

# THE GLOBAL FINANCING FACILITY: AN OPPORTUNITY TO GET IT RIGHT

Policy briefing, April 2018



## Executive summary

In 2018, the Global Financing Facility in Support of Every Woman Every Child (GFF) is seeking a \$2 billion replenishment for its Trust Fund. However, the GFF is very different to other grant-giving global health funds – it intends to depart from the ‘business as usual’ approach to development financing and transform how governments fund their health and nutrition services.

Created in 2015 the GFF’s proposed model is new and the optimism surrounding it needs to be continually tested and proven. Unless the GFF genuinely delivers on its transformational ambitions, it could simply become another traditional financing mechanism, cementing the existing development paradigm, and increasing aid dependency and indebtedness.

However, the GFF has the potential to drive increased investment in health and nutrition from both external and, primarily, domestic finance. Save the Children encourages donors to support the Trust Fund replenishment but calls on all governments and civil society to make the GFF transformational by implementing the reforms suggested in this paper, and thereby building adequate, equitable and sustainable financing for health systems. If the mechanism can demonstrate that it will live up to the ambitious recommendations in this paper, Save the Children believes that donors should support the 2018 GFF Trust Fund replenishment.

If this happens, the GFF can propel low- and lower-middle-income countries towards providing universal quality sexual, reproductive, maternal, newborn, child and adolescent health and nutrition (SRMNCAH+N) services, whilst also creating a new transformative model for development financing which could be adopted by bilateral as well as multilateral donors in the future.

Save the Children believes that, to achieve success, the GFF must base its efforts around universal access to quality, integrated SRMNCAH+N services, supporting investments that prioritise essential health services delivered at the primary healthcare level. These should form the basis for countries’ efforts to build universal health coverage (UHC), whilst also allowing the GFF to ensure that national nutrition plans are included and supported in all investment cases.

The financing gap for achieving universal coverage of these services is estimated to be \$33.3 billion<sup>i</sup> per year, and clearly the \$2 billion GFF replenishment is a small fraction of what is needed. However, the GFF model aims to be catalytic - it provides relatively small grants to countries which in turn enable the use of concessional loans and grants from the World Bank, leverage private sector finance, and, crucially, generate increased domestic resource mobilisation (DRM) for health and nutrition. Save the Children welcomes these ambitions, but challenges remain:

- Aid should be genuinely catalytic, targeted to bring about large-scale and long-term sustainable change, and not prop up inadequate health services. Donors should aim to support health systems strengthening and build national capacity so that all countries are funding health and nutrition services to the best of their ability. The GFF needs to ensure that its grants or those they facilitate truly help to grow domestic resources, rather than crowding them out.
- Loans to developing countries are important for short-term public services investment for growth and expansion. However, loans need to be repaid and the repayment burden has, in the past, taken up too large a proportion of national resources and contributed to low spending by low and middle-income countries (LMICs) governments on their public services. The GFF needs to demonstrate how it will protect countries from increased indebtedness, particularly when leveraging loans from the private sector.
- Sufficient DRM is essential to ensure health and nutrition coverage and remove financial barriers to quality healthcare. Currently the GFF’s DRM approach is limited to fiscal space analysis, efficiency gains, increasing the health share of governments budgets and sin taxes. Whilst these are important, the top priority must be to replace out-of-pocket payments with pooled and equitable resources collected through universal progressive taxation. The health financing strategies that accompany investment cases need to adhere to the principles of financing for UHC and have specific and measurable interim targets, with steps to be achieved within a single parliamentary or presidential term, and be published before GFF finance is approved.

The GFF is clear that its core principle is country ownership: governments develop their own investment cases in consultation with national advisory platforms. This approach is the right one, but is heavily dependent on governance and consultation structures, particularly for civil society to guide investment case creation, and accountability mechanisms to ensure that governments deliver on those investment cases. So far, there is little evidence that this is happening. The GFF is responsible for ensuring this occurs by, for example, sourcing adequate funding for meaningful civil society engagement throughout the entirety of the GFF process.

This briefing outlines the potential and reforms that could make the GFF anything but ‘business as usual’<sup>ii</sup>

## Key recommendations for the GFF

1. The GFF must be genuinely transformational in assisting governments to develop effective and holistic approaches to generating increased and sustainable domestic resources for health systems, underpinned by accountable health financing strategies, and fully costed national health and nutrition plans
2. The GFF must protect recipient countries from bad or unsustainable debt through diligent use of indebtedness protection controls, and employ additional controls and caution for private sector finance.
3. The GFF must continue to ensure that the services and activities it supports promote universal access to the comprehensive SRMNCAH+N 'continuum of care' principally through primary healthcare
4. The GFF needs to allow civil society to play a full and effective accountability role by increasing transparency, access, and financial support to civil society at all levels.

## Overview of the GFF

The Global Financing Facility in Support of Every Woman Every Child (GFF) was launched in September 2014 in response to the ongoing challenges of ensuring universal access to sexual, reproductive, maternal, newborn, child and adolescent health and nutrition (SRMNCAH+N) services, and to close the funding gap which persists in efforts to eliminate preventable mortality and morbidity of women, children and adolescents. Indeed, the stated goal of the GFF is ‘to accelerate efforts to end preventable maternal, newborn, child and adolescent deaths and improve the health and quality of life of women, children and adolescents’.<sup>iii iv</sup>

Save the Children welcomes the GFF’s efforts to increase and improve financing for SRMNCAH+N in line with the ambition of the Sustainable Development Goal (SDG) target of Universal Health Coverage (UHC) and the targets on maternal and child health, gender equality, nutrition and universal access to quality sexual and reproductive health.<sup>v</sup> Access to essential healthcare for all is a fundamental human right and governments have a duty to do all they can to ensure access to these services for everyone in the population.

