Country-powered Investments
For Every Woman, Every Child and Every Adolescent
# TABLE OF CONTENTS

- Letter from the Director .................................................. 5
- Overview ........................................................................... 6
- The Strengths and Challenges of Results Monitoring .......... 14
- Case Studies ....................................................................... 20
- Country Profiles .................................................................. 38
- Civil Registration and Vital Statistics ................................ 68
- Financials ............................................................................. 70
- Investors Group Members .................................................. 71
- Acronyms ............................................................................. 71
- Trust Fund Contributors ..................................................... 71
- Acknowledgments ............................................................... 71
- Appendix .............................................................................. 74
Dear GFF partners and friends,

We have been looking forward to this moment when we could share with you the first report on early results. We are at a crucial time in global health, seeking new ways of doing business that ensure impact at scale with sustainable and equitable results and, first and foremost, put countries in the lead. It’s an auspicious time, with the recognition that investing in people—their health, nutrition, and education—is the smartest investment we can make toward sustainable development. Three years ago, in July 2015, the Global Financing Facility (GFF) in Support of Every Woman Every Child was launched at the Financing for Development Conference in Addis Ababa by the secretary-general of the United Nations, the president of the World Bank Group, and many partners. In the three years since, the GFF has shifted from providing support to four front-runner countries (Cameroon, the Democratic Republic of Congo or DRC, Kenya, and Tanzania) to supporting 27 countries. Of those 27 countries, 16 are covered in this report, an additional 10 joined in November 2017, and Mali, the most recent, joined in June 2018.

The GFF model is transformative in that it places countries in the lead of their own development and takes sustainable financing to scale, using moderate amounts of GFF Trust Fund grants. What determines our success is not a process or model but whether we are achieving results for the women, children, and adolescents who are hardest to reach and whether we are able to achieve results at scale.

In this annual report we share the results and learning from three countries: Cameroon, DRC, and Tanzania, as well as updates from Nigeria on its resource mobilization. For the first time we share country profiles presenting data on GFF core indicators from the first 16 countries. In forthcoming reports, we will aggregate performance data from country-specific data to show global progress using a GFF dashboard of core indicators.

This report shows that countries are heading in the right direction, based on the results from the first countries. It also highlights the urgency to double down on our pace and expand our support to many additional countries with high maternal, newborn, child, and adolescent mortality burdens that have expressed a need and demand for GFF support.

To be able to first reach those women, children, and adolescents who have been left furthest behind and to support countries to get on track to sustainably finance health and nutrition and accelerate progress toward universal health coverage, we need to take the results we have achieved so far, learn from them, and go to scale. This means that the GFF partnership must reach more people who continue to be left behind because of where they live or who they are. We need to strengthen collaboration, communication, and engagement with all key partners at the country level; to continuously prioritize the resources we have and ensure that they are directed toward those who need them most; and to continue to innovate on financing, shifting from a dependency on development aid to using development aid catalytically to mobilize additional domestic and private resources.

I would like to thank all GFF partners, including contributors to the Trust Fund and members of the Investors Group, who have enabled us to take the GFF from an idea to practice, and from practice to results. But foremost, the results we have achieved are thanks to country leaders and their partners. The leadership that many governments and civil society organizations in countries have shown to date truly drives the process—and the early results speak for themselves.

The first three years of the GFF have been a time to establish our partnership, provide proof of our model, and define and start to generate results at the country level. Our aim for the next period is to expand our support to an additional 23 countries, and by 2023 to support a total of 50 countries. With the GFF partnership’s support, these 50 countries can end preventable deaths of women, children, and adolescents by 2030, and get on track to sustainable financing.

I look forward to our collective effort, moving to results at scale.

Mariam Claeson
Director, The Global Financing Facility
Accelerating Progress for Women, Children and Adolescents

Reaching Those Left Furthest Behind First

Every year, in 50 countries across the world more than 5 million mothers, children, and adolescents die from mostly preventable conditions, and the economies of these countries lose billions of dollars to poor health and nutrition. It is therefore urgent to accelerate progress on universal health coverage and to contribute to the achievement of the Sustainable Development Goals (SDG) of ending preventable maternal, newborn, and child deaths and improving the health and nutrition of women, children and adolescents by 2030.

The Global Financing Facility (GFF) in Support of Every Woman Every Child was established in 2015 as an innovative financing mechanism to close the financing gap to eliminate preventable deaths of mothers, newborns, and children by 2030 as well as improving the health and well-being of women, children, and adolescents. In countries, efforts are being made to identify and increase coverage of high impact RMNCH-A interventions and to tackle critical system bottlenecks to achieve impact at scale. A comparative advantage of the GFF approach is that it goes beyond a focus on specific interventions and disease-specific approaches to focus on outcomes at the critical stages of the life cycle: pregnancy, birth, the early years, and adolescence. The GFF helps countries build more resilient primary health care services and community health systems, reaching those left furthest behind—at the frontlines first.

The GFF approach is guided by two key principles: country ownership and equity. The GFF applies income and gender equity perspectives in priority setting, which steers resources into previously neglected geographic regions, including fragile countries and settings, and prioritizes people and interventions that have usually not received sufficient funding, such as adolescent girls and sexual and reproductive health and rights and nutrition.

Countries in the Lead

The GFF empowers countries by investing in existing institutions, and helps countries to bring together key multilateral stakeholders around the country platform—including the United Nations, the World Health Organization, Gavi, the Vaccine Alliance (hereafter, Gavi), and the Global Fund to Fight AIDS, Tuberculosis and Malaria (hereafter, the Global Fund), as well as bilateral, private-sector, and civil society partners.

The GFF and the Global Health Architecture

The GFF supports a country-centric global health architecture with global and local partners playing to their comparative advantages in support of country-led planning and implementation of RMNCH-A services and interventions.

+ Normative, implementation, and research support is provided by the H6 family (UNAIDS, UNFPA, UNICEF, UN Women, WHO, the World Bank Group) and other multilateral and bilateral agencies.
+ Advocacy and accountability for commitments and results globally are led by the Partnership for Maternal, Newborn, and Child Health and its constituencies, including the broader community of civil society organizations.
+ Financing is provided by the GFF, complementing and supporting investments made by Gavi, the Global Fund, and other funders.

To support the work at the country level, the GFF Investors Group, including governments, civil society organizations, the private sector, UN agencies, Gavi, and the Global Fund, came together biannually at the global level to discuss progress in financing and implementing the work at the country level and to strengthen collaboration across the partnership.

The GFF and Civil Society

Civil society organizations play an important role in advocacy for resources and policies, elevating the voices of affected populations, monitoring, and providing accountability. They also contribute research, technical assistance, and service delivery. Many of these organizations can provide services and community engagement in places the government or other organizations are unable to reach.

Advocacy and social mobilization are critical to ensure that national efforts are responding to the needs of affected populations and and are taking into account access, equity, and the quality of service delivery. Civil society organizations are therefore essential to the partnership model of the GFF. They are represented in the Investors Group with two seats and two alternates, including one youth representative seat.

The GFF strives to enable partners and stakeholders to identify their comparative advantages, avoiding duplication and reducing gaps by supporting the government to bring all key stakeholders together to develop and implement a single country-led investment case based on the specific needs of the country. A forum or committee under government leadership brings together the broad set of partners involved in RMNCH-A, including different parts of the government, civil society, the private sector, and development partners. Where available, the GFF supports the existing multistakeholder platform and processes, to avoid duplication.

Investment cases identify not only priority interventions to achieve agreed results, but the most significant health system bottlenecks that need to be addressed to deliver them. Such bottlenecks may be in governance, in the health workforce, in the financing operations, in supply chain management, or in information systems, including civil registration and vital statistics. Investment cases also consider the extent to which targeted investments in different sectors—such as education, water and sanitation, and social protection—might have a significant impact on women’s, children’s,

50 countries have asked to join the GFF; to date, 27 countries are receiving GFF support:

- Afghanistan
- Bangladesh
- Burkina Faso
- Cambodia
- Cameroon
- Central African Republic
- Côte d’Ivoire
- Democratic Republic of Congo
- Ethiopia
- Ghana
- Guinea
- Haiti
- Indonesia
- Kenya
- Madagascar
- Malawi
- Mali
- Mauritius
- Mozambique
- Nigeria
- Pakistan
- Papua New Guinea
- Rwanda
- Senegal
- Sierra Leone
- Tanzania
- Thailand
- Togo
- Uganda
- United States
- Vietnam
- Yemen

What is the GFF?

The GFF partnership supports governments to bring stakeholders around the table to agree on and adequately fund an investment case with a clear set of priorities across reproductive, maternal, newborn, child, and adolescent health and nutrition (RMNCAH-N), following a country-led plan. Focusing on women, children and adolescents, participating countries invest in high-impact and historically underfunded areas such as sexual and reproductive health and rights, maternal and newborn survival, adolescent health, and improved nutrition in the early years—and in strengthening the health systems needed to deliver at scale and with sustained impact.

The GFF Trust Fund acts as a catalyst for financing the investment case, with countries using modest GFF Trust Fund grants to significantly increase their domestic resources and external investment and by bringing together biannually at the global level to discuss progress in financing and implementing the work at the country level and to strengthen collaboration across the partnership.

The GFF Trust Fund is represented in the Investors Group with two seats and two alternates, including one youth representative seat.
and adolescents’ health and nutrition outcomes. The investment case for each country covers three to five years, but it is developed with a long-term perspective. That is, it emphasizes the priority obstacles that must be overcome to get a country onto the trajectory needed to reach the health-related SDG targets by 2030.

The GFF Trust Fund supports each country in mapping resources and aligning funders around the investment case and in identifying the key health financing reforms it needs to make to mobilize its domestic resources. It also collaborates in expenditure tracking. GFF-supported countries have their own South-South learning network, sharing successes and lessons in real time and learning from each other to accelerate results.

### Prioritizing Investments

The GFF Trust Fund catalyzes the following sources of funding, and has shown results in four of these areas:

- **Domestic Resource Mobilization**

  All countries joining the GFF agree to mobilize additional domestic resources for health. In most countries, the GFF partnership has supported the government in assessing different options to increase resources for health and nutrition. In addition to supporting countries in developing or strengthening their existing health financing strategies (as in Ethiopia, Myanmar, Senegal, and Uganda), the GFF has provided countries with technical assistance to evaluate their fiscal space for health and supported increased dialogue between the Ministry of Health and the Ministry of Finance. Engaging in this work is an important step for countries that want to identify and mobilize sources of additional public domestic funds for the sector, Cameroon and DRC being two examples.

  Some countries are able to secure domestic resources at current levels to avoid displacement, while others need to increase domestic resources up-front. For instance, in Mozambique the resources linked to disbursement—through “disbursement linked indicators” in their health-financing results agenda—are provided if domestic expenditure on health remains stable for the first three years, and then if expenditure increases in the subsequent two years disbursements are made to avoid substitution of domestic resources for external financing. Because of the GFF process, Cameroon is increasing the share of its health budget allocated for women’s and children’s health from 6 to 22 percent by 2020. Guatemala’s grant from the GFF Trust Fund is buying down the interest on a World Bank loan for a national stunting-reduction program, matched by domestic resources. These resources will finance a conditional cash-transfer program in Guatemala that targets families with children between ages 0 and 15, promoting health visits for children ages 0 to 6 and pregnant women and school attendance for children ages 6 to 15.

### Case Study: Nigeria

Nigeria has always been committed to the principles of universal health coverage and has adopted policy documents and legislation to that effect. However, indicators of Nigeria’s health outcomes and actual coverage of basic health services show underperformance, both in absolute terms and relative to other countries at similar levels of economic development. Key drivers of underperformance include a health system unable to ensure universal coverage of primary health care services and weak accountability for results. The health sector has long been underfunded, and its structural and institutional frameworks have placed concurrent responsibilities on all three tiers of government (federal, state, and local) without any mechanism for intergovernmental accountability.

To rectify the lack of a legal framework necessary to drive a high-performing health system, in late 2014 the Federal Government of Nigeria signed into law the National Health Act. This Act provides a framework for action, encompassing the regulation, development, and management of a national health system, and it sets standards for rendering health services throughout the federation.

The Mission to Provide the National Health Act with Adequate Funding

The National Health Act specifies that all Nigerians shall be entitled to a Basic Minimum Package of Health Services (hereafter the Basic Minimum Package), a set of preventive, protective, promotive, curative, and rehabilitative health services or interventions. One of the key provisions in the Act is the Basic Health Care Provision Fund (BHCPF), which will serve as the principal funding vehicle for the Basic Minimum Package while at the same time serving to increase overall financing to the health sector. Its funding is derived from three tracks, namely:

1. an annual grant from the Government of Nigeria of at least one percent of its Consolidated Revenue Fund;
2. grants by international donor partners; and
3. funds from any other source.

However, the BHCPF has remained unfunded since the law was signed in 2014, notwithstanding the fact that a diligent implementation of the Act could set Nigeria on the path toward universal health coverage. A turning point came in mid-2016, when Nigeria joined the GFF and the newly appointed minister of health proposed that US$20 million in grant resources from the GFF Trust Fund be used to pilot the BHCPF in three states. The Bill & Melinda Gates Foundation also committed US$2 million in grant resources to test the BHCPF’s early implementation and provided financing to the World Bank to undertake analytical work to strengthen the design. This inflow of resources further strengthened the advocacy by various partners for the implementation of the BHCPF. The World Bank supported the leadership of the Ministry of Health in engaging with Nigeria’s Economic Management Team, and development partners in the GFF supported an advocacy mission to the National Assembly. Civil society organizations and the media played a critical role in this advocacy campaign.

Nigerian parliamentarians responded by concluding that if external grant resources could support three states, the Government of Nigeria should be willing to commit its own resources as well. In this way, GFF resources proved to be an instrumental tool for a call to action. The outcome of these strategic investments and the associated analytical work and advocacy was that in May 2018, the Government of Nigeria decided to allocate the full one percent of its Consolidated Revenue Fund for the BHCPF in the FY2018 appropriation.

