



THE GLOBAL FINANCING FACILITY 2016-2017

Annual Report

COUNTRY-POWERED INVESTMENTS FOR EVERY WOMAN, EVERY CHILD



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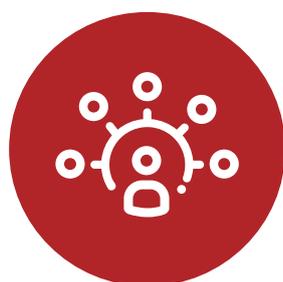
THE GLOBAL FINANCING FACILITY

COUNTRY-POWERED INVESTMENTS FOR WOMEN, CHILDREN AND ADOLESCENTS

In recent decades some of the world’s poorest countries, with much support from donors, have made progress in improving the health of their people. But they will be unprepared today and for the future without more coordinated and aligned country-driven efforts to invest in delivering the highest-impact health interventions, addressing systems barriers, and tackling social determinants of health. They can save and improve many more lives—and could do so more efficiently, with greater reach, equity, and sustainability. Smart, scaled, and sustainable financing is needed to support these countries’ efforts to save and improve the lives of women, children, and adolescents in their poorest communities, which calls for a transformational change in financing for development.

To respond to the tide of global change and prepare for the new development era, the United Nations (UN), in partnership with the World Bank Group, launched the Global Financing Facility (GFF), the financing arm and implementation platform of “Every Woman Every Child” at the Third International Financing for Development Conference in 2015.

The GFF is a new financing model that is country-led and draws on the diverse expertise and resources of a broad set of stakeholders, including the World Bank Group, the UN agencies, the Partnership for Maternal, Newborn, Child and Adolescent Health (PMNCH), Gavi, the Vaccine Alliance, the Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund), the Bill & Melinda Gates Foundation, bilateral donors, private sector partners including MSD for Mothers, and a wide range of civil society organizations to deliver results on reproductive, maternal, newborn, child, and adolescent health and nutrition.



This passage first appeared in the April 22, 2017 issue of The Lancet.

LETTER FROM THE DIRECTOR

■ Dear friends and partners,

This annual report marks not only another exciting year of the Global Financing Facility in support of Every Woman Every Child (GFF), but the end of its first phase. In this report from the GFF secretariat, we want to share with you what we have learned from countries that makes us excited and confident in the GFF as a pathfinder for a new way of financing development.

In 2017, we are in a changing global environment with finite resources for development assistance, where many global health and nutrition initiatives are competing for limited donor resources and where financiers—public and private—want the assurance of significant returns on the investments they make. This is also a time when the challenges that countries face—from fragility and climate change to changing disease patterns and health profiles across the life cycle—call for new thinking while poor communities in all countries also face the unfinished agenda of reproductive, maternal, newborn, child and adolescent health and nutrition (RMNCAH-N).

This calls for a change in the way we do business, with countries setting priorities based on evidence of what works and ensuring financing for them by mobilizing domestic resources, increasing efficiency, attracting and better aligning external resources, and leveraging private and innovative financing. We are now beyond proof of concept, testing the idea that with the relatively small amounts of catalytic funding available through the GFF Trust

Fund we can spark such broader changes. In this report you will find illustrative examples from across our portfolio of the GFF adding value to the efforts of countries to improve the health and wellbeing of women, children, and adolescents. We focus on what is happening in countries, since the most common question we hear is: what progress are countries making?

So, what is different and would not have happened this year without the GFF? As countries testify, the value add of the GFF is first and foremost the empowerment of countries to bring together stakeholders to identify priorities and finance them. These efforts build on the experiences of a history of sector-wide approaches in health and other health reform efforts and national health planning, which the GFF takes forward and improves on through a relentless focus on results and an approach to development finance that reflects the new realities of the Sustainable Development Goals (SDGs) era. Programmatically, the GFF brings a focus to quality and equity, and to issues and populations that the world is neglecting and underinvesting in, such as sexual and

reproductive health and rights, nutrition, newborn survival, and adolescent health and development. The GFF is also steering investments toward fragile settings: four of the 16 countries receiving GFF support are classified as fragile, another is just emerging from Ebola, and in another three countries GFF activities focus on fragile regions. The new approach to financing means creating a platform through which the resources of multiple partners—public and private, domestic and external—can come together in alignment behind a country-driven set of priorities and accelerate progress in the short term, while looking at what it will take over the long term to ensure sustainable financing.