There is no debate that health and nutrition services in most LMICs are vastly under-resourced, not organised in ways which will address the most glaring health and nutrition inequalities, and far from achieving the health and nutrition targets in the Sustainable Development Goals. The GFF has been established as the resourcing arm of the Global Strategy for Women’s Children’s and Adolescents’ Health with the intention of ensuring that it drives meaningful changes including to address the fact that:

- The fall in child mortality rates is far too slow to achieve the target of ending all preventable child deaths by 2030, with preventable and treatable conditions such as pneumonia continuing to kill many children every year.
- The world is currently off track for SDG2 and will not end malnutrition in all its forms by 2030. The world is also off course or has seen very limited progress for each of the 2025 World Health Assembly (WHA) targets including anaemia, stunting, wasting, exclusive breastfeeding and low birth weight.
- The continuum of care for reproductive, maternal, newborn, child and adolescent health – which should be the basis of primary healthcare in every community and which are particularly essential to women and girls’ health - have many aspects with extremely low coverage, especially of skilled birth attendance.

The GFF presents an opportunity to depart from ‘business as usual’ and develop a new approach, not only in terms of how governments fund their health and nutrition sectors, but also to shape the wider future of development financing. Save the Children believes the GFF has the potential to accelerate progress towards SDG2 and SDG3 if it is structured and implemented appropriately, and in ways which reflect international standards on the right to health and nutrition, including sexual and reproductive health and rights, and the principles of equity, universality, non-discrimination, transparency, participation, and accountability.

The GFF seeks to foster increased domestic and international financing commitments to global health and nutrition, and to improve coordination and efficiency in SRMNCAH+N spending. It aims to work with high-burden countries using GFF Trust Fund finance and technical assistance to mobilise a combination of domestic financing, external support from bilateral and multilateral donors, (including through the World Bank’s International Development Association (IDA) and International Bank for Reconstruction and Development (IBRD) and ‘innovative sources’, including the private sector. The GFF Secretariat has made it clear that the GFF Trust Fund and IDA funding will only make up a minority of the overall required financing for countries, with domestic resources providing the majority share.

This brief provides some recommendations for the current and subsequent phases of the GFF’s implementation.

## The GFF and UHC

UHC has only close to reality in a small number of mostly high-income countries (HICs) and very few middle-income countries (MICs). For nearly all low-income countries (LICs) the provision of UHC is far off, in some cases probably beyond the 2030 target, leaving the estimated half of the world’s population who currently lack access to even the most basic free healthcare hugely vulnerable, including over 200 million women who have inadequate family planning coverage.<sup>vi</sup>

UHC reforms are based on a set of core principles including the idea of minimum obligations, progressive realisation, financial protection, cost effectiveness, shared decision-making and reaching marginalised groups.<sup>vii</sup> To turn these principles into action, health strategies need to be carefully designed and implemented. Although by no means the only element of reform required to move towards UHC, financing underpins many elements of health systems. There are three core financing elements required to deliver UHC and protect people from healthcare induced financial hardship.



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- **Revenue raising** must be equitable and move from the reliance on out-of-pocket payments to public sources, preferably through progressive mechanisms such as taxation or compulsory contributions to a social health insurance scheme, with subsidies for those who cannot afford payments
- **Pooling** of resources from diverse population groups to maximise risk subsidisation
- **Purchasing** of goods and services informed by evidence and evaluated for impact and efficiency is required to meet the health needs of the relevant population group, and to prioritise the poorest and most vulnerable.<sup>viii</sup>

The GFF has natural synergies with UHC and in many countries it can play a key role in establishing financial structures that will enable UHC. However, it is important that the GFF is not seen as the financial solution to UHC or the "UHC fund" as the UHC financing gap is much larger than the amount the GFF will be able to help mobilise before 2030. That gap will only be filled by substantially increased domestic resources, supported by bilateral and multi-lateral donors and mechanisms.

## Thematic policy asks

### 1. Improving domestic financing

The GFF differs from other health and nutrition financing mechanisms in that it puts domestic resource mobilisation at the core of its theory of change, enabling LMICs to build a progressive and sustainable funding structure and help remove financial barriers for women and children to access quality healthcare.

Over the ten years from 2006-2015 the average government expenditure in LICs on health from domestic resources dropped from 1.45 to 1.18 percent of Gross Domestic Product (GDP),<sup>ix</sup> well below the recommended 5% GDP necessary to provide a basic package of essential services for all.<sup>x</sup> Figure 1 also shows that for most GFF countries out-of-pocket-spending (OOPS) is the primary source of health financing, often dwarfing domestic government expenditure.