### Strengthened Funding for Primary Health Care

As Nigeria begins to implement the BHCPF, the fund is expected to mobilize close to 60 billion Nigerian naira (approximately US$150 million) in new money per year for primary health care strengthening and service delivery. While the resource envelope for the BHCPF would currently be inadequate to guarantee full coverage of the Basic Minimum Package to the entire population, the government’s proposed gradual expansion of the BHCPF is well within reach, especially as the economy recovers and the size of the resource envelope increases.

### Performance-based Financing

The BHCPF employs proven, results-based and decentralized approaches and thus represents not only more money but “smarter money,” enabling Nigeria to translate bold innovations in service delivery into improved health outcomes. The implementation uses two interrelated approaches to improve service delivery, not only in public but also in private facilities.

First, a fee-for-service payment approach to providers will initially spur the delivery of a highly prioritized package of 10 high-impact maternal and child health interventions, including family planning. A focus on serving rural areas will help address equity challenges, because health outcomes are significantly poorer—and worsening—in rural areas.

Second, an accreditation system will be used to prequalify both private and public health facilities, contributing to the setting and maintaining of minimum quality standards. Payments will be made on the basis of verified data after the services have been provided, while keeping services free to beneficiaries, thus increasing accountability while reducing barriers to accessing care. The BHCPF signals a new era in service delivery for primary health care services in Nigeria.

In summary, the GFF platform and the investment case provide a mechanism for partners to jointly support the Government of Nigeria in delivering on its commitment, expressed through its FY2018 appropriation to fund the BHCPF. With this clear commitment, a growing number of development partners are contributing to the setting and maintaining of minimum quality standards. Payments will be made on the basis of verified data after the services have been provided, while keeping services free to beneficiaries, thus increasing accountability while reducing barriers to accessing care. The BHCPF signals a new era in service delivery for primary health care services in Nigeria.
Concessional Financing (IDA/IBRD): The GFF directly links GFF Trust Fund grants to substantially higher amounts of IDA funding than initially expected. The GFF also directly links GFF Trust Fund grants to IDA/BRD funding—such as in Guatemala and Vietnam, buying down interest to more concessional levels. The current ratio of GFF Trust Fund grants to IDA/BRD funding is 1 to 7.3. With a historically large IDA replenishment (US$75 billion, 2018–20), a vast window of opportunity has opened to front-load GFF Trust Fund investments and thereby accelerate progress on the SDGs, closing the financing gap.

Alignment of External Assistance: In the past three years, the GFF country-led multi-stakeholder platforms have contributed to donor alignment and harmonization, increasing the efficiency of individual and collective investments made by partners. GIFT support for resource mapping has helped align donor and government funding to the costed priorities of the investment case for RMNCAH-N. Of the initial 16 GFF countries, resource mapping is being done in Cameroon, DR Congo, Ethiopia, Guinea, Kenya, Liberia, Mozambique, Nigeria, Senegal, Sierra Leone, Tanzania, and Uganda. To date, at least three bilateral partners are aligning their financing to the priorities of the investment case in 14 countries among the first round of 16 GFF countries.

Private Sector: The GFF is developing and implementing innovative financing instruments to crowd in private capital and help close the financing gap. These instruments leverage a combination of flexible grant funding from the GFF Trust Fund and the financing expertise available within the World Bank Group (including the IFC and World Bank Treasury), at the GFF Secretariat, and among the GFF partners. The GFF also facilitates partnerships with the global private sector, enabling GFF countries to deploy private sector capabilities to deliver on investment case objectives, including support for service delivery and the development of supply chains to reach the front line of health systems.

Implementation, Learning, and Course-correction: The GFF links disbursements to results and shifts the focus away from inputs to outcomes, at all levels of the health care system. This is accompanied by a strengthening of governance, accountability, building capacity to manage public financing, and increasing transparency of continuous results monitoring.

Mozambique, for example, drives health system and finance reforms by linking disbursements to [among others] coverage of community health workers trained and active; institutional deliveries in priority districts; secondary schools offering sexual health and reproductive services; family planning; provision of nutrition interventions to children in provinces with the highest chronic malnutrition; health expenditures made in underserved areas; domestic health expenditures; total government expenditures; and deaths certified in health facilities with data on cause coded.

Starting by focusing on the health outcomes of the populations furthest left behind, the GFF model includes elements to strengthen health information systems and increase the country demand for high-quality routine data, so that countries and partners can continuously course-correct based on both financial information and results data and achieve results at scale. The implementation and their implementation are regularly reviewed and updated to ensure that prioritization and financing are addressing the shifting needs of the specific countries and their populations.

Among the main lessons learned from the initial GFF-supported countries are the need to strengthen coordination among partners and improve communication about in-country processes and milestones to enable all interested stakeholders to contribute throughout the design and implementation phases. Based on this learning, the GFF initiated the last round of 10 countries that joined the GFF partnership by inviting all key stakeholders to the launch and appointing GFF liaisons in each country tasked with improving communications about and transparency in the processes. The implementation and the names of these GFF liaisons are available on the GFF website. Most importantly, the participation of the private sector is key in the value proposition of the GFF, and effective private sector engagement is essential to reach the GFF objectives by 2030.

The GFF as a financing and operational platform is well-placed to design and launch innovative financing mechanisms, leveraging expertise and experience across GFF partners, reducing transaction costs, and increasing financial efficiency to create more effective instruments for mobilizing private capital at scale.

Over the last year, progress has been made in the development and early implementation of a stronger private sector strategy. The private sector is an important partner at both the global and country levels as a source of capital, technical expertise, capacity, and innovation, and it is a key partner for increasing countries’ capacity for delivering on key elements of the health system.

Together with the World Bank Treasury, the GFF launched a series of issuances of Sustainable Development Bonds to raise awareness among private investors of the financing needed to invest adequately in the health and nutrition of women, children, and adolescents. The inaugural issuance of CAD 60 million was announced during the G7 Summit hosted by the Government of Canada in June 2018, with continuing issuances since.

Through innovative financing instruments such as loan buy-downs and cofinancing grants, the GFF enables countries to access private sector capital at more affordable terms for RMNCAH-N, helping close the financing gap together with domestic resources, development assistance, and multilateral funding, all with a focus on results.

At the global level, the GFF has engaged in “shared-value” partnerships to align private sector, government, and development partners. Thematic areas for GFF private sector partnerships have included medical technology and, more recently, supply chains. The launch of a GFF public-private partnership with Merck for Mothers, the Bill & Melinda Gates Foundation, and The UPS Foundation aims to bring together private sector and best practices to help GFF-participating governments improve their supply chain management. The GFF partnership also continues to see strong engagement at the global level by the private sector through the Investors Group and through participation in multi-stakeholder country platforms led by country governments.

At the country level, several GFF countries are leveraging private capacity to deliver quality essential services and products by contracting at the national or multisector scale (examples include Cameroon, the DRC, and Nigeria). This strategic purchasing with private providers alongside the public sector, using performance-based financing, has been valuable in fragile and conflict-affected areas, where public infrastructure alone is insufficient or otherwise unable to adequately serve the basic health and nutrition needs of women and children.

Other GFF countries, including Uganda and Liberia, are using private sector capacity and technical assistance to deliver quality health and nutrition services at scale. With support from the GFF Trust Fund and co-financers and the participation of the private sector, the projects in the above five countries are expected to reach over 31 million beneficiaries.

In response to country demand, the GFF has expanded its technical assistance and capacity building support for governments to strategically and systematically engage the private sector for RMNCAH-N priorities. This capacity building has been done through online and face-to-face trainings such as the Managing Markets for Health course, whose first iteration occurred in April 2018 and reached 450 participants globally. This support also equips governments with various policy and financing tools to influence private markets so they can better serve development and equity objectives; an example of this is quality improvements achieved through the regulation of private sector service providers in Kenya. The GFF has also supported several GFF countries to conduct private sector assessments to identify opportunities to partner with the private sector to reach underserved populations and regions and to contribute to the global evidence base on private sector contributions to health systems.

Over the next year, the focus will be on further consolidating and scaling the successes achieved, as well as disseminating country-specific experiences and further mainstreaming effective public-private approaches across the country portfolio.
Importantly, the GFF is working with the Partnership for Maternal, Newborn, and Child Health to support civil society organizations in their key roles and functions, building capacity and more meaningful engagement.

**Driving Results and the Way Forward**

After its first three years, the GFF is showing results in some of the early front-runner countries it has supported to date. The GFF will expand to 50 countries over the next five years, by 2023, and the world will come closer than it ever has before to closing the health and nutrition gaps for women, children, and adolescents. That will translate to lives improved and saved, thriving families, and surging economic growth.

The mission of the GFF partnership is to contribute to the SDG3 targets: by 2030, reducing the maternal mortality ratio to 70 per 100,000, the under-five mortality rate to 25 per 1,000, and the newborn mortality rate to 12 per 1,000, and also improving the health and nutritional status of women, children, and adolescents. To achieve all of that, countries have to accelerate progress toward achieving universal health coverage now, with the GFF partnership and Trust Fund resources providing the catalytic financing required. There is no better time to close the gap and transform the lives of millions.
The Global Financing Facility: The Strengths and Challenges of Results Monitoring

Since its launch in 2015, the Global Financing Facility (GFF) has pioneered country-led Investment Cases and companion monitoring frameworks. While each country context is different, the urgency and the objectives of most initiatives in RMNCAH-N are similar. The GFF helps countries prioritize their activities based on sound data, adequately fund the highest-impact activities, mobilize their resources to ensure that investments are sustainable, and have underpinning systems that are strong and sustainable.

Monitoring Results and Impact: Results monitoring is vital to the success of this approach. Having access to routine data is critical to guide the planning, coordination, and implementation of the RMNCAH-N country-led response, specifically to assess the effectiveness of programs and identify areas for improvement during implementation for real-time course correction. Furthermore, strong health information systems are needed to aid countries in monitoring their health-financing reforms and tracking the funds allocated to health, specifically to RMNCAH-N. Investing in health information systems gives greater visibility to where and how efficiently resources are being allocated and spent, empowering governments and other policymakers, donors, and partners. In addition to measuring and assessing progress on the investment case, the GFF focuses on the necessity of optimizing health sector investments and continually improving equity and efficiency in service delivery and resource allocation.

To support the Every Woman Every Child initiative, the GFF aims to contribute to the achievement of the 2030 SDGs for RMNCAH-N in 50 countries. By providing support to countries to mobilize additional resources for health and nutrition, working together with governments and global health partners, the GFF aims to collectively add US$50 billion to US$75 billion over the next 12 years, so that by 2030 the GFF can contribute to:

- Reducing the maternal mortality ratio to 70 per 100,000, and
- Reducing the deaths of newborns to 12 per 1,000 and
- Reducing the deaths of children under age five to 25 per 1,000.

All of this will bring us closer to achieving the SDGs, which also include universal access to sexual and reproductive health, including family planning.

These goals will be monitored through the use of core impact indicators (see box). These indicators are collected by the GFF and partners by building on existing surveys and reporting systems. These include country survey data, such as the Demographic Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS), which are funded by domestic resources as well as by the World Health Organization (WHO), UNICEF, United States Agency for International Development (USAID), and many other multi- and bilateral organizations. Optimally, these surveys are conducted every three to five years to determine changes in important health and nutrition outcomes. The country profiles for the initial 16 countries include the most recently available data for these indicators. The GFF will continue to report new data, as surveys are implemented and more recent data become available.

GFF Approach to Country-Focused Process Monitoring

The GFF uses a country-led approach that includes several processes necessary to success. Based on our learning from several countries in the first three years and from monitoring of the GFF approach by civil society organizations, the GFF has developed a core set of indicators to monitor the implementation process of the GFF approach in each country. These include the monitoring of:

- The development of a prioritized and well-funded investment case
- A strong results framework
- A multi-sectoral country platform that focuses on continuous monitoring of implementation, and
- Strong leadership in the country-led process with inclusive representation from civil society, the private sector, and other stakeholders.

These efforts include monitoring of the development of health financing reforms (domestic resource budgets and expenditures), IDA and IBRD approval and disbursement, engagement with development partners, and private-sector investment. Data based on this monitoring are presented in the country profiles.

Health Financing Reforms: To accelerate progress in coverage of high-impact interventions, to learn and course correct, and generally to achieve the RMNCAH-N goals, the GFF partnership (including governments, the H6 partners, USAID, numerous bilateral, civil society organizations, the private sector, and others) aims to catalyze investments for RMNCAH-N with an additional US$2 billion of GFF Trust Fund resources between 2018 and 2023. The GFF estimates that countries will be able to use these Trust Fund resources catalytically to increase the proportion of government resources allocated to health, as well as increase the total volume of these resources allocated to investments in the most cost-effective RMNCAH-N interventions.

The GFF Trust Fund partnership aims to continue to align and catalyze additional resources by linking Trust Fund support with a combination of concessional financing from the IDA and IBRD (presently at a ratio of 1 to 7.3), by aligning external financing, and by further effectuating private-sector resources for RMNCAH-N. [Forthcoming publication] The collective GFF partnership is supporting these financing reforms by engaging with ministries of finance and ministries of health to strengthen domestic resource mobilization. This work seeks to ensure not only that more public resources are mobilized but also that they are aligned. In order for countries to progress toward universal health coverage and to ensure both effective coverage of high impact RMNCAH-N interventions and financial protection in case of ill health, investments in health information systems and routine data are critical. These investments are also critical to achieve health-financing reforms and increase the total volume and value of funding allocated to health and nutrition.

GFF Core Impact Indicators

- Maternal mortality ratio
- Under-5 mortality rate
- Newborn mortality rate
- Adolescent birth rate
- Birth spacing (proportion of the most recent children age 0-23 months who were born less than 24 months after preceding birth)
- Prevalence of stunting among children under 5
- Prevalence of moderate to severe wasting among children under 5
- Proportion of children who are developmentally on track (when the definition of this indicator has achieved global consensus)
The GFF approach additionally aims to increase allocative and technical efficiency through better coordinated implementation, both by supporting evidence-based strategies and interventions and by routinely course-correcting through continued monitoring of available resources and results. Increased efficiency and sustainability will also be promoted by the GFF and its partners focusing on supporting solutions for key systems bottlenecks, closing financing gaps, and strengthening systems to track progress, to learn, and to course-correct. Taken together, the objective of this approach is to accelerate the expansion of high-impact, cost-effective, affordable, and feasible interventions and introduce key health financing reforms to get countries onto the trajectory needed to accelerate progress on Universal Health Coverage, and achieve their SDG targets.

