve Tanzania's priority to reduce the high maternal mortality rate and improve maternal, child, and newborn

health. The government, with support from the GFF and the World Bank, are in the process of aligning this scorecard with Tanzania's RMNCAH Investment Case (One Plan II) results framework as a means of monitoring its implementation.

4. Anticipated results in the next six months

Tanzania has seen quality improvements at the primary healthcare (PHC) level through the star rating and RBF programs. Tanzania's RBF program is a core means for implementing One Plan II. The RBF program continues to see quality improvements in key indicators at the PHC level: postnatal care (49.43 percent in March 2016 to 83.38 percent in September 2017); facility transparency (19.85 percent in March 2016 to 85.75 percent in September 2017); and labor and delivery (55.88 percent in March 2016 to 87.61 percent in September 2017). Although quality indicators have improved overall, some indicators have stagnated. To continue to improve quality, the government plans to review how quality is measured through both RBF and the star rating system.

The government is also considering other innovative methods to address quality, which may be incorporated in the proposed additional financing for the World Bank/GFF supported project. There are also a number of key areas in One Plan II which have limited support from partners, such as adolescent health, which are also considered for the additional financing.

In the process of reviewing RMNCAH results, the government has noted challenges with the use of data at the facility, district, and regional levels. The use of data is key to achieve One Plan II's results. To help address this, the GFF plans to support the strengthening of data for decision making through analysis of data quality bottlenecks, and development of a data visualization platform. This support will help the country expand its use of data for decision making, which is active at the national level, to the regional, district, and facility levels.

UGANDA

IC period	2016/17 to 2019/20
IC Financiers include	Government of Uganda, AMREF, CHAI, UKAID, GAVI, Islamic Development Bank, JSI, KOICA, Living Goods, Marie Stopes Uganda, PSI, Save the Children Uganda, SIDA, SPAIN, UNFPA, UNICEF, UNOPS, UPMB, USAID, WHO, World Bank, BTC, Global Fund, World Vision Uganda.
Key technical areas	PBF and demand side financing (vouchers), 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; CRVS

1. RMNCAH-N situation

Uganda's health outcomes are steadily improving, but the disease burden remains high (DHS 2016). Malnutrition, infant mortality and under-five mortality rates have steadily dropped since 1995. Maternal mortality ratio and total fertility rate, which had previously stalled, also registered improvements.ⁱⁱ The high disease burden, mainly attributed to communicable diseases and maternal and perinatal conditions is further complicated by disparities in coverage of key services and health outcomes across regions. Malaria is the top cause of under-five morbidity and mortality; the share of deaths from pneumonia is increasing; neonatal mortality has remained unchanged at 27 deaths per 1,000 live births; and anemia and vitamin A deficiency remain prevalent. In addition, high rates of teenage pregnancy, unmet need for family planning and early marriages are major risk factors to pregnancy and pregnancy-related morbidity and mortality.

The coverage of priority RMNCAH interventions remains suboptimal. Whilst the share of women delivering under skilled attendance has improved (73 percent in 2016), coverage of emergency obstetric care services is still low and is the main driver of the high maternal mortality². The main underlying reasons for the low coverage of key interventions include: (a) low resource base to effectively respond to the high disease burden; (b) pronounced capacity constraints, especially at the district and health service provider levels, which renders them unable to deliver the full package of basic health services under the current decentralization arrangements; (c) weak capacity for coordination and regulation and poor compliance with health service and accountability norms and standards; and (d) household poverty, women disempowerment, and harmful traditional practices that hamper utilization of health services, especially for RMNCAH. Gender based violence is widespread with 22 percent of women reporting sexual violence in 2016.

2. Value-added of the GFF / Investment Case priorities

In Uganda, the GFF is envisaged to add value in improving the health outcomes of women, adolescents and children by supporting: (a) implementation of evidence-based high impact and cost effective

ⁱⁱ The direct causes of maternal mortality are hemorrhage, obstructed labor and abortion related complications while malaria, anemia, sepsis and HIV are the most important indirect causes.

RMNCAH interventions through implementation of the revised RMNCAH sharpened plan; (b) capacity building activities for CRVS to scale-up births and deaths registration; (c) the country platform to bring together all partners under the leadership of the government to plan, coordinate and monitor RMNCAH investments; (d) implementation of the Health Financing Strategy; and (e) joint learning and knowledge sharing.

Uganda's Sharpened Plan serves 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 multi-sectoral 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 interested in the support of key partners to help them flesh out an implementation roadmap to move quickly on a few key reforms. Central objectives of the strategy are i) increased mobilization of domestic resources, ii) promotion of financial risk protection for all Ugandans as they access health services, and iii) increased efficiency and effectiveness in the utilization of resources in the sector.

3. Achievements in the last six months

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 in addressing 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. Key achievements include:

- Initiation of implementation of the World Bank IDA and GFF-TF project that is co-financing the Sharpened Plan.
- Completion of preparation of the necessary tools and training resources for the scale-up of facility level results-based financing.
- Delivery of technical support for the development of an integrated RMNCAH commodity procurement plan.
- Securing of additional aligned financing for the Sharpened Plan from Sida.

4. Anticipated results in the next six months

Over the next six months, implementation will accelerate and the following deliverables are expected:

- Roll out of the results-based financing system to 25 districts (out of 111).

- Initiation of analytical work to assess:(a) feasibility of earmarking sin taxes for health and their revenue generation potential, (b) use of motor third party insurance revenue for health, and (c) operational feasibility of the two Trust Funds (HIV/AIDs and Immunization).
- Development of an implementation plan for the Health Financing Strategy.
- Completion of a baseline survey assessing birth and death registration.