What we are most proud of to date is the extent to which countries have embraced the GFF approach and are beginning to show progress toward closing the financing gap for women, children, and adolescents. Half of GFF-supported countries have completed the process of identifying programmatic priorities and have mobilized financing for them from multiple partners. Domestic resources are critically important to this in most countries, supported by



As countries testify, the value add of the GFF is first and foremost the empowerment of countries to bring together stakeholders to identify priorities and finance them.



Mariam Claeson

concessional financing from the World Bank Group—which has now approved projects in nine GFF countries—and by financing from a range of bilateral and multilateral organizations, including Gavi, the Global Fund, the Islamic Development Bank, the Japan International Cooperation Agency (JICA), the Swedish International Development Cooperation Agency (SIDA), and the United States Agency for International Development (USAID), among others.

We are also very pleased at the progress made among global actors to reduce the complexities of the global architecture, as we work with the PMNCH, the H6 Partnership, the UN, and the Every Woman Every Child movement toward a common framework with more clarity on the value add of different global actors—putting countries at the center. This year we achieved some significant milestones in our partnership with key stakeholders: the civil society communities finalized their GFF engagement strategy and MSD for Mothers joined the GFF as the first private sector contributor to the GFF Trust Fund. We have also broadened our engagement

with the World Bank Group, working with its private sector arm, the International Finance Corporation (IFC), to expand our private sector engagement and innovative financing.

Countries identify many challenges as they embark on this journey—the challenges of prioritizing among well-deserving areas, mapping resources, tracking financing, and monitoring for results, but the experience to date suggests that the approach that we have taken of learning by doing, building capacity in these areas, and sharing experiences south-to-south, is positioning countries well to manage these challenges. In fact, the rest of this report is organized around this journey, giving us the opportunity to show how the GFF adds value at every step along the way. We also showcase how the process is working in two countries – Tanzania and Liberia – which have been demonstrating the catalytic effect that the GFF is having through the achievement of some early results.

I am also happy to report that we in the GFF Secretariat are now better able to

support the high demand from countries. We are still a lean body of very few staff, but in collaboration with all our GFF partners, we are well positioned to expand and accelerate progress in 2017-18, to respond to requests for assistance, and to facilitate one of the most valuable ways of making progress: countries learning from each other. This was evident at our April 2017 GFF country workshop where 150 stakeholders across multiple disciplines and sectors from 16 countries came together to share progress and discuss how to tackle implementation challenges.