The GFF's DRM approach has so far consisted of fiscal space analyses, efficiency gains - budget performance and public financial management (PFM), increasing the share of government budgets being spent on health (in Mozambique GFF/IDA disbursement is in part linked to health budget prioritisation), and revenue raising through sin taxes.<sup>xi xii</sup> Whilst all these methods are

important elements of health and nutrition financing, there is a distinct lack of progressive and sustainable domestic revenue generation activities outlined in investment cases or where available in health financing strategies. Without this, no GFF country will be able to provide essential services to women and children, nor make significant progress towards UHC.

The GFF must work with countries to ensure that a credible revenue-raising approach is at the core of every investment case. Given its home within the World Bank and its relationship with national governments, it is well placed to do this. This must include working with Ministries of Finance to ensure necessary tax reforms, and where appropriate driving social health insurance design and implementation. It is also critical that an increased government health budget does not negatively affect government expenditure in other social sectors such as education. Only by meeting their own ambition to catalyse increased DRM can the GFF assist countries to make significant progress towards the domestic financing of health systems and breaking the aid paradigm.

Credible and actionable health financing strategies are as important as the investment cases that guide GFF support. To date, the majority of investment cases

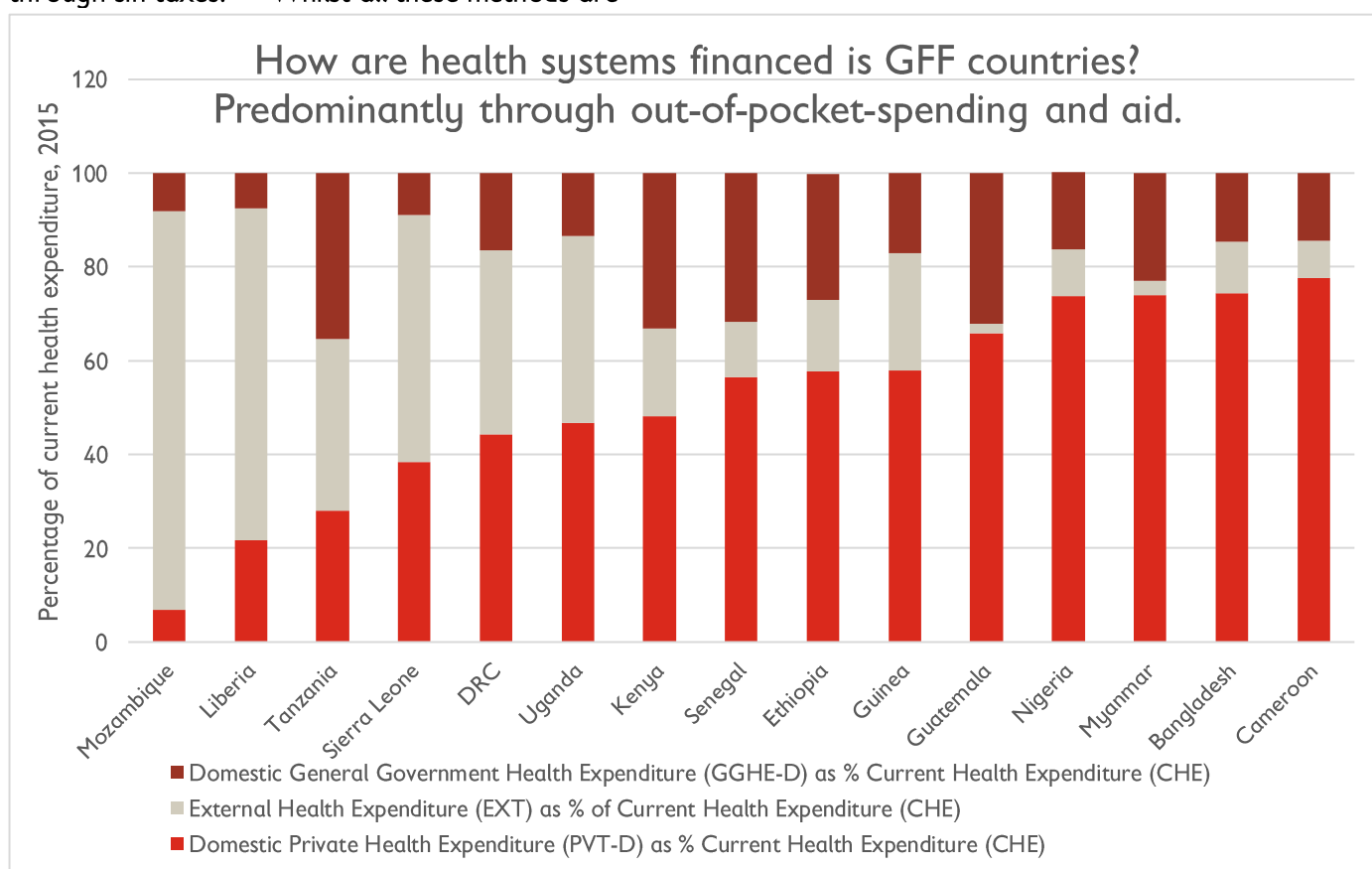


Figure 1: How are health systems in GFF countries financing? GFF 'active' country health system finance by domestic resources, external resources (ODA) and private expenditure (OOPS). Source: WHO Global Health Expenditure Database. The data for Vietnam is incomplete and so omitted from this table



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have been approved without a published health financing strategy.<sup>xiii</sup> Each health system operates within a different context and therefore each health financing strategy should be unique, but as outlined above, there are core principles which all health financing strategies must subscribe to if they are to remove financial barriers to accessing quality healthcare.