These health financing reforms will be measured through a set of core health financing indicators, as can be found in the country profiles, which present the most recent data available from country sources. Additionally, to track and ensure progress in each one of the GFF-supported health-financing reforms on a more frequent basis than available through the core indicators, the GFF will work with key technical partners to monitor the following recommended process and outcome indicators:

- Monitoring geographic priorities (regional disparities, urban versus rural)
- Are we in the right places?
- Do the results match the available resources?
- Do the committed investments match the amounts disbursed?
- Are the funds matching the needs?

The GFF has provided a summary of the process.

Support for strong financial and results data of this kind helps improve equity in funding decisions. When financial data can be linked to results, it supports efficiencies in the health care system, making it possible to optimize investments and to continuously improve equity and efficiency in service delivery. Therefore, in the future, the GFF, with partners, seeks to improve resource tracking systems to better understand budgeting processes and disbursement and expenditure data, and aims to integrate these with routine data monitoring systems. When data can be integrated this way, expenditure data can feed into priority-making and decisions on resource allocation, and in turn can be used to project the future resource requirements for meeting investment case objectives for improved equity and efficiency.

A table of all indicators presented in the country profiles can be found on page 74.
such as health delivery supply chain, the distribution of frontline providers, and budget execution. Proxy outcome indicators to monitor and reduce inefficiencies include the dropout rate between a child’s 1st and 3rd DTP vaccinations; the dropout rate between a mother’s ANC1 and ANC4 antenatal care visits; and the health budget’s execution rate. To truly understand health care efficiencies, the use of resource tracking and expenditure data is optimal. Therefore, where available, these data will be reported; where not available, the GFF will look for opportunities to strengthen these management and reporting systems.

**Investment Case Routine Monitoring**

Because each country has identified a distinct set of priority interventions, the routine monitoring frameworks vary. As part of our learning agenda, the GFF has conducted case studies of routine monitoring in a few of the GFF front-runner countries. Cameroon, DRC, and Tanzania have developed case studies highlighting their GFF country-led process, results, and use of data for improvement. As other countries progress in the development and implementation of their own investment cases, more routine monitoring data will be available (see box). It is anticipated that data will become available from countries’ routine Health Management Information Systems, including DHIS2 and laboratory and management information systems (LMIS), as well as from financial management and resource tracking systems, which the GFF will draw from in future reports, especially for learning and course correction (www.globalfinancingfacility.com).

The frequently incomplete registration and manual processes of civil registration and vital statistics limit access to the data required for timely monitoring of progress in ending preventable maternal, newborn, child, and adolescent deaths and morbidity, particularly at the subnational level. The GFF has thus prioritized the strengthening of civil registration and vital statistics systems, supporting countries to develop investment cases that include these systems as strong components and co-financing investments (data on GFF CRVS investments are presented on page 69).

**Role of the Country Platform:** The potential strength of the GFF partnership is its country-led process, where all relevant partner data on RMNCAH-N can be shared and reviewed through the country platform. This platform strengthens the data collected for the investment case, mainly through national data systems, and enables reviews and sharing of all relevant data by all partners. Partners such as FP2020, Gavi, the Global Fund, PEPFAR, and USAID may indeed have access to other sources of data with more detailed and even real-time data available, which they can share. Data collaboration at the country level can in turn improve the use and ownership of the results, and improve overall transparency and shared accountability.

The aim of the country platform is to review data routinely—quarterly or semi-annually—using routine subnational data where available. Additionally, when new data becomes available—such as financial data through the system of health accounts or periodic survey data such as Service Availability and Readiness Assessment (SARA), Service Delivery Indicators (SDI), Demographic and Health Survey (DHS) or Multiple Indicator Cluster Surveys (MICS)—it is intended to be incorporated into the analysis. An annual and midterm review should also be done, including monitoring of the disbursement-linked indicators that are also used by countries supported by GFF and the World Bank for results-focused financing.
In this annual report the GFF shares the results and learning from case studies of three countries—Cameroon, the Democratic Republic of Congo (DRC), and Tanzania—allowing a deeper dive into their progress and results. Additionally, in the this report the GFF shares the country profiles of the first 16 countries, presenting data on the GFF core indicators, including country investment case and geographic prioritization, baseline data on health and nutrition outcomes, and core intervention coverage data. For the most part the data presented predates the implementation of the investment cases and is considered a country baseline from which to improve. As part of the GFF process, most countries have completed their country-led investment cases, with multi-stakeholder engagement including civil society organizations, 10 of the countries engaged the private sector as well. Only one country has not yet completed its investment case, and 60 percent are currently implementing theirs. Twelve countries have approved and are disbursing World Bank projects.

The country profiles also focus on health financing data and resource mapping, including IDA/IBRD and co-financing, pooled and virtually pooled funding. Fourteen countries have developed health financing reforms incorporated into the investment case or in a separate document or process. Most countries have focused on identifying options for strengthening domestic resource mobilization and strategies to reduce key drivers of inefficiency, while fewer countries have identified drivers of limited financial protection. Based on the results from the first countries, this report shows that countries are heading in the right direction. In forthcoming reports, the GFF will present aggregated country-specific performance data, to show global progress using dashboards of the GFF core indicators.
CASE STUDY

The Republic of Cameroon

Despite its lower-middle-income status, Cameroon was recently ranked 153rd out of the 188 countries tracked in the Human Development Index (HDI 2014) and, indeed, it is one of a group of countries whose HDI scores have declined in the past two decades. Contributing to this HDI deterioration is slow progress on key health outcomes.

According to World Bank estimates, over the past 20 years under-five mortality declined by 54 percent, from 172 per 1,000 children under five (1998) to 80 per 1,000 (2016). Over that same period the maternal mortality ratio declined by 20 percent, from 750 per 100,000 live births (1998) to 596 per 100,000 (2015). However, mortality for mothers and children remains high and is mismatched to Cameroon’s economic status and relatively high per-capita health spending ($138 in 2014). For example, maternal mortality in Cameroon is 9 percent higher than the average rate for Sub-Saharan Africa and more than double the average rate for lower-middle-income countries.

Additionally, Cameroon suffers regional disparities in health and nutrition outcomes, with the three northern regions and the East region performing considerably worse than the national averages. For example, the proportion of girls between ages 15 and 19 who have begun child bearing is 44.2 percent in the East Region and 23.4 percent in the Far North Region, while in the capital, Yaounde, the rate is only 7.6 percent. Similarly, these four regions experience under-five stunting rates that are higher than the national average (32 percent; 42 percent in the Far North Region, 34 percent in the North Region, 38 percent in the Adamawa Region, and 36 percent in the East Region).

Plan Development, Partnerships, and Investment Case

To address these critical gaps, the Government of Cameroon led a consultative process with key partners on RMNCAH-N to plan support for partner alignment and government prioritization. The RMNCAH-N investment case was ratified in late 2016 and included interventions to address both health and nutrition outcomes as well as health financing reforms.

As part of the consultative process, the RMNACH-N investment case is supported through domestic funds from the Government of Cameroon, the World Bank IDA and Islamic Development Bank, and the GFF-Trust Fund, as well as by Gavi, the Global Fund, the UN Population Fund (UNFPA), UNICEF, WHO, the German Corporation for International Cooperation (GIZ), the German Development Bank (KfW), Agence Francaise de Dévelopement (AFD), the US government, UNITAID and the Bill & Melinda Gates Foundation. The private sector is also supporting the
The Government of Cameroon used the investment case to inform its 2018 national budget, developed at the end of 2017. Despite a decline in the overall health budget that resulted from a fiscal consolidation, the Direction des Ressources Financieres et du Patrimoine (DRFP) in the Ministry of Public Health reports a substantial increase in the health budget allocation to priority regions identified as being high-burden as part of the investment case.1

Additionally, in 2017 the government committed to a series of fiscal and policy reforms in the public sector as part of a budget support program with the World Bank. The OIT process provided the analytical underpinnings for the health sector reforms, including a trigger that commits the government to increase the health budget allocation to the primary and secondary levels from a baseline of 8 percent in 2017 to 20 percent by 2020. The investment case was a useful tool for informing the dialogue between the ministries of health and finance.

Increasing Uptake of Essential Services

Cameroon has been working to increase the uptake of the essential health services included in the investment case through an expansion of facility-level performance-based financing and demand-side efforts such as Chèque Santé (health vouchers), which seeks to activate demand for maternal and newborn health services and reduce the burden of out-of-pocket expenditure. The government of Cameroon expects to achieve full coverage of the performance-based financing system in the investment case priority regions by mid-2018.

Early progress noted. The increased service utilization seen in Figure 1 is partly accounted for by the expansion of the national performance-based financing program to the Adamawa, North, and Far North regions (the East Region was already implementing this prior to 2017). In 2017, the country expanded performance-based financing contracting to an additional 921 facilities (there were 1,428 total facilities under contract in the last quarter of 2017). However, 55 percent of this growth was concentrated in the four priority regions identified in the investment case, even though these four regions only account for 20 percent of the healthcare facilities in the country.

There is also data to suggest that once facilities are under contract they show improvements in productivity. In the North and Far North regions, there were 34 facilities that had contracts for the first time and reported results starting in the first quarter (additional facilities were added throughout the year). By the fourth quarter, the number of skilled births that these facilities had attended increased by 71 percent. This suggests that the combined efforts of partners working on the supply side and the easing of demand-side bottlenecks to service access are driving improvements at the facility level.2

Increasing Access to Family Planning

In addition to maternal and child health services, the Investment Case also places a priority on increasing access to modern methods of contraception, diversifying the method mix, and improving access to contraception among adolescent girls. Nationally, only 21 percent of married women were using a modern method of contraception as of 2014 (MICS 2014). As of 2017, investment case priority regions had the lowest rates of use of such modern methods in the country, at just 3.5 percent in the Far North Region, 6.1 percent in the North Region, 7.7 percent in Adamawa Region, and 14.5 percent in the East Region.

Early progress noted. Family planning visits in facilities using performance-based financing increased over the course of 2017, with growth in visits for both short-term methods and long-acting reversible methods. This progress has been supported by several financiers and technical partners, including support for commodity procurement through UNFPA Supplies and supply-side efforts such as performance-based financing (Figure 2).

Pilot Project for Adolescent Sexual Health

Throughout the year, preparations for a pilot project focused on quality counseling and contraceptive uptake in sexually active adolescents were undertaken in the East Region by the Family Health Directorate in the Ministry of Public Health in collaboration with UNFPA and the World Bank. This pilot will begin in mid-2018 and will test a technology solution for improving the counseling experience of adolescent family planning clients as well as an evaluation intended to better understand the supply and demand-side response to family planning subsidies.

The priorities articulated in Cameroon’s investment case are being reflected in the national budget, in the activities of health sector actors, in improvements in the utilization of priority health interventions, and in efforts to strengthen the health sector broadly. As Cameroon enters its second year of investment case implementation, greater scale will be achieved, and there will be even more emphasis placed on partner engagement and communication. In particular, there will be support focused on the national health management information system, including data quality and completeness and the use of data to understand service utilization trends, and on strengthening efforts to track partner and government financing for investment case priorities. This focus will strengthen the “learning-system approach” that will be key to sustaining progress on RMNCHaN outcomes in Cameroon.

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1. Personal communication with the Sous-Directeur du Budget et du Financement who performed the budget analysis.
2. Analysis is based on facility-level performance-based financing data available at http://fhir.reconciliation.org/
Democratic Republic of Congo

In the Democratic Republic of Congo (DRC), the GFF was launched in April 2015. The government put in place a GFF platform that brought together the key government health stakeholders, other line ministries, civil society representatives, and development partners. The GFF platform took the lead in developing the country’s RMNCAH-N investment case, which prioritizes the interventions laid out in the National Strategic Development Plan 2016-2020. The Ministry of Health, with representatives from civil society organizations, focused on defining RMNCAH-N priorities; UNICEF conducted a health system bottleneck analysis; WHO provided support in costing the investment case; and the GFF Secretariat helped with the resource mapping exercise with the support of the government and several donors.

Scaling Up Essential Services

The investment case has identified 12 priorities with a goal of reducing maternal mortality from 890 to 800 per 100,000 and child mortality from 119 to 88 per 1,000, over a period of five years, in 14 priority provinces. Among the 12 priorities, Priority 1 is to scale up an essential package of high-impact, cost-effective RMNCAH-N services. This priority is the cornerstone of the investment case and accounts for three-quarters of its total budget. The Ministry of Health, the World Bank, the GFF, the Global Fund, Gavi, UNICEF, UNFPA, and USAID have aligned their technical and financial resources in support of the implementation of the identified priority areas.

**FIGURE 3**
Provision of Key Maternal and Child Health Services in the 14 Targeted Provinces, DRC, 2017

- **Average Number of Assisted Deliveries per Primary Health Care Facility in DRC, 2017**
- **Average Number of Pregnant Women Receiving 4th ANC in the 36th Week of Pregnancy per Primary Health Care Facility in DRC, 2017**
- **Average Number of Children Vaccinated with the BCG Vaccine in DRC, 2017**
- **Average Number of Children Vaccinated for DTP/HepB/Hib (3 doses) in DRC, 2017**

**CASE STUDY**

Democratic Republic of Congo (DRC), 2015

Source: Ministry of Public Health, 2017

**FIGURE 4**
Provision of Key Maternal and Child Health Services in the 14 Targeted Provinces, Showing Averages for Participating vs. Nonparticipating Facilities, DRC, 2017

Source: Authors estimates based on SNIS, 2017

1 Tanganyika, Haut-Lomami, Sankuru, Maniema, Lomami, Tshuapa, Kinshasa Central, Sud-Kivu, Kasaï, Kasaï-Central, Lubukala, Mongala, Sud-Ubangi, Kwango
Early progress noted. During 2017, the number of women and children in the 14 provinces using the essential package of health services under Priority 1 has increased substantially. Looking at utilization data from 2017, in December 2017 there were 39,000 more women vaccinated with the BCG vaccine and 25,000 more children vaccinated with three doses of the DTP/Hepatitis B/Hib pentavalent vaccine compared to January 2017. Similarly, there were 15,000 more assisted deliveries and about 4,000 more women attended four antenatal counseling sessions in December 2017 compared to January 2017 (Figure 3). Put differently, from January to December 2017, the number of children vaccinated with BCG vaccine increased by about 35 percent, 36 percent of the number of children vaccinated with the DTP/Hepatitis B/Hib vaccine by 25 percent, the number of assisted deliveries by 14 percent, and the number of antenatal care consultations by 6 percent.