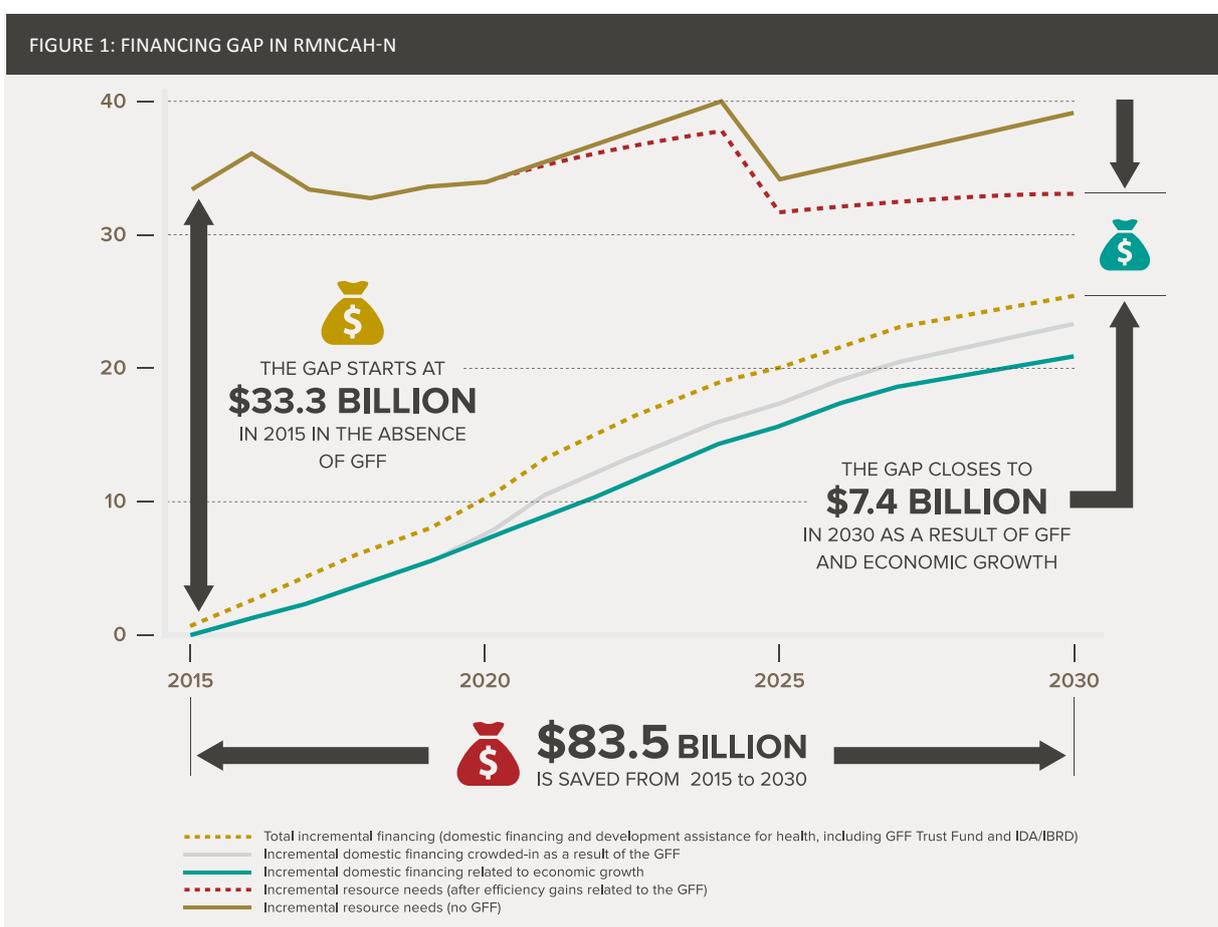
I want to end this letter by thanking all of you who come together at the country level to support these efforts. Over the next 18 months we will gear up to further expand and meet the huge demand from the remaining 46 GFF-eligible countries, and mobilize the resources it will take, with your help.

Mariam Claeson
Director, The Global Financing Facility

A NEW ERA OF DEVELOPMENT FINANCE

- The GFF's objective is to close the financing gap for RMNCAH-N. The annual amount of additional financing required has been estimated at more than \$33 billion in 2015. This amount will prevent the deaths of an estimated 24-38 million women, children, and adolescents by 2030.

As shown in Figure 1, the most important source of financing to close this gap is domestic, which is driven by economic growth increasing the availability of domestic resources (shown as the green line in the figure).



THE GFF COMPLEMENTS DOMESTIC RESOURCE MOBILIZATION BY CLOSING THE REMAINING GAP IN THREE WAYS:

1. BY MAKING FINANCING FOR RMNCAH-N MORE EFFICIENT,

which reduces the need for financing by approximately 15 percent by 2030 (as signified by the gap between the top yellow line and the red dotted line);

2. BY CROWDING IN ADDITIONAL DOMESTIC RESOURCES,

which results in the mobilization of more than \$18 billion cumulatively from 2015 to 2030 (as represented by the light grey line);

3. BY FURTHER MOBILIZING EXTERNAL ASSISTANCE AND IMPROVING COORDINATION OF THIS FINANCING,

resulting in the mobilization of nearly \$39 billion cumulatively from 2015 to 2030 (seen in the increase in financing to the dotted yellow line).



WHO IS THE GFF?