As well as adhering to those principles, equity can be further increased when reforming health financing systems. Child- and gender-responsive budgeting, for example, can be built into purchasing arrangements to ensure that sufficient resources are allocated to provide women and children with quality services, including educational and sexual and reproductive health services.

One further consideration is that of decentralisation. Many health systems are moving towards a decentralised structure, either in line with wider political reforms or through health system reforms. This has implications for where and how central governments and donors should support sub-national authorities to deliver health services; it is often these authorities that are responsible for primary health care. Therefore, investment cases must reflect the financial structure of the health system and clearly demonstrate how finance will be allocated and flow to those implementing SRMANCAH+N services at a local level.

### *Nutrition*

Malnutrition is one of the world's most endemic but most under-addressed public health challenges. Malnutrition profoundly affects children's overall life chances, is estimated to be the root cause of 45% of under-five deaths, irreversibly damages a child's physical and cognitive growth, and is a key barrier to equitable development. Good nutrition is foundational to SRMNCAH outcomes, and therefore, in line with its *Every Woman Every Child* ethos, the GFF must support nutrition programming to achieve its ambitions.

Whilst there has been a substantial increase in commitments to nutrition financing at global and national levels in recent years, the nutrition funding gap to deliver the World Health Assembly targets remains vast<sup>xiv</sup>, and the implementation and scale-up of proven nutrition interventions remain too slow. The consequences of this underinvestment, both human and economic, are overwhelming. The only way to sustainably bridge that funding gap is through catalysing significant increases in domestic resources, as the GFF is promoting. Therefore, the GFF has great potential to help high-burden countries take a big step towards eliminating malnutrition in all its forms.

However, despite this alignment in objectives, the attention given to malnutrition across GFF Secretariat policy documents and country-driven investment cases is mixed. It is vital that nutrition is wholly integrated in all investment cases, and that countries are enabled to prioritise nutrition interventions at every step of their journey towards closing the SRMNCAH funding gap. To ensure this is done systematically, the GFF should include – and where necessary encourage the creation of – costed, multi-sectoral, multi-stakeholder, equity-driven national nutrition plans within investment cases, and channel all funding for nutrition into the activities prescribed by those plans. This will allow a better picture of nutrition financing requirements to be developed at a country level, and ensure that nutrition interventions are wholly integrated into the overall health programming agenda. As it stands, 33 countries now have fully costed nutrition plans<sup>xv</sup>, and the SUN Movement's ambition is that by 2020 all SUN countries will have a nutrition plan “endorsed at the highest level, with national nutrition targets and costed actions that guide collective implementation and resource allocation”<sup>xvi</sup>. The GFF should use its remit as a coordinating mechanism to support this effort and ensure an integrated approach to nutrition spending, thereby enhancing transparency and accountability.

Further, given the estimated 19% of GFF funds<sup>xvii</sup> that are currently spent on nutrition, there should be at least one additional standalone indicator tracking the impact of GFF nutrition investments. The only existing nutrition-specific indicator pertains to stunting, which will only demonstrate long-term impact; it is important that interim and short-term benefits of nutrition investment are also shown. An appropriate choice for this indicator would be rates of exclusive breastfeeding, using the same framework as the WHA target on that theme.

### *Recommendations*

- Health financing strategies, including fiscal space analyses, must be published as a prerequisite to investment case approval.
- Health financing strategies must include commitment to spending at least 5% GDP in domestic resources on the health system, with concrete short-term milestones within a parliamentary or presidential term.
- Health financing strategies must adhere explicitly to the three core financing elements for UHC: progressive revenue, increased pooling and strategic purchasing, moving away from out-of-pocket payments for services. The GFF should have



an unambiguous position against fees at the point of service.

- investment cases must reflect the financial structure of the health system and clearly demonstrate how finance will be allocated and flow to those implementing SRMANCAH+N services at a local level with a focus on leaving no one behind, including the most deprived and marginalised children and adolescents from the start.
- Governments should introduce budget classification systems that identify budget allocation and spending affecting children - including girls - at a minimum disaggregated by age, gender, geographical area, and children in vulnerable situations.
- National nutrition plans should be included and supported in all investment cases, and all nutrition funding should be channelled into activities prescribed by those plans.
- At least one additional standalone nutrition indicator should be added to the GFF evaluation framework, and this should track shorter-term benefits of nutritional interventions, complementing the existing long-term impact indicator on stunting.

## 2. Global financing architecture

For many LMICs, the make-up of external resources is currently nearly as important as the financial structures within a country. As outlined above, the GFF aims to employ its Trust Fund resources to leverage a combination of domestic financing, external support from bilateral and multilateral donors, and 'innovative sources' including the private sector.

Aid can play an important part in strengthening national health systems. Save the Children supports the principle that wealthy countries should contribute to support those countries with far fewer resources. Aid should be catalytic and targeted to bring large-scale and long-term sustainable changes. It should not consist of a multitude of vertical funding streams which prop up and distort inadequate health services. It should not add to the burden of governments with low capacity but demanding multiple reporting streams.