Performance-based Financing

The investment case has served as a catalyst for health financing reforms. One of these was the introduction of strategic purchasing, that is, paying health facilities based on their performance and providing financial incentives for increasing the quantity and quality of the essential maternal and child services provided (IC Priority 9). The strategic purchasing program is supported through pooled financing from the Norwegian Agency for Development Cooperation (Norad), the Government of Canada, the Bill & Melinda Gates Foundation, USAID, the Global Fund, and the World Bank. It is supplemented by complementary activities and interventions financed by a number of other partners.

Early progress noted. In January 2018 about 2,940 out of 17,000 health facilities in the DRC were participating in the program. The rationalization of the payment system and the introduction of strategic purchasing have resulted in additional increases in the number of children and women receiving services, above and beyond the passive trends in the prioritized provinces (Figure 4). Over the 12 months of 2017, when compared with health facilities that did not participate in the strategic purchasing program, on average each participating facility added 16 more antenatal care consultations, 36 more assisted deliveries, and 31 more children vaccinated with BCG and more with the third and final dose of the DTP/Hepatitis B/Hib pentavalent vaccine². Put differently, over the 12 months of 2017, strategic purchasing has increased the levels of BCG vaccination by 11 percent, DTP/ Hepatitis B/Hib vaccination by 13 percent, antenatal care consultations by 14 percent, and assisted delivery by 19 percent, on average, in facilities that participate in the program.

At the national level, thanks to strategic purchasing, 8,500 more children were vaccinated with the BCG vaccine, 8,700 more children were vaccinated with the DTP/Hepatitis B/Hib vaccine, there were 10,000 more assisted deliveries, and about 4,000 more women received three antenatal care consultations³ in December 2017 than in January of the same year.

Developing Accurate, Timely Data

The investment case stresses the need to develop accurate, complete, and timely data for effective management of the health sector and to ensure quality and efficiency of service delivery. It includes strengthening the health information system (system of information sanitaire or SNIS) and its electronic DHIS² platform with a focus on the provincial and health zone levels.

Early progress noted. To date, financial resources for the strengthening of the SNIS have been allocated by the World Bank with additional support from USAID, Gavi, the Global Fund, and the United Kingdom’s Department for International Development (DFID). These investments have resulted in tangible improvements to data quality. During 2017, the number of health centers with missing monthly reports on the key RMNCAH-N services prioritized in the investment case has declined by 0.2 percent for the DTP/ Hepatitis B/Hib pentavalent vaccine, 71 percent for the BCG vaccine, 10 percent for four antenatal care visits, and 16 percent for assisted deliveries.

Streamlining Financing

To further improve the alignment of domestic and external resources and achieve more effective coverage of services at a decentralized level, the investment case has scaled up an existing mechanism called the “single contract” or contract unique (CU) (Priority 9). The contract unique is a contract between the Ministry of Health at the provincial level (contracting authority), the provincial health authority (providers of health services), and development partners. The objective of the contract unique is to pool virtually all financial resources to support a single, integrated provincial health action plan, thereby reducing the fragmentation of financing and ensuring that the RMNCAH-N package of services is properly implemented and monitored. The contract unique is intended to strengthen the fiduciary capacity of the provincial health administration by using a single accounting system, and it is a powerful mechanism for tracking government and development partners’ commitment and expenditures with respect to the provincial workplans (Figure 5).

“…and the nurses are always welcoming.”

– Marie Kumba, Holy Spirit Health Center. She came to the center for all of her prenatal consultations, where she also received a bednet provided by Sanru, an NGO that delivers Global Fund bednets.

Conclusion

While the added value of GFF was to prioritize further high-impact interventions of the PNDS in provinces with the lowest health indicators, this was only made possible with the support of the government and many partners with long-standing RMNCAH-N experience in DRC. The GFF contributed to boosting alignment and financing with respect to Priority 1, the essential package of health services, whose funding was extended through a pooling of resources from the World Bank (IDA), the GFF, USAID, and the Global Fund. It is noteworthy to highlight that the investment case is building on existing successful interventions financed and implemented by the government and partners, including strategic purchasing and the single contract. The objective of the investment case is to make these high-impact interventions more visible, scale them and help the Ministry of Health pool more domestic and international resources toward them in order to sustain them and close the RMNCAH-N financing gap and save more maternal, child, and adolescent lives. While the GFF platform focused on provinces with the weakest health and socioeconomic indicators, many donors—including the World Bank, UNICEF, the European Union, the Global Fund, Gavi, and many others—made a substantial contribution outside the investment case’s provinces to reach universal health coverage through RMNCAH-N funding.

2 Estimates based on the results of regression analysis using generalizable equation (GEE) models comparing the trends in service provision between facilities that did and did not participate in the strategic purchasing program.

3 The trend in antenatal consultations was stagnant in the facilities that did not participate in the strategic purchasing program in the 14 IC provinces and, based on statistical analysis, virtually all of the increases recorded in these provinces can be attributed to strategic purchasing.

4 Other activities under this Priority Action include the development and implementation of a supply chain and human resource information systems and improvement of the links between the health management information system and the DHS² system.
Between 2010 and 2015, Tanzania saw notable improvements in life expectancy (from 61.6 to 64.9 years), infant mortality rate (from 51 to 43 per 1,000 live births), under-five mortality rate (from 81 to 67 per 1,000 live births), and under-five stunting prevalence (from 42 to 34.4 percent). However, during this period the country’s maternal mortality rate increased from 454 to 556, and its total fertility rate remained stubbornly high at 5.2 (as of 2015). The increase in maternal mortality elevated maternal health to a national priority. To address this and other lingering challenges in RMNCAH-N, in 2015 Tanzania began implementing its RMNCAH-N investment case, known as One Plan II. This was developed in a consultative process through Tanzania’s RMNCH Technical Working Group. Key financiers support different aspects of the government’s strategy to address RMNCAH-N challenges and improve financial transparency. The GFF played a critical role in mobilizing financiers to pool funding in support of the World Bank Primary Healthcare for Results initiative. The financiers of this initiative are the GFF Trust Fund, Power of Nutrition, USAID, and the World Bank. The Health Basket Fund pools support from the governments of Canada, Denmark, Ireland, and Switzerland, as well as UNFPA, UNICEF, and the World Bank. A recent resource mapping of funds provided by these major financiers shows that the plan is 75 percent funded (see Figure 6).

Several priority areas of One Plan II remain underfunded. These include strengthening service delivery for maternal complications and newborn care, adolescent health, gender-based violence, reproductive cancers, and community health. Despite major strides in partner alignment and resource transparency, further work is needed to align all partners around One Plan II and further share information on financial commitments.

The government is also implementing key initiatives to improve equity in access to health services. Improved access to services for the poor is essential for Tanzania to ensure RMNCAH-N achievements are reached and equitable. Early progress noted. In regions implementing results-based financing, the number of individuals identified by the Tanzania Social Action Fund as being below the poverty line who receive outpatient care increased considerably between mid-2016 and the end of 2017 (see Figure 7).
A Results Focus

One Plan II implementation has a strong results focus. A district-level scorecard is currently used at all levels (national, regional, and district) to monitor One Plan II results and allow continuous programmatic improvements—all based on data.

Early progress noted. A recent review of One Plan II results showed improvements between 2014 and 2017 in key service delivery interventions to improve RMNCAH-N, including increases in institutional deliveries, the percentage of pregnant women receiving at least four antenatal care visits (ANC4), the percentage of facilities receiving at least three stars (out of five) in the star-rating assessment, and coverage of intermittent preventive treatment (IPT2) for malaria during antenatal care visits (Figure 8)[refer to page 31]. Although it is too early to tell if maternal mortality will be impacted by these interventions, improvements in their coverage should result in reductions in the maternal mortality ratio. In addition, the continuous availability of 10 tracer medications has undergone notable improvement: there has been a doubling in the number of facilities that have the entire tracer drug package (from 31 percent in 2014-15 to 60 percent in 2016-17). These increases represent gradual, substantive quality and coverage improvements.

Areas where progress is lagging. Along with the above-noted improvements, however, iron supplementation coverage declined during this period. Analysis into the reasons behind this decline found gaps in the availability of iron tablets. In addition, ANC4 coverage improvements have been more modest than hoped. The 2014 baseline for ANC4 coverage was low at 35.1 percent and increased only to 46 percent by 2017.

Corrective Actions. These results have spurred the government to conduct in-depth analysis into the underlying reasons for lagging ANC4 coverage. The analysis revealed substantial geographic disparities between regions, with coverage ranging from a low of 34 percent to a high of 69 percent (Figure 9)[refer to page 32]. Further exploration into the root causes of low ANC4 coverage has found that it is influenced by women’s reluctance to disclose that they are pregnant during the early stages, health workers encouraging patients to seek initial antenatal care appointments only after 12 weeks of pregnancy, and low availability of pregnancy tests to confirm early pregnancy. Based on this in-depth data and qualitative analysis, the government is taking action to improve ANC4 coverage, including improving the RMNCAH-N component of community health workers’ training, conducting refresher trainings on antenatal care guidelines for health workers, strengthening the antenatal care component of the facility supervision checklist, and improving data use at the facility level.

Improving Service Quality

To ensure improved RMNCAH-N outcomes and service uptake, strengthened service quality is a priority in One Plan II. Tanzania’s star rating system, evaluated by a quality assessment tool administered by the Ministry of Health’s quality unit, ranks facility quality on a scale from zero to five stars. The system acts both as a measure of quality and a way of creating improved, publicly available, information on facility quality.

Early progress noted. The 2015-16 baseline star rating assessment found that only 1 percent of facilities received three or more stars. Initial results from a 2017 reassessment found that this number jumped to 22 percent of facilities receiving three or more stars. Although there are marked differences in the level of improvements between regions, all regions reassessed to date have seen some improvements (Figure 10)[refer to page 32]. These quality improvements are expected to have substantial impacts on RMNCAH-N outcomes. Review of the star rating tool and other quality measures found that many of the current quality achievements are based on improvements in structural quality, such as facility buildings and equipment availability. Currently, work is underway to update the star rating tool and other quality measures to more thoroughly assess the quality of health service delivery.

To further improve results tracking, the Office of the Vice President of Tanzania is launching an RMNCAH-N scorecard, which will incorporate the district scorecard as well as other key aspects of One Plan II’s results framework. This scorecard will help the RMNCH Technical Working Group and the government continuously monitor all areas of One Plan II implementation and make programmatic adjustments based on results. In addition, the scorecard will be used to hold regional level authorities accountable for RMNCAH-N results, a critical step towards institutionalizing RMNCAH-N as a national priority.

Steps for Continued Programmatic Improvement

In the process of reviewing RMNCAH-N results, the government found remaining challenges with data use at the facility, district, and regional levels. To further improve data use, the GFF Trust Fund plans to support improved data tracking, including analysis of data quality bottlenecks, development of a data visualization platform, strengthening the RMNCH Technical Working Group, and improved resource tracking.

As a GFF front-runner country, Tanzania was one of the first countries to develop a GFF investment case. To maximize RMNCAH-N improvements, the country is embarking on a midterm review of One Plan II which will include a review of implementation progress, comprehensive resource mapping, adjustment and reprioritization of strategies based on lessons learned, available resources and current RMNCAH-N evidence; and updates to the plan’s results framework and baseline data.

The government also plans on requesting additional financing from the World Bank to improve adolescent health services, expand civil registration and vital statistics, further improve service quality, and take additional steps to reduce the country’s high maternal mortality rate.

These next steps, identified through review of One Plan II results, will build on the investment case’s initial progress to further catalyze RMNCAH-N improvements.

“When mothers have to go into delivery, the Community Health Workers escort them to the hospital. This is the area where they have helped us a lot.”

– Justing Mayumbav, registered nurse, Mhandu Dispensary, Shinyanga District
Country Profiles
Investment Case Priorities

1. Strengthen governance and stewardship of the public and private health sectors.
2. Undertake institutional development for improved performance at all levels of the system.
3. Provide sustainable financing for equitable access to health care and accelerated progress towards universal health coverage.
4. Strengthen the capacity of the Ministry of Health and Family Welfare’s core health systems (Financial Management, Procurement, Infrastructure development).
5. Establish a high-quality health workforce available to all through public and private health service providers.
6. Improve health measurement and accountability mechanisms and build a robust evidence base for decision making.
7. Improve equitable access to and utilization of quality health, nutrition, and family planning services.
8. Promote healthy lifestyle choices and a healthy environment.