A foundational principle of the GFF is the importance of partnerships. This is brought to life every day in GFF countries as, under the leadership of governments, civil society, the private sector, and international partners come together to discuss priorities and coordinate financing. This work is described in more detail in the section on country leadership and ownership on page 18.

This is supported at the global level by the “GFF Investors Group,” the broad set of partners that are committed to the objectives of the GFF. Its membership includes representatives from participating countries, contributing bilateral donors, non governmental organizations, the private sector, private foundations, multilateral financiers and technical agencies. The purpose of the GFF Investors Group is to mobilize the resources and institutional commitment of key investors in RMNCAH required at the global and regional levels to optimally support efficient collective action at the country level.

To help support and catalyze this, a multi donor trust fund—the GFF Trust Fund—has been established at the World Bank through generous contributions from the governments of Canada and Norway, the Bill & Melinda Gates Foundation, and MSD for Mothers. Countries themselves are the engines that drive the progress described in this report, but the trust fund and the secretariat that manages it have a key role to play in bringing the principles of the GFF to life by advising countries, convening partners, sharing lessons learned, conducting analytical work and using trust fund resources to catalyze financing from multiple sources.

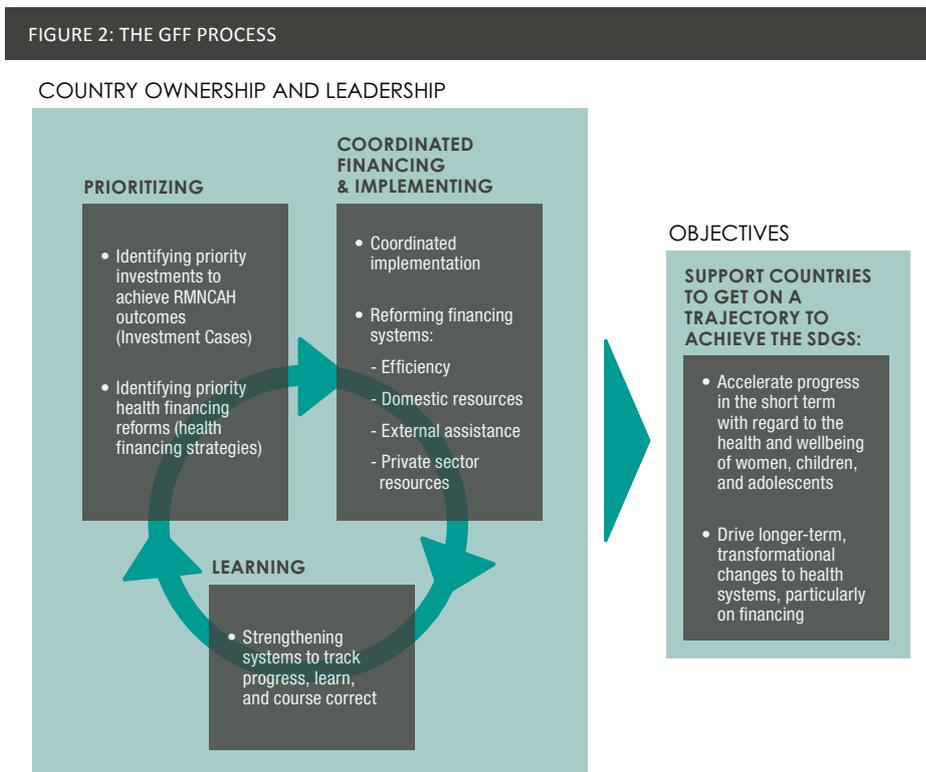
HOW THE GFF WORKS

- The foundation of the GFF approach is country ownership and leadership. Built on this are three interrelated processes: prioritization, coordinated financing and implementation, and learning, as shown in Figure 2.

The prioritization step involves identifying, through evidence-based processes, both the key investments that are needed to improve RMNCAH-N outcomes in an efficient, equitable, feasible, and affordable manner (which is typically done through the development of an “investment case”), and the health financing reforms that will result in scaled-up and more sustainable and equitable financing (which is often done through the development of a health financing strategy). These priorities are then implemented in a coordinated manner, with the GFF catalyzing improved efficiency, increased domestic resources, increased and better aligned external assistance (including concessional financing), and leveraging of the private sector.