Fundamentally, as evidenced by a World Health Organisation (WHO) report in 2017, aid should not displace domestic resources for health and keep health and other public services at inadequate levels.<sup>xviii</sup> Aid should aim to build national capacity so that all countries are funding health and nutrition services to the best of their ability. The GFF needs to ensure that its grants truly help to grow and not undermine national resources.

### IDA/IBRD

The largest source of finance within GFF leveraged support to investment cases comes from World Bank IDA and IBRD sources. Of the \$1,572.6m that have been approved for GFF countries, \$1065m has come from IDA and \$100m from IBRD.<sup>xix</sup>

An effective use of GFF funds has been for 'buy-downs' where the GFF trust fund will pay for or 'buy-down' the interest on a country's loan. This is happening in Guatemala where an existing \$100m IBRD loan to finance efforts to curb malnutrition in pregnant mothers and children under two was bought-down, with the Guatemalan Government investing the saved funds into a conditional cash transfer programme<sup>xx</sup>.

Loans to developing countries are important for substantial short-term investment in public services which can allow growth and expansion in the short term, to be repaid by countries as their economies grow. The purpose of the World Bank is to provide these loans at concessional or zero interest rates.

With loans of any type, increasing indebtedness of countries is a growing concern. The amount of public finance used to service government debt has recently grown in LICs, increasing the number of governments who are considered vulnerable to defaulting on loans.

<sup>xxi</sup>

#### Box 1: What are development impact bonds?

The main goal of a DIB mechanism is to attract private capital to address social outcomes where private investors earn a profit if the social outcome is achieved. The DIB structure ensures that governments, donors, or other MNCS funders will pay for interventions *only if they are deemed to be successful by an independent evaluator*. Unlike much current international development funding, DIBs focus on outcomes, not inputs or outputs. By guaranteeing investors' capital is spent only on successful projects (as determined by an independent evaluator), DIBs aim to attract new sources of funding through a different development finance model.

This type of new financing model based on pay-for-performance seeks to add new sources of funding to address social and economic needs in the developing and developed world.

*Source: Andrew Wainer, Development Impact Bonds for Maternal and Child Health: Potential and Early Learning, Save the Children, 2018*

Though the GFF is often operating alongside the World Bank - and presumably under the governance of their indebtedness risk mitigation - there is no mention of country indebtedness protection in GFF policies to cover non-IDA/IBRD related projects, such as those leveraging private sector finance; the GFF needs to make much clearer its approach to encouraging loans.

The GFF promotes the use of results-based-financing (RBF) for the finance they leverage in agreed specific pre-defined results such as the positive example in Mozambique with one disbursement linked indicator depending on the government increasing the health budget, giving an incentive to prioritise the health sector. RBF will look different in each country and can be effective, but it is important that RBF does not distort finance and is proportional to needed outcomes.

### *Innovative financing*

A prominent part of the GFF plan is to attract innovative financing. Some of this derives from match funding, such as through the Power of Nutrition mechanism which aims to drive increased and diversified funding for nutrition by addressing a major donor concern – the value and return they receive on their investment. Power of Nutrition does this in two ways: firstly, by multiplying the original investment by a minimum of four times, and secondly by only investing in 11 proven interventions from the Lancet series<sup>xxii</sup>.

A second major source of innovative financing is the private sector. The use of ODA by donors to leverage private finance and build private sector activity in developing countries has gained political priority for donors. This is a concern for Save the Children given the potential for shortcomings in additionality,<sup>xxiii</sup> development results and compliance to effectiveness principles. Public funds are limited and private sector investment can result in this money being diverted from directly supporting sectors that benefit the poorest and most marginalised children.

One innovative financing approach is development impact bonds (DIBs) which aim to attract private capital investment by allowing private investors to earn a profit only if social outcome that are met (based on independent evaluation). With the vast resource gap in reducing maternal, newborn and child mortality, DIBs are one potential tool to help meet that challenge but not intended to replace traditional bilateral or multilateral assistance. Box 1 explains the positive role that DIBs can play in leveraging private sector finance link to outcomes, however, as with all

private sector finance, caution and additional governance is needed. For DIBs, this is particular concern of investors demanding lower 'success thresholds', trade-offs between social impact, which could damage the reputation of DIBs and the investment community.

So far private sector finance is only included in one of the investment cases – the Cameroon DIB – but the GFF has invested in private sector entities such as the Medical Credit Fund (\$1m) which provides loans to small and medium-sized healthcare facilities in Africa.

### *Recommendations*

- Supported enterprises, investors and intermediaries should be required to comply with child and human rights, environmental, social, governance, fiscal and transparency criteria, including due diligence and grievance mechanisms.
- To achieve the best value for money for ODA and focus on quality results, both financial and development additionality of supported private investments should be sufficiently proved.
- The GFF must protect recipient countries from bad debt or further indebtedness by developing (or adopting) and implementing indebtedness protection controls on all GFF finance to countries. Lending to health and nutrition must not increase countries debt vulnerability, as measured by the newly updated World Bank and IMF debt sustainability framework for Poverty Reduction and Growth Trust (PRGT) eligible countries.<sup>xxiv</sup>
- Consideration of private debt and risks related to contingent liabilities must be included in all debt sustainability analyses for GFF countries. For countries where these potential sources for heightened debt risks are not considered in the debt sustainability analysis, additional assessments must be carried out, in line with the updated debt sustainability framework for PRGT eligible countries to be rolled out from medi-2018.<sup>xxv</sup>
- Attention should be paid to debt sustainability and the legitimacy of the loan in humanitarian contexts and fragile states.
- The GFF should recognize the shared responsibility of lenders and borrowers in ensuring that debt burdens remain sustainable, and that government debt is incurred in transparent way with sufficient parliamentary oversight. The Facility should adhere to the UN Conference on Trade and Development (UNCTAD) Principles on promoting responsible lending and borrowing.
- A mechanism should be put in place to write off debt that turns out unpayable in the future, for example



due to crises or a change in external factors such as commodity prices.