VIETNAM

IC period	n/a
IC Financiers include	TBD
Key technical areas	grassroots-level health care system (PHC), service delivery, basic essential service package including maternal, newborn and child care services, malnutrition, NCDs (including cancer, cardiovascular disease, diabetes), health financing (including health insurance reform and financial protection from out-of-pocket health spending), private sector engagement, and equity in access to health services

1. RMNCAH-N situation

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, and 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. In 2014, child mortality rates in rural areas (26.5 per 1,000 live births) were more than double those in urban areas (12.9); child mortality rates in the remote mountainous provinces exceeded 50 per 1,000 live births but were less than 20 in the delta provinces. Similarly, while the national under-five stunting prevalence is 24.6 percent, it reaches over 35 percent in some remote mountainous provinces.

Vietnam is no longer highly dependent on external assistance for the health sector, along with the achievement of middle income country status. Many development partners – including GTZ, EU, the Global Alliance for Vaccines Initiative (GAVI), and the Global Fund for HIV/AIDS, Tuberculosis and Malaria (GF) – have completed, or in transitional phases of their assistance and working with the government to shift previously externally financed programs to government budget or health insurance. There is a need to ensure and sustain the gains made with development assistance particularly for vertical programs (like immunization, tuberculosis, HIV/AIDS and others) as the country transitions away from supply-side subsidies and toward more demand-side financing through social health insurance. Since graduating from World Bank International Development Assistance (IDA) in June 2017, Vietnam is facing less concessional lending terms and reduced volumes of World Bank financing. The pressure of the national debt ceiling is dampening the demand for borrowing, especially for health and other human development sectors.

2. Value-added of the GFF / Investment Case priorities

The GFF is playing a pivotal role in Vietnam's transition by buying down the interest rate of the first WB loan to be lent on IBRD terms to Vietnam to more concessional terms, thereby encouraging the Government of Vietnam to invest more domestic resources in human development, especially for RMNCAH and primary care service delivery. The GFF-supported project will ensure that commune health stations (CHS) and regional polyclinics in the project provinces can deliver – with quality – the RMNCAH services that are within their current mandate, while also taking on a new role in the management of select non-communicable diseases (such as cervical cancer screening, breast cancer screening, diabetes and hypertension) for which services are currently only available at the district level. In so doing, the

project will improve quality, efficiency, and patient confidence in the grassroots (district and commune) level.

The GFF engagement is also helping to advance health financing reforms, especially in primary care. The health financing reforms will cover two main areas: (i) the creation of financial mechanisms needed for the new role that the CHS will assume in the project provinces (i.e. screening for cervical cancer and breast cancer as well as management of hypertension and diabetes), enabling services to be reimbursed by health insurance when conducted at CHS level, and (ii) support to provider payment reforms, specifically the capitation reform for primary care and the piloting of a DRG model.

In addition, the GFF is strengthening CRVS, particularly death registration and cause of death reporting. While Vietnam performs relatively well when it comes to birth registration, cause of death (COD) is only available for those who die at health facilities. This accounts for only about 14 percent of the total numbers of deaths. The GFF resources will provide technical assistance to the Ministry of Health to further detail the activities needed to implement the MOH's action program on CRVS and support the implementation of new standards for COD diagnosis and reporting at health facility and commune level. Finally, the GFF is supporting the creation of an enabling environment for PPPs at the grassroots service delivery level. The current models in Vietnam focus more on revenue-generation for public providers than on achieving the 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, technical assistance to the MOH and other relevant government agencies will strengthen design and implementation of health PPPs for alignment with public health objectives, i.e. improving access to care and providing financial protection from out-of-pocket spending.

3. Achievements in the last six months

Since the last IG meeting, preparation work for the GFF-supported project has continued. The project design is well advanced. On the Bank side, a draft Project Appraisal Document has been drafted and will be subject to an internal Quality Enhance Review (QER) on 23rd April. On the government side, a Project Proposal (and subsequent revisions) was submitted by the MOH in July 2017, with subsequent revision to address comments of MOF (in Dec 2017 and again in April 2017). Government's processing of the different authorizations needed before final project approval has been very slow. This is a cross-cutting challenge across all sectors in government, not unique to this project. Consequently, World Bank Board approval has been delayed.

On analytics and capacity building, support to strengthening the Vietnam CRVS system has progressed and the outline of a draft action plan was developed during a CRVS mission. at the end of March. With respect to PPPs, a number of capacity-building activities have been undertaken (including a number of local training events and seminars), and a short-list of candidate PPP business cases have been identified.

4. Anticipated results in the next six months

While the Board date of the project will need to be postponed from its current date of June 21, 2018), approval is still expected within the next six months. In the meantime, the program of analytical work and technical assistance to strengthen the CRVS system and the design and delivery of health public partnerships (PPPs) continue to move forward. For the CRVS work, a sub-committee of the National Action program on CRVS Steering Committee will be established to oversee the implementation of the MOH Action Plan and two workshops are planned: a validation workshop for the draft implementation plan

with stakeholders to revise and finalize the implementation plan; and a workshop to disseminate the Action Plan and raise awareness among policy makers within the health sector.

In the next six months, at least one capacity strengthening workshop for exchange of knowledge and experience on global best practice for PPPs in the health sector is planned along with opportunities for public-private dialogue on challenges faced when entering into PPPs. Ongoing technical assistance for policy development and strategic planning for PPPs will also be undertaken and the team will select a PPP business case to develop in-depth.