The final way in which the GFF adds value is creating a feedback loop that enables course correction during implementation, which the GFF supports by strengthening systems which allow all parties to track progress and learn. This includes investments in the civil registration and vital statistics systems that are needed to provide solid data to track changes in mortality. These different ways that the GFF adds value at the country level form the structure of this report. Each of the ways that the GFF supports countries is discussed in more depth in rest of the report, with examples from the experiences in countries to date.

Although the GFF has not been in existence long enough for countries to show measurable changes in metrics such as changes in maternal or under-five mortality, it is nonetheless important to monitor progress and see what countries are trying to achieve with the support of the GFF.



The objective of the process described above is to support countries to get on a trajectory to achieve the SDGs, which has both short and long-term elements. In the short term, the emphasis is on accelerating progress toward improving the health and wellbeing of women, children, and adolescents, such as by increasing the coverage of high-impact interventions. Over the longer-term, the GFF helps countries to drive transformational changes to their health systems, with a particular emphasis on reforms to the financing systems.

This report looks at each of these areas in turn, covering both how the GFF approaches each issue and the initial progress that has been made.

46%

The 16 countries account for 46% of the total financing gap across all GFF countries.



FIGURE 3: GFF EXPANSION AND CURRENT STATUS OF COUNTRIES



MOVING FROM DESIGN TO IMPLEMENTATION

There are 62 countries eligible for financing through the GFF Trust Fund. In 2015, four countries were part of the process of creating the GFF. Since then, 12 additional countries have been added in two subsequent waves.

Figure 3 shows the GFF expansion and the extent to which countries are progressing from the design phase to implementation. The 16 countries that are now actively part of the GFF represent one-quarter of the countries eligible to participate in the GFF.

These countries have a disproportionate share of the total burden of disease related to women and children. Together, these 16 countries represented 46% of

the total financing gap for RMNCAH-N in 2015. The GFF is putting a particular emphasis on fragile settings: four of the 16 countries receiving GFF support are classified as fragile, another has just emerged from Ebola, and in another three countries, GFF activities focus on fragile regions.

The GFF has begun to close this financing gap through a process whereby countries identify evidence-based, feasible, affordable and equitable priority investments and key financiers agree to direct their funding to these priorities. In the first 18 months of GFF implementation, significant progress has been made in the country prioritization process, as seen in the fact that eight countries have completed the investment case process and four others have nearly completed the process.

Significant progress has been made in mobilizing complementary financing for the investment case. At least three donors are supporting the process in most GFF-supported countries, including Gavi, the Vaccine Alliance; the Global Fund; JICA; USAID; and the World Bank Group.

The GFF Trust Fund contributes to this complementary financing by linking trust fund resources to projects from the World Bank's International Development Association (IDA) or International Bank for Reconstruction and Development (IBRD). In the first 18 months of the GFF, 71 percent of the trust fund financing for countries was approved.

World Bank Group projects had been approved in nine countries as of May 2017, totaling almost \$1.2 billion in concessional financing and \$292 million in