### 3. The continuum of care

With a focus on finance it is important to ensure that the GFF is financing the correct activities within countries. The GFF must support universal access to quality, integrated SRMNCAH+N services, prioritising essential health services delivered at the primary health care level. These should form the basis for countries efforts to build universal health coverage and must be embedded in national health systems, policy and programs. This is critical to ensure real progress in tackling the gross inequalities that persist in women's, children's, and adolescents' health, and to ensure that equity is a key priority in efforts to implement the Global Strategy on Women's, Children's and Adolescents Health. The poorest and most marginalised sections of the population must benefit first from the activities supported by the GFF.

This includes key health interventions such as family planning and contraception, adolescent friendly and comprehensive sexual and reproductive health services, nutrition interventions (including the promotion of exclusive breastfeeding), expert care in pregnancy, childbirth, essential newborn care (including the promotion of early initiation and exclusive breastfeeding) and the postnatal period, care of small and sick newborns, immunisation, health promoting practices and treatment for childhood illness.

Care needs to be available at the community, primary and referral level and resources should be focused where they are most needed and where they reach the most vulnerable. Nearly half (46 %) of children dying before the age of five, die in their first month of life and this proportion is increasing, and the proportion of under-five deaths in the newborn period has increased from 2000 to 2016. Many of the solutions needed to reduce newborn mortality, such as skilled care around time of birth, require support from well-functioning health systems. An integrated and comprehensive continuum of care is essential to make progress in reducing preventable mortality and morbidity.

Essential SRMNCAH+N services to all women, children and adolescents delivered at a primary healthcare (PHC) level, are the foundation for building UHC. The GFF can support this by the strengthening of universally accessible primary health care as the bedrock of effective healthcare systems, and to ensure synergy and consistency with WHO's 'quality, equity and dignity' initiative, which aims to increase political commitment, leadership, and improved practice for

dignified and high-quality care for all women, children, and adolescents.

The GFF has the potential to make a huge positive impact on addressing childhood illnesses such as pneumonia, the largest infectious killer of children. Of the 16 currently 'active' GFF countries, 9 are amongst the 30 countries with the highest pneumonia burden. Child mortality due to pneumonia will only be reduced through investing in equitable primary healthcare systems that provide universally accessible preventative and curative treatment such as the increased coverage of pneumococcal conjugate vaccine (PCV), which is currently only 77% across GFF 'active' and second wave countries.<sup>xxvi</sup>

#### *Recommendations:*

- The GFF must ensure that the services and activities it supports promote universal access to the comprehensive SRMNCAH+N 'continuum of care'
- The GFF must work with governments to ensure that primary healthcare services are prioritised in investment cases and receive adequate funding.
- The GFF should wholly integrate nutrition with the health agenda

### 4. Governance and accountability

#### *Governance*

The primary governance bodies of the GFF are the Investors Group (IG) a decision-making multistakeholder group, and the Trust Fund Committee. The IG is responsible for raising funding for investment cases, decisions on funding for investment cases, as well as the presiding over GFF Secretariat policies and guidance documents.<sup>xxvii</sup> The IG is crucial in driving development of the policies and reforms that Save the Children is calling for. For the IG to function effectively in this way it must be more open and transparent and follow models such as the Global Fund which allows greater civil society engagement with their equivalent to IG meetings.

There is a national platform in each GFF country, which should be formed of a wide range of stakeholders; fair and balanced representation is essential to ensuring all constituencies and recipients of GFF support have their interests protected. The inclusion of strong civil society presence on national platforms, meaningful engagement of those representatives in the development of investment cases, and the monitoring of implementation, are particularly vital elements of the governance structure within countries.

In practice however, civil society engagement has thus far been poor, with weak consultation processes and in some countries civil society are not meaningfully engaged with country platforms. Civil society has reported that multi-stakeholder country platforms vary in terms of how well they embody and employ the principles and recommendations given in guiding documents such as the Civil Society Engagement Strategy (CSES). Some countries still do not seem to have a well-functioning country platform for GFF governance.<sup>xxviii</sup>

This has led to ‘challenges with clarity and transparency around decision-making processes, communication about the GFF and its priorities, RMNCAH investment cases and health financing strategies, and clear entry points for civil society engagement, which could all be strengthened through a well-functioning multi-stakeholder RMNCAH country platform.’<sup>xxix</sup>

CSO engagement can only be effective if CSOs are enabled to engage throughout and beyond the GFF process. The GFF must facilitate this by encouraging governments to consult with civil society organisations, including women’s and child rights organisations and children themselves, in activities such as budget formulation. This example includes ensuring civil society’s and other actors timely access to budgetary and other fiscal information.