Monitoring the Country-led Process

- Investment case review in progress
- Country platform complete
- Country platform set up
- Development and initial assessment of results monitoring capacity available
- Not yet established
- Government focal point established
- Government focal point not yet identified
- Civil society representation identified
- Civil society representation not identified
- Not considered at this time
- Project not ready to launch
- Project approved and ready to launch
- Project implementation
- Civil registration and vital statistics (CRVS) not identified as a priority
- CRVS identified as a priority in the investment case
- Civil registration and vital statistics (CRVS) identified as a priority for monitoring
- Supply chain interventions identified
- Supply chain interventions not identified as a priority
- Health financing reforms identified
- World Bank-funded project in support of the IC
- Private sector engagement
- Civil registration and vital statistics (CRVS) made a priority
- Management of medicines and supplies/ priority supply chain interventions
- Other Areas of Interest

Geographic Focus Areas

World Bank-funded Project

- Approved amount: $500M
- IDA amount: $500M
- Board date: 7/28/17
- Country: Bangladesh

Health Financing Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health expenditure per capita from domestic sources</td>
<td>Expenditure per capita from domestic sources</td>
<td>World Bank, GFF, Government of Bangladesh</td>
</tr>
<tr>
<td>Ratio of government health expenditure to total government expenditure</td>
<td>Ratio of government health expenditure to total government expenditure</td>
<td>World Bank, GFF, Government of Bangladesh</td>
</tr>
<tr>
<td>Percent of current health expenditures on primary/total outpatient health care</td>
<td>Percent of current health expenditures on primary/total outpatient health care</td>
<td>World Bank, GFF, Government of Bangladesh</td>
</tr>
<tr>
<td>Incidence of catastrophic and impoverishing health expenditures</td>
<td>Incidence of catastrophic and impoverishing health expenditures</td>
<td>World Bank, GFF, Government of Bangladesh</td>
</tr>
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</table>

Bangladesh

RMNCAH-N Data

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal mortality rate</td>
<td>194 per 100,000 live births</td>
</tr>
<tr>
<td>Under-five mortality rate</td>
<td>46 per 1,000 live births</td>
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<tr>
<td>Neonatal mortality rate</td>
<td>28 per 1,000 live births</td>
</tr>
<tr>
<td>Adolescent birth rate</td>
<td>113 per 1,000 women</td>
</tr>
<tr>
<td>Stunting among children under 5 years of age</td>
<td>36%</td>
</tr>
</tbody>
</table>

Coverage Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>People living with HIV receiving ART</td>
<td>16%</td>
</tr>
<tr>
<td>Coverage of pregnant women who received ARV for PMTCT</td>
<td>17%</td>
</tr>
<tr>
<td>Children aged &lt;5 years with pneumonia symptoms taken to a healthcare provider</td>
<td>42%</td>
</tr>
<tr>
<td>Modern contraceptive prevalence rate</td>
<td>54.1%</td>
</tr>
<tr>
<td>Girls Secondary School Retention Rate</td>
<td>66% Grade 10</td>
</tr>
<tr>
<td>People aged 50+ years</td>
<td>46% Grade 12</td>
</tr>
</tbody>
</table>

Core Impact Indicators

- **ANC4 = four antenatal care visits; ART = antiretroviral therapy; ARV = antiretroviral; DTP3 = Diphtheria, Tetanus, and Pertussis; ORS = oral rehydration solution; PMTCT = prevention of mother-to-child transmission; PNC = postnatal care.**
- **Investment Case being complete**
- **Funding was allocated, disbursed and released – payment done**
- **Meaning that funding was allocated, disbursed and released – payment done**
- **Priorities fully funded**
- **Both included in the IC document or a separate document**
- **ANC4 = four antenatal care visits; ART = antiretroviral therapy; ARV = antiretroviral; DTP3 = Diphtheria, Tetanus, and Pertussis; ORS = oral rehydration solution; PMTCT = prevention of mother-to-child transmission; PNC = postnatal care.**

Resource Mapping

The GFF is supporting Bangladesh in aligning financing and technical support with a focus on improving RMNCAH-N outcomes. Through support to the government’s programs in both the health, nutrition and population and the education sectors, the GFF is catalyzing the coordinated impact of international financing totaling more than $US1 billion and influencing domestic government spending of US$30 billion in the two sectors over five years. The Health Sector Support Project is financed by US$15 million from the GFF, US$500 million from IDA, US$23 million from Sweden, US$13 million from the Netherlands, US$60 million from the United Kingdom (and proposed co-financing from other partners). The Health Sector Support Project contributes to the government’s Fourth Health, Nutrition and Population 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, and a focus on lagging regions.
Investment Case Priorities

1. Pursue a health financing strategy that allocates resources based on results, focuses attention on high-burden regions, and ensures that resources make it to primary and secondary healthcare facilities.
2. Leverage the comparative advantages of the private sector through performance-based contracting.
3. Use targeted subsidies to ensure access to healthcare services among the poor.
4. Strengthen community-level interventions through community health workers and qualified community organizations.
5. Focus effort on high-impact health interventions like Kangaroo Mother Care (to address newborn mortality) and family planning while also taking a multisectoral approach to address key social determinants for RMNCAH-N outcomes.
6. Focus on the health needs of adolescents to ensure access to services, mentoring, and education (separate performance-based financing in education).

Focus effort on high-impact health interventions like Kangaroo Mother Care (to address newborn mortality) and family planning while also taking a multisectoral approach to address key social determinants for RMNCAH-N outcomes.

Focus on the health needs of adolescents to ensure access to services, mentoring, and education (separate performance-based financing in education).

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Focus effort on high-impact health interventions like Kangaroo Mother Care (to address newborn mortality) and family planning while also taking a multisectoral approach to address key social determinants for RMNCAH-N outcomes.

Focus on the health needs of adolescents to ensure access to services, mentoring, and education (separate performance-based financing in education).
Democratic Republic of Congo

Investment Case Priorities

1. Expand an integrated RMNCAH-N package of services, including provision of medical and psychosocial services to support victims of sexual and gender-based violence.
2. Improve reproductive and adolescent health.
3. Increase coverage and improve quality of nutrition services through a multisectoral approach.
4. Accelerate access to safe water and utilization of improved sanitation and hygiene.

5. Use results-based financing.
6. Follow a community-based approach.
7. Strengthen the supply chain.
8. Improve the geographic distribution and quality of human resources.
9. Improve the fiscal space for, the availability of, and financial access to the poor to RMNCAH-N services.
10. Strengthen governance.
11. Strengthen health information systems: create link between DHIS2 and civil registration and vital statistics.
12. Establish a functional civil registration and vital statistics system.

Monitoring the Country-led Process

Geographic Focus Areas

Resource Mapping

World Bank-funded Project (IDA/IBRD/GFF)

Gap
US$44,751,949

Total
US$52,645,980,369

Country
CIRC [AF]
CIRC [AF-CVKS]

Board Date
3/31/17
3/29/16

GFF approved amount
$40M
$10M

IDA amount
$320M
$30M

Health Financing Indicators

Core Health Financing Impact Indicators

1. Health expenditure per capita financed from domestic sources 5.36
2. Ratio of government health expenditure to total government expenditure 5.87%
3. Percent of current health expenditure on primary/ outpatient health care 43%
4. Incidence of catastrophic and impoverishing health expenditure 4.6% catastrophic, 0.8% impoverishing

Investment Case

- Health financing reforms identified
- World Bank-funded project in support of the IC
- Private sector engagement
- Civil registration and vital statistics (CRVS) made a priority
- Management of medicines and supplies: supply chain interventions

Country platform

- Health financing in progress
- Project planning
- Project implementation
- Project management
- Project evaluation

Other Areas of Interest

- Supply chain management identified as a priority
- Supply chain management identified as a priority
- Supply chain management identified as a priority
- Supply chain management identified as a priority

FOCUS AREAS

- WF/GF
- Government
- Global Fund
- USAID
- GAVI
- UNICEF
- OTHER DONORS (Canada, UNFPA)
- OTHER (Non-Donor)

Financing Gap

Note: The category "other" (Non-Donor) includes household payment for medicines and funding from faith-based organizations.

Core Health Financing Impact Indicators

Health expenditure per capita financed from domestic sources 5.36

Investment Case

- Health financing reforms identified
- World Bank-funded project in support of the IC
- Private sector engagement
- Civil registration and vital statistics (CRVS) made a priority
- Management of medicines and supplies: supply chain interventions

Country platform

- Health financing in progress
- Project planning
- Project implementation
- Project management
- Project evaluation

Other Areas of Interest

- Supply chain management identified as a priority
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FOCUS AREAS

- WF/GF
- Government
- Global Fund
- USAID
- GAVI
- UNICEF
- OTHER DONORS (Canada, UNFPA)
- OTHER (Non-Donor)

Financing Gap

Note: The category "other" (Non-Donor) includes household payment for medicines and funding from faith-based organizations.
Investment Case Priorities

1. Improve equitable access to quality health services.
2. Improve health emergency risk management.
3. Enhance good governance.
4. Improve regulatory systems.
5. Improve supply chain and logistics management.
6. Improve community participation and engagement through strengthening of the functionality of the Health Development Army.
7. Improve resource mobilization.
8. Improve research and evidence for decision making.
9. Improve the development and management of human resources for health.
10. Improve health infrastructure.
Investment Case Priorities

1. Improve access to primary health care and nutrition services, prioritizing the reduction of chronic malnutrition:
   - Focus on integrated packages of interventions in frontier areas and with fewer implementing agencies
   - Enhance monitoring and supervision

2. Improve water and sanitation services to ensure proper supply of quality drinking water and waste disposal

3. Strengthen financial flows to support the flow of funds to implement the National Strategy to Prevent Chronic Malnutrition:
   - Support Conditional Cash Transfer Program to increase both financial protection and demand for critical health and nutrition services
   - Implement financing for results and target communities with greater needs

4. Improve governance and multisectoral coordination:
   - Ensure strong government commitment
   - Promote strong advocacy and communication for behavioral change
   - Strengthen local involvement in reducing chronic malnutrition
   - Support multi-sectoral efforts targeting the determinants/risk factors of malnutrition

Investment Case in 2017-2018

- 36% of live births attended by skilled personnel
- 20% of cases of diarrhea from 2017 to 2018
- 36% of cases of diarrhea from 2017 to 2018

Monitoring the Country-led Process

- Conducted and reported on a biannual basis
- Country platform holds regular multi-sectoral meetings to discuss results and identify gaps in monitoring capacity

Resource Mapping

It is important to recognize that Guatemala is different from other OIT countries, with only 2 percent of total health expenditure coming from external financing. Additionally, several development partners are further reducing their investments in Guatemala, as it is now a lower-middle-income country. Thus, OIT’s comparative advantage, to help coordinate efforts and reduce duplication of activities, while still useful, is expected to have less focus on external partners and improving donor coordination, and more focus on internal coordination. In consultation with the Government of Guatemala, the OIT will focus more on: (1) contributing to improved intra-ministerial coordination in the context of Guatemala’s investment case, which is the National Nutrition Strategy to Prevent Chronic Malnutrition (NSPCM), and coordination within the health sector; and (2) convening government and local partners to strengthen integrated service delivery networks.
Investment Case Priorities

1. Service delivery:
   - Pursue coverage of a complete package of high impact interventions
   - Provide medications and necessary health commodities
   - Make infrastructure investments for water, sanitation, and hygiene, as well as infrastructure of basic community sanitary services (improved health centers and health posts) to contribute to increased coverage.

2. Human resources: Recruit and train primary care and community healthcare workers (midwives, nurses, technical healthcare workers, community health workers).

3. Governance and health system management: Empower central and regional managers with means to supervise the health workforce, provide water, sanitation, and hygiene services, and free primary care and community health services.

4. Health Financing: Increase availability of financial resources at the lower levels of the health sector to decrease out-of-pocket payments by households.

5. Monitoring and evaluation activities (for civil registration and vital statistics monitoring and evaluation activities).

Investment Case for RMNCAH-N

**Set of evidence based priorities financed**

- Maternal mortality ratio 72% per 100,000 live births
- Neonatal mortality ratio 33% per 1,000 live births

**Output Indicators**

- Maternal mortality coverage
- Neonatal mortality coverage
- Percentage of births attended by skilled personnel

**Efficiency**

- ANC coverage
- DTP3 coverage

**Geo Focus Areas**

Costs of interventions for health services

- Maternal mortality coverage
- Neonatal mortality coverage
- Percentage of births attended by skilled personnel

Resource Mapping

The investment case is closely linked to the Plan National de Développement Sanitaire (PNDS), which covers the period 2015-24 and is costed assuming different scenarios of growth in government budget allocations to health. The scenario assumes a 10 percent increase in government budget allocations to health over this period, estimated to require US$4,735,796.

The Ministry of Health undertook a resource mapping exercise with support from the GFF in 2017 and estimated the total external resources available to be US$471,280,009. Taking into account the estimated government budget of US$3,021,267,767 for implementation of the PNDS, this leaves a funding gap of around 26 percent. The funding gap, however, does not take into account any new external resources coming in over this relatively long time period. The high-level resource mapping exercise has been useful in assessing the feasibility of the PNDS and identified areas of overlap between partners. As a next step, a more detailed mapping of external resources against the priorities in the PNDS and the related Community Health Strategy will be completed and validated to provide more concrete recommendations.
Kenya

Investment Case Priorities

1. Address disparities and increase equitable coverage through prioritized investments in underserved counties, and accelerate action for underserved and marginalized populations.

2. Address prioritized demand-side barriers to increase access, utilization, coverage, and affordability of RMNCAH-N services, and ensure financial protection for the poor:
   - Expand community health services networks and access to preventive and primary care interventions
   - Expand universal health coverage through subsidized insurance cover for essential primary health services

3. Address prioritized supply side health system bottlenecks to improve access, efficiency, high quality service delivery for high-impact interventions:
   - Maternal and newborn health services: BEmONC, CEmONC, and functional equivalent (e.g., BEmONC/CEmONC, and functional referral system)
   - Family planning: availability, accessibility, acceptability and quality of FP services
   - Child health: access to preventive services, primary health care, and emergency care
   - Nutrition: focus on nutrition for early childhood development
   - Adolescent Health: Scale-up availability and accelerate action for underserved populations.