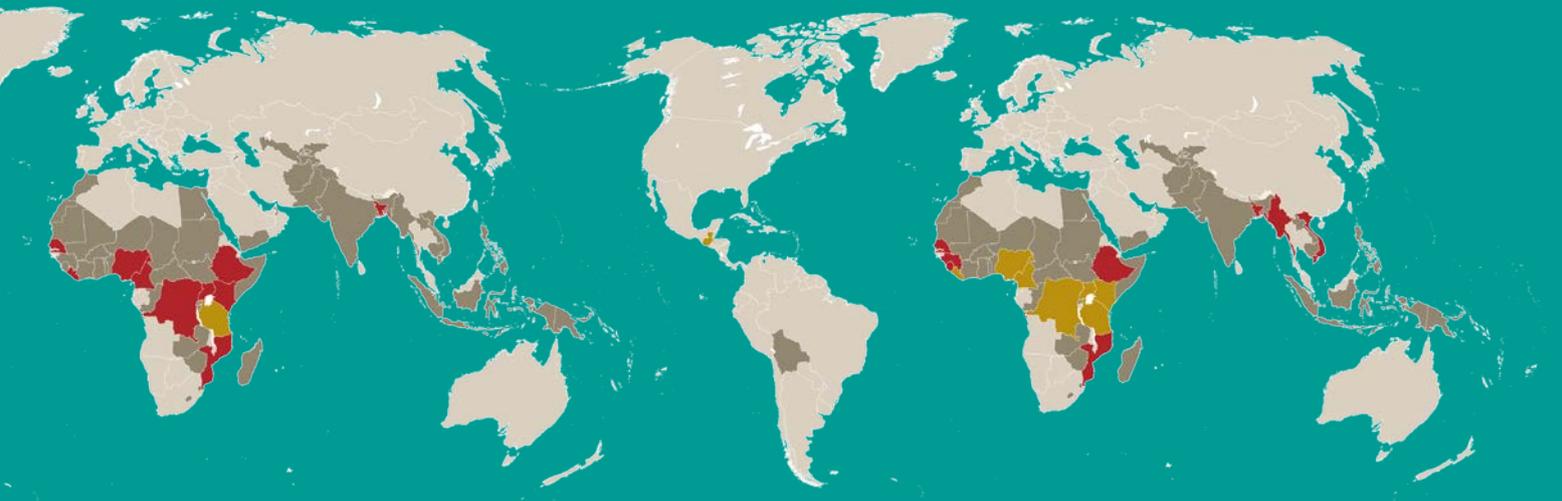
- BANGLADESH
- CAMEROON
- DEMOCRATIC REPUBLIC OF CONGO
- ETHIOPIA
- KENYA

- LIBERIA
- MOZAMBIQUE
- NIGERIA
- SENEGAL
- TANZANIA
- UGANDA

- BANGLADESH
- CAMEROON
- DEMOCRATIC REPUBLIC OF CONGO
- GUINEA

- KENYA
- LIBERIA
- MOZAMBIQUE
- MYANMAR
- NIGERIA
- SENEGAL

- SIERRA LEONE
- TANZANIA
- UGANDA
- VIETNAM



016 BEGINNING OF 2017

grant resources from the GFF Trust Fund (a ratio of \$4.06 concessional financing for every \$1 grant financing; see Table 1). Nine other projects are under preparation, totaling approximately \$1.3 billion in concessional financing and \$122 million from the GFF Trust Fund. More than \$125 million of IDA/GFF Trust Fund financing has been disbursed as of May 1, 2017 to support GFF country implementation. The disbursements are on track and are expected to accelerate to over \$200 million by the end of 2017, and more than \$500 million by the end of 2018.

TABLE 1: APPROVED FINANCING FROM THE GFF TRUST FUND AND IDA/IBRD

COUNTRY	FINANCING APPROVED FROM THE GFF TRUST FUND (US\$, MILLIONS)	FINANCING APPROVED FROM IDA/IBRD (IDA UNLESS NOTED) (US\$, MILLIONS)
Cameroon	27	100
Democratic Republic of Congo	50	350
Ethiopia	60	150
Guatemala	9	100
Kenya	40	150
Liberia	16	16 (TBC)
Nigeria	20	125
Tanzania	40	200
Uganda	30	110
Total	292	1,301

PROGRESS ON THE GROUND: SPOTLIGHT ON IMPLEMENTING INNOVATIVE SOLUTIONS IN TANZANIA

- As a GFF-supported frontrunner country, Tanzania is showcasing innovative ways to scale up a results-focused approach across the health system and increase momentum for better RMNCAH-N outcomes.

Tanzania developed a new plan—the sharpened One Plan II—as the GFF investment plan in 2015 and partners including Canada, Denmark, Ireland, Switzerland, the United Nations Population Fund (UNFPA), the United Nations Children’s Fund (UNICEF), the World Bank and IDA as well as the GFF Trust Fund, USAID and the Power of Nutrition are pooling and supporting the government to scale up the results-focused approaches.

As part of this approach, the Government of Tanzania is leading efforts to improve the coverage and quality of maternal and neonatal health and nutrition services, with a particular emphasis on performance and accountability in primary health care facilities and among their personnel.