Well-functioning CSO coalitions are also a vital part of GFF governance as well as natural societal partners of health duty bearers. However, CSO coalitions need financial support to be effective. In November 2017, the GFF and PMNCH announced \$800,000 in funding for CSES Implementation Plans in 2018, however this is not nearly enough to meet required amounts.

### *Accountability*

The GFF has developed 16 indicators which are used to monitor and evaluate the impact of funds committed according to the investment cases. As yet, monitoring and evaluation of GFF investments has yet to begin at an effective level and no performance review has been published; this provides an opportunity to extend the range of indicators to include pneumonia treatment

seeking, equity, gender sensitivity and catastrophic payments.

In two countries, Kenya and Nigeria, accountability scorecards have been completed, measuring performance in the fields of country platform development, civil society engagement, design and publication of key documentation, and implementation.<sup>xxx</sup> The GFF should provide or help source funding for accountability activities such as scorecards to be developed across all countries with active funding.

Beyond civil society, the GFF needs to implement systematic integration of accountability operating at different levels, therefore the funding required is not just for scorecards but for institutionalization of the accountability processes throughout the GFF system. This must include greater transparency on how funding decisions are made, particularly around the criteria which are employed to make those decisions.

### *Recommendations*

- National platforms must be truly multi-stakeholder, including civil society representatives, and should be meaningfully engaged both in development and evaluation of investment cases
- The range of GFF indicators should be extended to include pneumonia, treatment seeking, equity, gender sensitivity, health systems strengthening and financial risk protection
- Civil society must be funded to institutionalise accountability scorecards in all GFF countries
- The GFF should be more transparent about how funding decisions are taken
- The GFF should source adequate funding for meaningful civil society engagement in countries throughout the entirety of the GFF process.
- The GFF needs an independent accountability mechanism tracking progress and impact as per ambitions outlined above
- The GFF must support strengthening of national and sub-national monitoring systems with data being available publicly, continuously and disaggregated by, at a minimum, income, gender, age, race, ethnicity, migration status, disability, and geographic location.

## Conclusions

Save the Children endorses the GFF's model and its ambitions as an exciting chance to finally correct many of the problems in the way that global aid is structured. The twin principles of putting country ownership at the core and using donor funds catalytically to drive increased domestic and external investment are both vital to the sustainable development of health and nutrition services in high burden countries, and to make significant progress towards UHC. The current aid paradigm is not working, and the GFF offers hope of a new pathway to building quality SRMNCAH+N services for all.

However, the GFF must ensure that it truly delivers on the principles laid out in its business plan and other key policies. The objective must be long-term financing, primarily through domestic resources – this requires a deeper engagement with taxation and encouraging countries away from reliance on out-of-pocket payments than is currently evident, and greater awareness shown on the danger of overburdening countries with debt. Overall, the GFF must be more transparent, and show more clearly how Trust Fund grants will sustainably increase domestic resources for health and nutrition.

If these principles can be upheld, and the mechanism demonstrates its intent to phase in the recommendations this paper has outlined, then Save the Children calls on donors to support the 2018 GFF replenishment, and to use their positions, not least through the IG, to ensure that those recommendations are fully implemented. In so doing, Save the Children believes that the GFF can become a transformational force for the health and nutrition funding landscape, and set a new paradigm for development financing more broadly under which aid dependence is ended.