Investment Case for RMNCAH-N

- Maternal mortality ratio 362 per 100,000 live births
- Neonatal mortality ratio 22 per 1,000 live births
- Percent of births <24 months after the preceding birth 17.9%
- Stunting among children under 5 years of age 26%
- Moderate to severe wasting among children under 5 years of age 4%

Coverage of pregnant women who receive ARV for PMTCT 80%

Children aged <5 years with pneumonia 75%

Modern contraceptive prevalence rate 39.1%

Efficiency

- DTP3 dropout rate 7.7%
- ANC dropout rate 40%

Health Financing Indicators

- Share of health expenditure from domestic sources 23.19
- Ratio of government health expenditure to total government expenditure 6.29%
- Percent of current health expenditure on primary/outpatient health care 40%
- Incidence of catastrophic and impoverishing health expenditures 5.8%
- 1.4% impoverishing

Resource Mapping

Health sector coordination, resource mapping, and joint planning and review in Kenya have, for various reasons, been dormant for several years, but are now being revived by Kenya’s Ministry of Health with support from the GFF and World Bank THS-UCP, RMNCAH-N Multi-donor Trust Fund, Clinton Health Access Initiative, USAID, WHO, and other partners. Resource mapping informs and supports the implementation of the government’s new Health Sector Strategic Plan 2018-2022, in which RMNCAH-N, guided by the RMNCAH investment case, will feature as the central component in delivering health services and universal health coverage.

The financial requirement for RMNCAH investments for the 20 priority counties was estimated at US$999 million from 2017/18 to 2019/20. Although detailed information is not currently available, Kenya’s Ministry of Health estimates that the government contributes 40% of all health expenditures, households (through out of pocket payment) 31 percent, donors 23 percent, and other private sources 6 percent, representing a slow but steady trend toward an increased government share of funding and a decreased share from external partners. Major external contributing health partners include the Bill & Melinda Gates Foundation, the Clinton Health Access Initiative, Global Fund, Gavi, the governments of Denmark, Japan (JICA), United Kingdom (DfID), and United States (PEPFAR, USAID, CDC), the UN H4 partners, and the World Bank.
### Investment Case Priorities

1. Provide quality emergency obstetric and newborn care, including antenatal, postnatal care, and child health.
2. Strengthen the civil registration and vital statistics system.
3. Carry out 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.
4. Establish emergency preparedness, surveillance and response, especially focusing on maternal and newborn deaths surveillance and response.
5. Promote sustainable community engagement, established, enhanced, and maintained through community structures.
6. Build an enabling environment: reinforce RMNCAH leadership, governance, and management at all levels.

### RMNCAH-N Data

<table>
<thead>
<tr>
<th>Data Point</th>
<th>Indicator</th>
<th>Target</th>
<th>Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal mortality ratio</td>
<td>1,072 per 100,000 live births</td>
<td>50%</td>
<td>61.2%</td>
</tr>
<tr>
<td>Neonatal mortality ratio</td>
<td>26 per 1,000 live births</td>
<td>60%</td>
<td>53%</td>
</tr>
<tr>
<td>Under-five mortality ratio</td>
<td>94 per 1,000 live births</td>
<td>20%</td>
<td>16.6%</td>
</tr>
<tr>
<td>Percentage of births &lt;24 months after the preceding birth</td>
<td>15.5%</td>
<td>10%</td>
<td>9.2%</td>
</tr>
<tr>
<td>Stunting among children under 5 years of age</td>
<td>52%</td>
<td>20%</td>
<td>18.2%</td>
</tr>
</tbody>
</table>

### Coverage Indicators**

<table>
<thead>
<tr>
<th>Data Point</th>
<th>Indicator</th>
<th>Target</th>
<th>Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>People living with HIV receiving ART</td>
<td>30%</td>
<td>79%</td>
<td>78%</td>
</tr>
<tr>
<td>Coverage of pregnant women who receive ARV for PMTCT</td>
<td>39%</td>
<td>50.7%</td>
<td>50.7%</td>
</tr>
<tr>
<td>Children aged &lt;5 years with pneumonia symptoms taken to a healthcare provider</td>
<td>60%</td>
<td>50.7%</td>
<td>50.7%</td>
</tr>
<tr>
<td>Modern contraceptive prevalence</td>
<td>20%</td>
<td>44%</td>
<td>44%</td>
</tr>
</tbody>
</table>

### Monitoring the Country-led Process

- **Investment Case being designed**
  - Set of evidence based priorities identified
  - Country-led multi-stakeholder platform in support of IC
  - Country platform holds regular country meetings to discuss results attained
  - Government focal point not yet identified
  - Government focal point not yet established
  - Country platform holds regular country meetings to discuss results attained
  - Government focal point not yet identified
  - Government focal point not yet established
  - Country platform holds regular country meetings to discuss results attained
  - Government focal point not yet identified
  - Government focal point not yet established

### Health Financing Indicators

- **Health expenditure per capita financed from domestic sources**
  - 3.1%
- **Output Indicators**
  - Share of health in total government budget: 15%
  - Monitoring of catastrophic and impoverishing health expenditures with data less than three years old: Yes
  - Country has implemented or updated a resource mapping exercise: Yes
  - Health budget execution rate: 84%
- **Efficiency**
  - DTP3 dropout rate: 23%
  - ANC dropout rate: 15%

### Geographic Focus Areas

- **World Bank-funded Project (IDA/IBRD/ODA)**
  - Project amount: $164M
  - Country: Liberia
  - Board date: 2/23/17
  - IDA approved amount: $164M
  - GAVI amount: $164M

### Health Financing Indicators

- **Health expenditure per capita financed from domestic sources**
  - 3.1%
- **Output Indicators**
  - Share of health in total government budget: 15%
  - Monitoring of catastrophic and impoverishing health expenditures with data less than three years old: Yes
  - Country has implemented or updated a resource mapping exercise: Yes
  - Health budget execution rate: 84%
- **Efficiency**
  - DTP3 dropout rate: 23%
  - ANC dropout rate: 15%

### Other Areas of Interest

- **Civil registration and vital statistics (CRVS)**
  - Identified for strengthening domestic resource mobilization: Yes
  - Implemented reforms to address key drivers of inefficiency: Partially
  - Identified drivers of limited financial protection (especially in relation to RMNCAH services): Yes

### Resource Mapping

- **GAP**
  - World Bank-funded project (IDA/IBRD/ODA)
  - Project amount: $164M
  - Country: Liberia
  - Board date: 2/23/17
  - IDA approved amount: $164M
  - GAVI amount: $164M

Note: The OPRF prioritization areas in Liberia closely align with the districts with the highest rates of wasting in the country.

Source: WHO, Global Database on Child Growth and Development 2017 Publication Date: 6/15/2018
**Investment Case Priorities**

1. **Equity and expansion of coverage:**
   - Analyze regional inequalities (the investment case prioritizes 42 lagging districts in 10 provinces, characterized by lower population density, fewer resources available, lower access and use of services and healthcare networks, and higher disease-specific burdens).
   - Strategies to reach rural populations include expansion of community health worker network and mobile teams.

2. **Reduction of barriers:**
   - Reduce barriers to both the demand and supply to implement high-impact interventions in RMNCAH-N, including childhood and adolescent malnutrition, as well as family planning.

3. **Improve the following:**
   - EmONC at district hospitals
   - Human resources for health (availability, skills and distribution of HCPs, specialized professionals for ONC and surgical teams; professional motivation and satisfaction)
   - Supply chain management (national chain of warehouses, stock, transportation and allocation)
   - Health information systems and civil registration and vital statistics
   - Health financing (commitment to increase the share of the government budget allocated to the health sector in the next five years).

**Monitoring the Country-led Process**

- Investment Case living in progress
- Investment Case complete
- Set of evidence based priorities financed
- Results monitoring strategy and framework in support of IC
- Country-led multisectoral platform (e.g., new or established from an existing platform)
- Government focal point
- An inclusive country platform process with HCP engagement

**Health Financing Indicators**

- Health expenditure per capita financed from domestic sources: 2.2%
- Ratio of government health expenditure to total government expenditure: 9%
- Percent of current health expenditures on primary/outrpatient health care: Not available
- Incidence of catastrophic and impoverishing health expenditures: 1.0% catastrophic, 0.5% impoverishing

**Geographic Focus Areas**

- **World Bank-funded Project (IDA/IBRD/Off)**
  - Project disbursement: $80M
  - Project approval date: 12/20/17
  - IDA approval date: 12/20/17
  - IDA amount approved: $256

- **Resource Mapping**
  - Total: US$1,233,100,000

**Country-led Multi-sectoral Platform**

- Health financing reforms identified
- World Bank-funded project in support of the IC
- Private sector engagement
- Civil registration and vital statistics (CRVS) made a priority
- Management of commodities and supplies: support chain interventions

**RMNCAH-N Data**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal mortality rate</td>
<td>408 per 100,000 live births</td>
</tr>
<tr>
<td>Neonatal mortality rate</td>
<td>30 per 1,000 live births</td>
</tr>
<tr>
<td>Percentage of births &lt;24 months after the preceding birth</td>
<td>18.8%</td>
</tr>
<tr>
<td>Stunting among children under 5 years of age</td>
<td>43%</td>
</tr>
<tr>
<td>Moderate to severe wasting among children under 5 years of age</td>
<td>6%</td>
</tr>
</tbody>
</table>

**Coverage Indicators**

- People living with HIV receiving ART: 54%
- Coverage of pregnant women who receive ARVs for PMTCT: 80%
- Children aged <5 years with pneumonia symptoms taken to a healthcare provider: 56.3%
- Modern contraceptive prevalence: 25.7%

**Investment Case in Mozambique**

- Investment Case being prioritized, but not yet fully funded
- Country platform (or new or established from an existing platform)
- Government focal point identified
- Country has started implementing a private sector intervention
- Country has identified a priority on the investment case
- Country has identified as a priority

**Inequity and Expansion of Coverage**

- Health financing (commitment to increase the share of the government budget allocated to the health sector in the next five years).

**Scorecard**

- Health budget execution rate: 84%
- Health financing rate: 89%
- ANC4 coverage: 54%
- DTP3 coverage: 31%
- ANC4 coverage: 67%
- DTP3 coverage: 39%
- ANC4 coverage: 65%
- DTP3 coverage: 45.9%
- ANC4 coverage: 41%
- DTP3 coverage: 0%
Investment Case Priorities

1. Extend access to the Basic Essential Package of Health Services to the entire population while increasing financial protection (including the critical role of primary health care and the delivery of essential services and interventions at Township level and below, starting within the community).

2. Strengthen the health system to support effective delivery of quality services and interventions:
   - Human Resources: Accreditation of training institutions; pre-service training
   - Infrastructure: Construction, rehabilitation, and equipment of health facilities
   - Service delivery: Health management information system; extending service delivery to the communities; referrals, procurement and supply chain management; fund flow and financial management; quality of care; demand for services
   - Health Financing: Resource mobilization (government spending on health and development assistance for health); purchasing (engaging health providers outside the Ministry of Health and Sports and developing the functions of a purchaser); and financial protection.

3. Create or increase demand for essential services and interventions.

Monitoring the Country-led Process

**CORE IMPACT INDICATORS**

- Maternal mortality ratio: 227 per 100,000 live births
- Neonatal mortality ratio: 25 per 1,000 live births
- Under-five mortality ratio: 50 per 1,000 live births
- Adolescent birth rate: 36 per 1,000 women
- Percent of births <24 months after the preceding birth: 13.2%
- Stunting among children under 5 years of age: 29.2%
- Moderate to severe wasting among children under 5 years of age: 6.9%
- People living with HIV receiving ART: 55%
- Coverage of pregnant women who receive ARV for PMTCT: 87%
- Children aged <5 years with pneumonia: 58.3%
- Modern contraceptive prevalence: 31.1%

**INVESTMENT CASE HEALTH FINANCING INDICATORS**

**OUTPUT INDICATORS**

- Share of health expenditure per capita financed from domestic sources: 13.6%
- Ratio of government health expenditure to total government expenditure: 4.94%
- Percent of current government expenditures on primary/outpatient health care: Not available
- Incidence of catastrophic and impoverishing health expenditures: 13.8% catastrophic, 2.2% impoverishing

- Share of health budget that is pooled or on budget: 77.75%
- Health budget execution rate: Not available

- Identified options for strengthening domestic resource mobilization: Yes
- Implemented strategies to reduce key drivers of insufficiency: Yes
- Identified drivers of limited financial protection: Yes
- Implemented reforms to address identified drivers: Yes

**INVESTMENT CASE being completed or established**

- Investment Case partially complete
- Investment Case not complete
- Investment Case not identified
- Investment Case not identified as a priority
- Investment Case not identified as a priority (catastrophic and impoverishing)
- Investment Case not identified as a priority (catastrophic and impoverishing)

- Country has taken actions to support domestic resource mobilization: No
- Country has started implementing a private sector intervention: No
- Country has either developed or identified GEF/DFG priority: No
- Country has identified CSOs as a priority: No
- Country has identified CSOs as a priority: Not available
- Country has identified CSOs as a priority: Identified with contact available online
- CSOs are not involved in the process
- CSOs are not involved in the process

- Health financing reforms identified
- World Bank-funded project in support of the IC
- Private sector engagement
- Civil registration and vital statistics: IDVS
- Management of medicines and supplies: Supply chain interventions

**SCORES**

- Health financing reforms
- World Bank-funded project
- Private sector engagement
- Civil registration and vital statistics
- Management of medicines and supplies

- Investment Case
- Country platform
- Country platform
- Government focal point
- Civil society representative: Not identified
- CSOs not involved in the process
- CSOs not involved in the process
- CSOs not involved in the process

**BENCHMARK DATA**

- Core Health Financing Indicators
- Core Health Financing Impact Indicators
- Health financing Indicators
- Output Indicators
- Geographic Focus Areas
Investment Case Priorities

1. Mobilize additional resources for health care at the front lines (in primary health care centers and for community-based approaches) by:
   - Prioritizing domestic resource mobilization through the operationalization of the Basic Health Care Provision Fund in three states.
   - Contributing to the commitment of achieving universal health coverage by focusing on primary health care.
   - Seeking efficiencies in service delivery through results-based approaches for facility-based and community-based delivery modalities by scaling up performance-based financing in areas of high need in five conflict-affected states in the Northeast of the country.
   - Scaling up, for the first time in Nigeria through performance-based contracts, a core package of nutrition services in 12 states.