At the core of the GFF approach in Tanzania is the focus on the delivery of a package of reproductive, maternal, child, and newborn health and nutrition services through a results-based approach. Implementation has started in regions with the poorest health outcomes and highest poverty levels. Health facilities are contracted and incentivized to improve the delivery of a pre-defined

package of key RMNCAH-N services, including antenatal and post-natal care; institutional deliveries; family planning; the prevention of mother-to-child transmission of HIV; the availability of essential supplies, equipment, and water; and adherence to infection control practices. Payments are disbursed based on the attainment of verified quantity and quality-related results and are used by health facilities to further improve service, and to provide performance bonuses to health care providers.

The Tanzanian GFF program is already displaying promise. After a year of implementation, several quality-related indicators are showing progress. For instance, the availability of 10 tracer medicines increased from 30 to 46 percent; the number of pregnant women receiving two doses of intermittent preventive therapy improved from 34 to 57 percent; and the number of women receiving iron and folic acid increased from 56 to 67 percent. In addition, qualitative evidence further indicates that the program is positively influencing the motivation and attitudes of health care providers, and is, in particular, reducing absenteeism and enhancing performance.

The process through which the Government of Tanzania is stimulating change among primary health care facilities can be showcased by the experience of the Maganzo dispensary, which covers almost





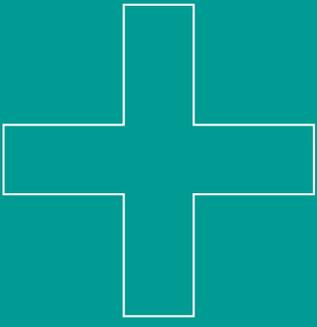
TANZANIA

3,000 households. The dispensary received a start-up grant of 10 million Tanzanian shillings under the program, which was invested in infrastructure improvements, including electricity and clean water for the delivery room as well as medical equipment needed for quality clinical services. These targeted investments enabled the dispensary to improve its accreditation score from an initial 1 star to 3 stars in 2016.

Throughout the first year of implementation, the Maganzo dispensary continued to improve its quality score through results-based financing, spurring an increase from 46.8 percent in the second quarter of 2015 to 88.5 percent in the first quarter of 2016. This resulted in increased performance payments, which motivated staff to provide high-quality service, stimulating an increase in patient attendance from 3,432 patients in 2015 to 5,418 in 2016, including a significant jump in the number of women who have attended at least four antenatal care visits. The combined effects of structural investments and individual incentives have enabled the creation of an enabling and motivating environment for health care personnel. Patient satisfaction and service use are on the rise, leading to a reduction in morbidity and mortality, particularly among women and children. Part of the GFF's role in this project is to assist in bringing these efforts to scale and to ensure the sustainability of these improvements.



TANZANIA



ADDING VALUE
THROUGH COUNTRY
LEADERSHIP
AND OWNERSHIP



COUNTRY OWNERSHIP IS AT THE FOUNDATION OF EVERYTHING THAT THE GFF SUPPORTS

- This is typically organized through a “country platform,” which, as described earlier, is an inclusive and transparent mechanism that brings together a broad range of partners to improve the health of women, children, and adolescents. The flexibility of the GFF approach enables countries to take different approaches to the country platform: most use existing committees while some create new structures. Some countries prefer smaller, high-level bodies for the formal decision-making process supported by technical working groups, while others opt for having larger committees engage throughout the process.

These platforms drive the prioritization process and provide a forum in which to discuss which partners will provide financing for the priorities. Once implementation has begun, the partners review progress and use data to make course corrections.

Cameroon is an example of a country that has seized the opportunity presented by the arrival of the GFF to strengthen coordination. The minister of public health has shown personal leadership in the process from the outset. He launched the GFF process in a very inclusive manner at a workshop that brought together

approximately 200 people from various government ministries (and different administrative levels, with participation from government staff from across the country), civil society representatives, the private sector, and the full gamut of international partners in the country. That inclusiveness has continued throughout the process, with large meetings led by the minister attracting 100 or more stakeholders at key points in the process, such as to agree on the priorities of the investment case and to review the situation analysis on health financing.