# Endnotes

- <sup>i</sup> The GFF, Business Plan, The GFF, 2015
- <sup>ii</sup> The research methodology included four elements: a review of all country investment cases and project appraisal documents (PADs); a review of GFF policy and literature; a survey of Save the Children staff in GFF 'active' countries; a grey literature review. Save the Children is grateful to the GFF for reviewing for inaccuracies and the Bill and Melinda Gates Foundation for helpful comments.
- <sup>iii</sup> The GFF approach also complements the WHO Global Strategy for Women's, Children's, and Adolescents' Health (2016–2030): early childhood development.
- <sup>iv</sup> GFF, 2015
- <sup>v</sup> Sustainable Development Knowledge Platform, Sustainable Development Goal 3, Ensure healthy lives and promote well-being for all at all ages, <https://sustainabledevelopment.un.org/sdg3> [accessed: 28<sup>th</sup> February 2018]
- <sup>vi</sup> The World Bank, WHO, Tracking Universal Health Coverage: 2017 Global Monitoring Report, World Health Organization and the International Bank for Reconstruction and Development / The World Bank, 2017
- <sup>vii</sup> D Sridhar et al, 'Universal health coverage and the right to health: from legal principle to post-2015 indicators', *Int J Health Serv.* 2015; 45(3): 495–506
- <sup>viii</sup> For more information see: Save the Children, Within Our Means, Save the Children, 2015
- <sup>ix</sup> WHO, Global Health Expenditure Database, <http://apps.who.int/nha/database> [accessed: 28<sup>th</sup> February 2018]
- <sup>x</sup> McIntyre, Diane, F Meheus, J A Røttingen, What level of domestic government health expenditure should we aspire to for universal health coverage? *Health Economics, Policy and Law*, 2017 Apr;12(2):125-137
- <sup>xi</sup> The GFF, GFF's Contribution to Domestic Resource Mobilization for Health and Nutrition, The GFF, 2018
- <sup>xii</sup> Sin taxes are designed to discourage harmful behaviour and can serve an important public health function, particularly when coupled with public health campaigns. But revenues generated from sin taxes are likely to decline if behaviour changes and they are often regressive, placing a greater burden on poor households. As such, sin taxes should be pursued primarily for public health promotion, and not relied on as a revenue source. See: <http://www.who.int/healthsystems/topics/financing/healthreport/51Hypothecation.pdf>
- <sup>xiii</sup> Only one investment case (Uganda) has been approved alongside a published health financing strategy, with four countries (Cameroon, Ethiopia, Liberia, Mozambique, and Tanzania) having investment cases approved with no accompanying health financing strategy, and two countries (DRC and Kenya) having approved investment cases with health financing strategies in existence but not published.
- <sup>xiv</sup> World Bank Group, Catalysing Progress Toward the Global Nutrition Targets, p.4, [https://openknowledge.worldbank.org/bitstream/handle/10986/26069/3\\_intervention\\_pack\\_WEB.pdf?sequence=11](https://openknowledge.worldbank.org/bitstream/handle/10986/26069/3_intervention_pack_WEB.pdf?sequence=11)
- <sup>xv</sup> Scaling Up Nutrition (2017), *Annual Progress Report 2017*, p.148, [http://docs.scalingupnutrition.org/wp-content/uploads/2017/11/SUN\\_Main\\_Report\\_ENG\\_2017\\_WEB2.pdf](http://docs.scalingupnutrition.org/wp-content/uploads/2017/11/SUN_Main_Report_ENG_2017_WEB2.pdf)
- <sup>xvi</sup> Scaling Up Nutrition, *Strategy and Roadmap (2016-2020)*, p.8, [http://docs.scalingupnutrition.org/wp-content/uploads/2016/09/SR\\_20160901\\_ENG\\_web\\_pages.pdf](http://docs.scalingupnutrition.org/wp-content/uploads/2016/09/SR_20160901_ENG_web_pages.pdf)
- <sup>xvii</sup> Save the Children conversations with GFF Secretariat and Nutrition Specialist, January 2018
- <sup>xviii</sup> WHO, 2017; Save the Children, 2018 (blog)
- <sup>xix</sup> Authors' research from Project Appraisal Documents published on GFF website
- <sup>xx</sup> Global Financing Facility (2018), *The GFF's contribution to Domestic Resource Mobilisation for Health and Nutrition*
- <sup>xxi</sup> <https://jubileedebt.org.uk/press-release/developing-country-debt-payments-increase-by-60-in-three-years>
- <sup>xxii</sup> Interventions are: Iron & Folic Acid Supplementation, iron fortification of staple foods, Vitamin A supplementation, salt iodisation, multiple micronutrient supplements, promotion of breastfeeding, complementary feeding, handwashing with soap, management and prevention of acute malnutrition, preventive zinc supplementation, and deworming. Source: Power of Nutrition (2016), *Investment Index*, <http://www.powerofnutrition.org/investment-index/>
- <sup>xxiii</sup> There are at least three different notions or types of additionality, financial, development and added value. "A transaction is financially additional if it is extended to an entity that cannot obtain finance from local or international private capital markets with similar terms or quantities without official support, or if it mobilises investment from the private sector that would not have been otherwise invested. It is additional in value if the public sector offers to recipient entities or mobilises, alongside its investment, non-financial value that the private sector is not offering and which will lead to better development outcomes e.g. by providing or catalysing knowledge and expertise, promoting social or environmental standards or fostering good corporate governance", see: OECD (2016c). "Implementation of the principles of ODA modernisation on private-sector instruments: Template for the ODA-eligibility assessment of DFIs and other vehicles and definitions and reporting on additionality". DCD/DAC/STAT(2016)1/Rev2. Paris. Development additionality "refers to the development impacts that arise as a result of investment that otherwise would not have occurred. In this case, one of the main rationales for partnership is that it facilitates faster, larger, or better development impacts than the public or private sector would be able to achieve working alone", see: OECD (2016). "Private Sector Peer Learning. Peer Inventory 1: Private Sector Engagement Terminology and Typology".

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<sup>xxiv</sup> Forthcoming (mid 2018) updated debt sustainability framework for LICs

<sup>xxv</sup> These countries are non PRGT eligible LMICs and PRGT eligible LMICs that had their last debt sustainability analysis carried out under the existing framework pre-mid-2018.

<sup>xxvi</sup> 2016 data for xx of xx GFF countries, WHO, Global Health Observatory data repository, <http://apps.who.int/gho/data/node.main.PCV3n?lang=en> [accessed: 28<sup>th</sup> February 2018]

<sup>xxvii</sup> PAI, Civil Society Guide to the GFF, PAI, 2016

<sup>xxviii</sup> GFF, GFF Civil Society Workshop Summary Report, GFF, 2017

<sup>xxix</sup> GFF, GFF Civil Society Workshop Summary Report, GFF, 2017

<sup>xxx</sup> Nigeria Global Financing Facility (GFF) Performance Scorecard, January - December 2017, see:

<https://globalsentinelng.com/wp/wp-content/uploads/2017/12/2017-Nigeria-Global-Financing-Facility-GFF-Performance-Scorecard-Zero-draft-I.pdf> ; Kenya scorecard yet to be published.