2. Create a financing mechanism to facilitate pooling of donor resources to match domestic resources, in order to scale up the Basic Health Care Provision Fund in the remaining states.

3. Learn and innovate to increase private sector participation in improving quality and access to services.

RMNCAH-N Data

**Maternal mortality ratio** 576 per 100,000 live births

**Neonatal mortality ratio** 37 per 1,000 live births

**Under-five mortality ratio** 120 per 1,000 live births

**Adolescent birth rate** 120 per 1,000 women

**Percent of births <24 months after the preceding birth** 32.7%

**Stunting among children under 5 years of age** 44%

**People living with HIV receiving ART** 30%

**Coverage of pregnant women who receive ARV for PMTCT** 32%

**People aged <5 years with pneumonia symptoms taken to a healthcare provider** 24%

**Modern contraceptive prevalence rate** 11.1%

Investment Case being

Priorities fully funded

Country platform (for national level) exists framework to measure progress in a variety of areas.

Country platform holds regular country meetings to discuss results arising from implementing the strategies.

Government focal point identified with contact available online (GFF website).

Government focal point not yet identified.

Civil society represented or active country platform meetings to discuss implementing the strategies.

Civil society not represented in the process.

Health financing reforms identified

World Bank-funded project in support of the IC

Project disbursement

Project approved but not identified.

Civil registration and vital statistics (CRVS) identified at a priority.

Country has started implementation of targeted sector intervention.

OPEX priority funded (country IDA, other).

Country has other OPEX identified or classified.

Government focal point identified.

Not identified at this time.

Supply chain management identified as priority.

Supply chain management not identified as a priority.

Civil society engagement not identified at the time.

Private sector engagement identified at this time.

OPEX identified as a priority in the investment case.

Supply share not management identified or classified.

Supply share management identified as a priority.

Country has started implementation of targeted sector intervention.

OPEX priority funded (country IDA, other).

Country has other OPEX identified or classified.

Civil registration and vital statistics (CRVS) identified at a priority.

Country has started implementation of targeted sector intervention.

OPEX priority funded (country IDA, other).

Country has other OPEX identified or classified.

Civil society engagement not identified at the time.

Private sector engagement identified at this time.

OPEX identified as a priority in the investment case.

Supply share not management identified or classified.

Supply share management identified as a priority.

Country has started implementation of targeted sector intervention.

OPEX priority funded (country IDA, other).

Country has other OPEX identified or classified.

Civil society engagement not identified at the time.

Private sector engagement identified at this time.

OPEX identified as a priority in the investment case.

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Private sector engagement identified at this time.

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Supply share management identified as a priority.
Investment Case Priorities

1. Provide a high-impact RMNCAH-N package.
2. Enhance equity and financial access for the poor to improve access to the RMNCAH-N package.
   - Strengthening behavioral change
   - Improving communication interventions
   - Improving community health interventions
   - Scaling up the Cover-to-Cover scale-up strategies
3. Improve adolescent health through multisectoral approaches.
   - Strengthening health system governance
   - Improving community health interventions
   - Improving communication interventions
4. Strengthen the health supply chain to improve effective coverage of the RMNCAH-N package.
5. Strengthen health system governance through capacity strengthening for efficient management of external resources by the Ministry of Health, by:
   - Developing a common work plan at the regional level
   - Financing a PAH coordinator supporting the ministry
   - Providing innovative and sustainable funding to reach universal health coverage
   - Improving civil registration and vital statistics systems.

Core Health Financing Impact Indicators

- Maternal mortality ratio 392 per 100,000 live births
- Neonatal mortality ratio 21 per 1,000 live births
- Under-five mortality ratio 51 per 1,000 live births
- Adolescent birth rate 72 per 1,000 women
- Percent of births <24 months after the preceding birth 14.5%
- Stunting among children under 5 years of age 17%
- Moderate to severe wasting among children under 5 years of age 7%
- People living with HIV receiving ART 52%
- Coverage of pregnant women who receive ARV for RMNCAH-N 53%
- Children aged <5 years with pneumonia seen by a healthcare provider 64%
- Modern contraceptive prevalence rate 28%
- Births attended by skilled healthcare personnel 99%
- ANC coverage 90%
- DTP3 coverage 79%
- Children aged <5 years with diarrhea receiving ORS 44%
- Children aged <5 years with meningitis 75%
- Children aged <5 years with pneumonia 75%
- Children aged <5 years with pneumonia 75%

Efficiency

- DTP3 dropout rate 5.69%
- ANC dropout rate 4.3%

Health Financing Indicators

- Health expenditure per capita financed from domestic sources 15
- Ratio of government health expenditure to total government expenditures 4.2%
- Percent of current government health expenditure on primary/ Outreach health care 42%
- Incidence of catastrophic and impoverishing health expenditures 3.3%
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- Incidence of catastrophic and impoverishing health expenditures 3.3%
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- Incidence of catastrophic and impoverishing health expenditures 3.3%
Investment Case Priorities
1. Strengthen health systems for effective provision of RMNCAH-N services (adequate, skilled and motivated Human Resources for Health, strengthened leadership and governance at all levels, availability of essential RMNCAH-N drugs, supplies and equipment, infrastructure development, availability of a functioning emergency referral system, and availability of safe blood at all CEmONC facilities).
2. Improve the quality of RMNCAH-N services at all levels of service delivery: Support implementation of a national RMNCAH-N quality improvement program and systematic quality improvement procedures, approaches and practices, with a special focus on Emergency Triage Assessment and Treatment, respectful delivery, and availability of essential RMNCAH-N services at all levels of service delivery: Support implementation of a national RMNCAH-N quality improvement program and systematic quality improvement procedures, approaches and practices.
3. Strengthen community systems for effective delivery of RMNCAH-N services. (Address accessibility, geographical and financial barriers. Implement Integrated Community Case Management plus. Promote implementation of RMNCAH interventions at the community level, including social accountability. Address other sector determinants.)
4. Strengthen health information systems, monitoring, evaluation, and research for effective RMNCAH-N service delivery, and strengthen civil registration and vital statistics systems.

Monitoring the Country-led Process

Investment Case
- The process to develop the RMNCAH-N strategy brought together all partners working in RMNCAH in Sierra Leone. The Government of Sierra Leone took a lead role, and with contributions from the World Bank, the United Kingdom (DfID), WHO, UNICEF, UNFPA, and USAID, as well as many implementing nongovernmental organizations, including CUAMM and Partners in Health, decided on the priorities for the country. The financial requirement assessed under the “strategy scenario” in the RMNCAH strategy amounts to US$545 million over five years. An initial resource mapping exercise has been conducted, however, complete information on financial commitments from all partners were not available as of the time of writing. Nonetheless, it is anticipated that there will be a large gap between the total commitments made and the requirement.

Resource Mapping
- The process to develop the RMNCAH-N strategy brought together all partners working in RMNCAH in Sierra Leone. The Government of Sierra Leone took a lead role, and with contributions from the World Bank, the United Kingdom (DfID), WHO, UNICEF, UNFPA, and USAID, as well as many implementing nongovernmental organizations, including CUAMM and Partners in Health, decided on the priorities for the country. The financial requirement assessed under the “strategy scenario” in the RMNCAH strategy amounts to US$545 million over five years. An initial resource mapping exercise has been conducted, however, complete information on financial commitments from all partners were not available as of the time of writing. Nonetheless, it is anticipated that there will be a large gap between the total commitments made and the requirement.

Health Financing Indicators

**CORE HEALTH FINANCING IMPACT INDICATORS**

- Health expenditure per capita financed from domestic sources 9.56%
- Ratio of government health expenditure to total government expenditures 7.86%
- Percent of current health expenditure on primary/ outpatient health care 44.69%
- Incidence of catastrophic and impoverishing health expenditures
  - 45% catastrophic
  - 9.2% impoverishing

**OUTPUT INDICATORS**

- Share of health in total government budget Not available
- Identified options for strengthening domestic resource mobilization Yes
- Implemented strategies to reduce key drivers of insufficiency
  - No
- Identified drivers of limited financial protection (especially related to RMNCAH-N) No
- Taken actions to support domestic resource mobilization Yes
- Share of external funding for health that is pooled or on budget 7.27%

**EFFICIENCY**

- DTP3 dropout rate 16.69%
- ANC dropout rate 22%
- Health budget execution rate 64%
**Tanzania**

### Investment Case Priorities

1. **Strengthen RMNCAH-N**:
   - Strengthen maternal health and newborn health services.
   - Strengthen and improve visibility of adolescent reproductive health services.
   - Scale up and expand the coverage for reproductive health services.

2. **Scale up the child health program** by:
   - Scaling up coverage of the immunization and vaccine development program.
   - Scaling up the Core for the Sick Child program and emergency triage assessment and treatment.
   - Strengthening the implementation of the Integrated Management of Child Illnesses interventions.
   - Scaling up newborn, infant and young child feeding services.

3. **Strengthen the response to cross-cutting issues**:
   - Strengthen RMNCAH interventions through the operationalization of the One Plan II operational plans.
   - Improve the availability of RMNCAH and nutrition commodities.
   - Strengthen community involvement in RMNCAH and nutrition services.
   - Provide comprehensive health promotion and education services in all RMNCAH programs.
   - Strengthen RMNCAH management.
   - Strengthen information system and operational research activities (including civil registration and vital statistics).

### Geographical Focus Areas

- **Focus Areas**
  - **Regional Health**
  - **High HIV Prevalence**
  - **High PPM**
  - **High PPM-Decline**
  - **High Inequity**
  - **High Infant Mortality**
  - **High Stunting**
  - **High Under-5 Mortality**

### Monitoring the Country-led Process

- **Investment Case Completeness**
  - Priorities clearly identified
  - Country platform for project implementation established
  - Country platform for multi-stakeholder platform established
  - Balanced and prioritized resource allocation framework
  - Government focal point identified
  - Civil society represented on multi-country platform meetings
  - Country platform endorsed by key stakeholders

- **Country-led Multi-stakeholder Platform**
  - Developed and initial meeting held
  - Not yet established
  - Not yet established
  - Not yet established
  - Not yet established
  - Not yet established

- **Core Health Financing Impact Indicators**
  - Health expenditure per capita financed from domestic sources 11.2
  - Ratio of government health expenditure to total government expenditure 7.43%
  - Percent of current health expenditure on primary health care 48.64%
  - Incidence of catastrophic and impoverishing health expenditures 10.3% catastrophic, 2.8% impoverishing

- **Health Financing Indicators**
  - Share of health in total government budget Not available
  - Monitoring of catastrophic and impoverishing health expenditure with data less than three years old: No
  - Country has implemented or updated a resource mobilization exercise Yes
  - Taken actions to support domestic resource mobilization: Poo
  - Implemented reforms to address identified drivers of financial protection (especially related to RMNCAH) Yes

### Resource Mapping

- **World Bank-funded Project (IDA/IBRD/OF)**
  - Project approved and disbursement fully completed
  - Project disbursing $40M

- **Resource Mapping**
  - Gap US$93,209,527
  - Total US$368,360,131

---

**United Republic of Tanzania**

### RMNCAH-N Data

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal mortality rate (per 100,000 live births)</td>
<td>356</td>
</tr>
<tr>
<td>Under-five mortality rate (per 1,000 live births)</td>
<td>67</td>
</tr>
<tr>
<td>Adolescent child rate (120-1,000 women)</td>
<td>96</td>
</tr>
<tr>
<td>Stunting among children under 5 years of age</td>
<td>34%</td>
</tr>
<tr>
<td>Modern contraceptive prevalence rate</td>
<td>24%</td>
</tr>
</tbody>
</table>

**Coverage Indicators**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Coverage Rate</th>
</tr>
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<tbody>
<tr>
<td>People living with HIV receiving ART</td>
<td>62%</td>
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**Efficiency**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>DPT3 dropout rate</td>
<td>2.02%</td>
</tr>
<tr>
<td>ANC coverage rate</td>
<td>38%</td>
</tr>
</tbody>
</table>

**Geographic Focus Areas**

- **United Republic of Tanzania**
  - **Regional Health**
  - **High HIV Prevalence**
  - **High PPM**
  - **High PPM-Decline**
  - **High Inequity**
  - **High Infant Mortality**
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  - **High Under-5 Mortality**

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**Geographic Focus Areas**

- **Focus Areas**
  - **Regional Health**
  - **High HIV Prevalence**
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</table>
Investment Case Priorities

1. Emphasize evidence-based high-impact solutions, including identifying a package of evidence-based interventions for each service delivery level.
2. Increase access for high-burden populations by promoting a set of service delivery mechanisms that operate synergistically, such as by:
   - Strengthening district health management
   - Scaling-up community-based service delivery
   - Building capacity through a skills hub
3. Employ geographical focusing and sequencing to determine where the package of interventions will be rolled out first (priority is given to districts with the highest RMNCAH burden)
4. Address the broader multisectoral context, with a particular focus on adolescent health (including the social determinants of RMNCAH and galvanizing other sectors)
5. Ensure mutual accountability for RMNCAH-N outcomes, including through strengthening data systems (including civil registration and vital statistics)

RMNCAH-N Data

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<td>132</td>
</tr>
<tr>
<td>Adolescent birth rate 64 per 1,000 live births</td>
<td>100,000 live births</td>
</tr>
<tr>
<td>Under-five mortality ratio 24.3%</td>
<td>64%</td>
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<tr>
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</table>

Monitoring the Country-led Process

- Country platform: Comprehensive
- Country platform: Integrated
- Government focal point: Identified

Geographic Focus Areas

- World Bank-funded Project: US$500,000,000
- Total: US$1,586,000,000
- Resource Mapping: World Vision Uganda

Health Financing Indicators

- Health expenditure per capita financed from domestic sources: 6.1%
- Ratio of government health expenditure to total government expenditures: 5.61%
- Percent of current health expenditure on primary/ outpatient health care: 31.55%
- Incidence of catastrophic and impoverishing health expenditures: 10.5% catastrophic, 2.7% impoverishing

World Vision Uganda

- Role: Focal point
- Engagement: Identified as priority
- Sector involvement: Included in IC

Uganda

- Role: Focal point
- Engagement: Identified as priority
- Sector involvement: Included in IC

Other DPS

- Role: Focal point
- Engagement: Identified as priority
- Sector involvement: Included in IC
Vietnam

Investment Case Priorities

1. Strengthen the grassroots-level health care system (primary health care).
2. Strengthen the delivery of quality services to improve maternal and child health outcomes, including a new basic essential service package for health insurance reimbursement at the commune level.
3. Prevent and manage malnutrition.
4. Prevent and manage noncommunicable diseases, including cancer, cardiovascular disease, diabetes, chronic obstructive pulmonary disease, asthma, and other noncommunicable diseases.
5. Promote healthy aging.
6. Improve the efficiency and sustainability of health financing and service delivery arrangements, including (among others):
   - Reducing the one-reliance on hospital centered delivery
   - Supporting health insurance reform
   - Enhancing financial protection from out-of-pocket health spending
   - Creating an enabling environment for private sector participation
7. Ensuring equity of access to health services for ethnic minority populations.

Monitoring the Country-led Process

- Creating an enabling environment for private sector participation
- Enhancing financial protection from out-of-pocket health spending
- Supporting health insurance reform
- Creating an enabling environment for private sector participation

Resource Mapping

The key value-added of the GFF in mobilizing resources for health in Vietnam has been through the buy-down of a World Bank loan to more favorable terms (first at IBRD terms) for the Investing and Innovating for Grassroots Service Delivery Reform Project (P161283). In a constrained macroeconomic environment, with a high debts-GDP ratio, the government is reluctant to use loans, especially loans made at less-concessional IBRD terms and even more so when the loans are for non-revenue-generating activities for investment in the health sector, specifically RMNCAH and primary care. The GFF-supported loan/project also crowds in financing from other development partners, including the private sector, leveraging their individual contributions for greater collective impact. Project resources are US$800 million from IBRD, US$5 million in counterpart financing, US$17 million from the GFF grant, US$5 million grant from Ireland (DFAT) through a Multi-Donor Trust Fund (MDTF), and a US$3 million grant from the Pharmaceutical Governance Trust Fund. The project also leverages around US$2 million in-kind financing from Gavi and is being prepared in coordination with an Asian Development Bank-financed project with similar objectives, but covering complementary provinces. External financial assistance for health now makes up only a tiny share of total health financing in Vietnam, with several funders phasing out their programs, shifting to domestic resources. Presently, development partners that provide technical and financial support to the health plan include the Asian Development Bank, the European Union, the governments of Japan (JICA, Korea), and the United States (USAID, CDC), other UN agencies (UNICEF, UNFPA, UNDP, UNAIDS), and WHO.

Health Financing Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health expenditure per capita from domestic sources</td>
<td>48.81</td>
</tr>
<tr>
<td>Ratio of government health expenditure to total government expenditures</td>
<td>7.89%</td>
</tr>
<tr>
<td>Percent of current health expenditure on primary/ outpatient health care</td>
<td>46.07%</td>
</tr>
<tr>
<td>Incidence of catastrophic and impoverishing health expenditures</td>
<td>9.8% catastrophic, 0.35% impoverishing</td>
</tr>
</tbody>
</table>

**Note:** All indicators are core health financing impact indicators and are reported in the Country-led Process.
### Counting and Accounting for Every Life and Death: Civil Registration and Vital Statistics

Many low- and lower-middle-income countries generally have poor civil registration and vital statistics (CRVS) systems, with low registration coverage of births, deaths, and other vital events and almost non-existent recording of causes of death. Often they are paper-based. This limits access to the documentation required to establish legal identity, civil status, and family relationships and thus fails to protect the basic civil and human rights of all individuals, especially women, children, and adolescents. The incomplete registration and manual processes limit access to data required for timely monitoring of progress made in ending preventable maternal, newborn, child and adolescent deaths, particularly at sub-national level.

The GFF has thus prioritized the strengthening of CRVS systems, supporting countries to develop investment cases with strong components of CRVS and core-financing investments for CRVS. Nine GFF-supported countries are currently implementing or preparing to implement activities to strengthen CRVS systems, which include establishing electronic CRVS systems; expanding CRVS services with a strong health sector focus; creating innovative ways to accelerate registration including application of performance-based financing; revising the legislative framework; engaging in advocacy and awareness creation, and stakeholder engagements and coordination at the country, regional, and global levels.

#### Table: CRVS System Status and Availability

<table>
<thead>
<tr>
<th>Country</th>
<th>&lt;5 Birth Registration</th>
<th>Death Registration</th>
<th>Cause of Death Availability</th>
<th>Electronic / Paper-based</th>
<th>CRVS in IC/Health Strategy</th>
<th>CRVS in Project/Advisory Services and Analytics</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>N/A</td>
<td>No</td>
<td>N/A</td>
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<tr>
<td>Cameroon</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes Implementation</td>
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</tr>
<tr>
<td>DRC</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes Implementation</td>
<td>Yes Implementation</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>N/A</td>
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<tr>
<td>Guinea</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes Awaiting effectiveness</td>
<td>Yes Awaiting effectiveness</td>
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<tr>
<td>Kenya</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes Implementation</td>
<td>Yes Implementation</td>
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<tr>
<td>Liberia</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes Implementation</td>
<td>Yes Implementation</td>
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<tr>
<td>Mozambique</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>Myanmar</td>
<td>Yes</td>
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<td>Nigeria</td>
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<td>Yes Implementation</td>
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<tr>
<td>Senegal</td>
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<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<td>Yes Implementation</td>
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</tr>
<tr>
<td>Sierra Leone</td>
<td>Yes</td>
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<td>Yes</td>
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<td>Yes Implementation</td>
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<tr>
<td>Tanzania</td>
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<td>Yes</td>
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<td>Yes Implementation</td>
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<td>Yes Implementation</td>
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</tr>
<tr>
<td>Vietnam</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes Implementation</td>
<td>Yes Implementation</td>
</tr>
</tbody>
</table>

1. Most recent DHS or MICS data
7. UNICEF www.data.unicef.org/resources/crvs
10. UNFPA http://getinthepicture.org/sites/default/files/resources/Comprehensive%20Assessment%20of%20Civil%20Registration%20Status%202014%20Bangladesh.pdf
11. UNICEF www.data.unicef.org/resources/uns

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**Note:**

- **No data**
- **<33%**
- **33-66%**
- **67%+**
- **Paper**
- **Paper + Electronic**
- **Electronic**
As of June 30, 2018, the GFF Trust Fund contributions are a total of US$807 million equivalent, of which US$620 million is committed for 31 projects in 26 countries. This amount is combined with an additional US$3.9 billion in IDA and IBRD financing. Regionally, 77 percent of the funding supports GFF countries in the Africa region, followed by 10 percent supporting South Asia, 9 percent supporting East Asia, and 4 percent supporting Latin America and the Caribbean region (see figure). As of June 30, 2018, 73 percent of all commitments have been Board-approved, and the remaining 27 percent are under preparation and scheduled for Board approval by December 2018 in FY2019 (see figure). The full list of the Board-approved projects is provided in the accompanying table. Regarding the financing of the projects under implementation, 24 percent have disbursed, which includes both IDA financing and GFF Trust Fund grants for projects that are effective.

GFF Financials

List of Board-Approved Projects and Projects Scheduled for Board Approval before end-FY18

<table>
<thead>
<tr>
<th>Country</th>
<th>GFF approved amount</th>
<th>IDA amount</th>
<th>IBRD amount</th>
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<tbody>
<tr>
<td>Tanzania</td>
<td>$400</td>
<td>$200</td>
<td></td>
</tr>
<tr>
<td>DRC (AF-CRVS)</td>
<td>$100</td>
<td>$30</td>
<td></td>
</tr>
<tr>
<td>Cameroon</td>
<td>$270</td>
<td>$100</td>
<td></td>
</tr>
<tr>
<td>Nigeria (AF)</td>
<td>$200</td>
<td>$125</td>
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</tr>
<tr>
<td>Nigeria (Part 2)</td>
<td>$200</td>
<td>$150</td>
<td></td>
</tr>
<tr>
<td>Nigeria (Nutrition)</td>
<td>$70</td>
<td>$225</td>
<td></td>
</tr>
<tr>
<td>Kenya</td>
<td>$400</td>
<td>$150</td>
<td></td>
</tr>
<tr>
<td>Uganda</td>
<td>$300</td>
<td>$150</td>
<td></td>
</tr>
<tr>
<td>Liberia (AF)</td>
<td>$150</td>
<td>$15</td>
<td></td>
</tr>
<tr>
<td>Guatemala</td>
<td>$90</td>
<td>$100</td>
<td></td>
</tr>
<tr>
<td>DRC (AF)</td>
<td>$400</td>
<td>$220</td>
<td></td>
</tr>
<tr>
<td>Ethiopia</td>
<td>$400</td>
<td>$150</td>
<td></td>
</tr>
<tr>
<td>Bangladesh - Education</td>
<td>$150</td>
<td>$500</td>
<td></td>
</tr>
<tr>
<td>Mozambique</td>
<td>$220</td>
<td>$80</td>
<td></td>
</tr>
<tr>
<td>Rwanda (Health)</td>
<td>$100</td>
<td>$25</td>
<td></td>
</tr>
<tr>
<td>Afghanistan</td>
<td>$350</td>
<td>$140</td>
<td></td>
</tr>
<tr>
<td>Rwanda (SP-AF)</td>
<td>$80</td>
<td>$80</td>
<td></td>
</tr>
<tr>
<td>Guinea</td>
<td>$150</td>
<td>$50</td>
<td></td>
</tr>
<tr>
<td>Indonesia</td>
<td>$200</td>
<td>$400</td>
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Total GFF Projects: $4,535,000,000

GFF Country-led Investment Case Complementary Financing

The Investors Group includes representatives of the following countries and organizations:

- ABT Associates (representing the private sector constituency)
- African Health Budget Network (representing the civil society constituency)
- Government of United States
- Government of Korea
- Government of Liberia
- African Union (representing youth for the civil society constituency)
- Bill & Melinda Gates Foundation
- Gavi, the Vaccine Alliance
- Global Fund to Fight AIDS, Tuberculosis, and Malaria
- Government of Canada
- Government of Denmark
- Government of Ethiopia
- Partnership for Maternal, Newborn, and Child Health
- Plan International
- Office of the UN Secretary-General
- UNICEF
- World Bank Group
- WHO World Health Organization

Trust Fund Contributors

The GFF Trust Fund is supported by the governments of Canada, Denmark, Japan, Norway, and the United Kingdom; the Bill & Melinda Gates Foundation; and MSD for Mothers.

Acknowledgments

This report was written by the GFF Secretariat in collaboration with the GFF countries profiled in this report, under the guidance of Dr. Mariam Claesson, GFF Director and Dr. Monique Vadler, Practice Manager. The GFF Secretariat would like to thank the contributors, who gave their time, expertise and, in particular, Anna Astvatsatryan, Kimberly Boer, Marion Cros, Jessica Flannery, Brendan Hayes, Jakub Jan Kakietek, Joasine Karangwa, Kati Kemppainen-Bertram, Luc Laviolette, Melanie Mayhew, Augustina Nikolova, Oluwaduro Oladoye, Calub Rufo, Hadia Samaha, Aissa Soroco, Petra Vergeer, and Sara Walker. Editorial support was provided by Marc Defrance.

Most photographs © Dominic Chavez/Global Financing Facility
APPENDIX A

Data Sources

<table>
<thead>
<tr>
<th>INDICATOR / SOURCE TYPE</th>
<th>EASTER ISLAND</th>
<th>CAMBODIA</th>
<th>DEC</th>
<th>EPINOPA</th>
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<th>SOMALIA</th>
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<tbody>
<tr>
<td>Health expenditure per capita financed from external funding</td>
<td>World Bank-financed project</td>
<td>IDA/IBRD/GFF</td>
<td>Projects available on WB portal</td>
<td>Projects available on IDA/IBRD/GFF</td>
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HEALTH FINANCING INDICATORS

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ADDITIONAL SOURCES

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<tr>
<th>INDICATOR / SOURCE TYPE</th>
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## APPENDIX B

<table>
<thead>
<tr>
<th>Indicator Description</th>
<th>Description</th>
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<tbody>
<tr>
<td>Maternal Mortality Ratio</td>
<td>Number of female deaths from any cause related to or aggravated by pregnancy or its management (excluding induced abortion) during or within 42 days of pregnancy per 100,000 live births.</td>
</tr>
<tr>
<td>Adolescent Mortality Rate</td>
<td>Probability of dying between ages 10 and 19 years per 1,000 live births.</td>
</tr>
<tr>
<td>ANC coverage*</td>
<td>Percentage of women receiving 1+ ANC visits in a 2-year period.</td>
</tr>
<tr>
<td>Modality and Service Provider Coverage of pregnant women who receive ARV for PMTCT</td>
<td>Percentage of pregnant women who received ARV for PMTCT.</td>
</tr>
<tr>
<td>People living with HIV receiving ART</td>
<td>Percentage of people living with HIV currently receiving ART among the estimated number of adults and children living with HIV at the end of the reporting period.</td>
</tr>
<tr>
<td>Children &lt;5 years with diarrhea receiving ORS</td>
<td>Percentage of children ages 0–59 months with diarrhea in the two weeks prior to the survey, who received ORS (oral rehydration solution packets or oral rehydration solution rehydration solution).</td>
</tr>
<tr>
<td>Share of health in total domestic government budget</td>
<td>Percentage of government budget, from domestic resources, allocated to health.</td>
</tr>
<tr>
<td>Share of domestic health financing from taxation</td>
<td>Share of domestic government health spending that is derived from domestic resource mobilization (including local taxes and/or domestic resource mobilization from foreign and external sources).</td>
</tr>
<tr>
<td>Share of health in total government budget</td>
<td>Percentage of total government expenditures from domestic sources.</td>
</tr>
</tbody>
</table>

*The definitions for these indicators might vary slightly depending on the source of the data and/or the country.
The Catalyst for Country-led Health and Nutrition