These large meetings were complemented by more focused consultations with key constituencies that were less able to participate in the big meetings. For example, specific meetings with the private sector were held in the country’s commercial capital of Douala. As the country has shifted into implementation

in four priority regions, local-level consultations are being held in the regions, chaired by regional governors to ensure a wide ownership of the process.

This consultation process has built broad ownership around the GFF process in Cameroon. As a result, a range of partners—including the local private sector organizations and international organizations—have seen the importance of directing their financing to the priorities identified in the country’s investment case.

“ THIS CONSULTATION PROCESS HAS BUILT BROAD OWNERSHIP AROUND THE GFF IN CAMEROON.







ADDING VALUE
THROUGH
PRIORITIZATION

SMART CHOICES GENERATE BETTER OUTCOMES

The past several decades have seen significant progress in identifying what works in development. However, this new evidence is not always translated into policies and practices on the ground.

A persistent challenge in many countries is that there are simply not enough resources—human and financial—to do everything that a country would like to do, which means that choices need to be made about how to use those scarce resources. This prioritization process is often complex and progress on it has been uneven. Poor decision-making around prioritization results in resources being wasted and ultimately harms women, children, and adolescents. To avoid this, the GFF supports countries in evidence-based prioritization across critical phases of the life cycle: around birth, the early years, and adolescence. This involves both deciding on the investments in RMNCAH-N that are needed now to accelerate progress for the survival, health, and wellbeing of women, children, and adolescents, and agreeing on the most important health financing reforms that will contribute to building equitable and sustainable health systems.

Accelerating Progress Now Through Prioritization

The GFF supports an evidence-based planning process to help prioritize investments in RMNCAH-N that will drive the changes a country wants to see in the health status of its women, adolescents and children. The process is grounded in an assessment of what is cost-effective, affordable, equitable, and can feasibly be delivered to the populations most in need. The flexible tool that is used for prioritization is called the “investment case.”

Interventions that have been proven to work in improving the health and nutrition of women, children, and adolescents are at the heart of most investment cases, but the GFF process also looks more broadly. In particular, the process considers the reforms required to strengthen health systems, out of recognition that it is impossible to improve and sustain results for women, children, and adolescents without stronger and more resilient primary health care systems. Given evidence on the important contribution of non-health approaches to improving health outcomes, the investment case process is also rooted in a multisectoral perspective that emphasizes investments in other sectors such as education, social protection, and water and sanitation, among others. Encouraged by this focus on outcomes rather than by traditional disciplinary boundaries, countries are increasingly adopting multisectoral approaches, including collaboration with the education sector to improve adolescent sexual and reproductive health in Bangladesh, Cameroon, Kenya, and Liberia; engagement on water and sanitation to address hygiene promotion and latrine construction in the Democratic Republic

of Congo; work with the social protection sector to scale up the unconditional cash transfer program for poor and vulnerable households and introduce cash transfers to keep adolescents in school and work with the education and civil registration sectors to pilot performance-based financing in schools and civil registration offices in Cameroon, and collaboration with those focusing on governance to address public financing management issues in Mozambique.

Another important aspect of the prioritization process is a focus on equity, so that the most disadvantaged women, children, and adolescents are reached. Countries have approached this in different ways, including by concentrating investments in geographic areas that have historically lagged behind; by targeting neglected periods of life, such as the early years or adolescence; and by covering key areas that have historically not been invested in sufficiently, such as family planning, newborn care, and nutrition.

Since the GFF is built on country ownership, one of the most encouraging aspects of the GFF experience so far is how the individual countries supported by the GFF have tailored the investment case process to their own national and subnational settings, as shown in the following country examples.



CAMEROON

Equity considerations were at the heart of the prioritization process for the investment case in Cameroon. With the majority of poor and vulnerable groups and the highest burden of RMNCAH-N problems concentrated in specific regions, geographic prioritization emerged as a key approach to improve outcomes. Approximately 87 percent of the poor live in rural areas and are concentrated in the three northern regions of Cameroon, namely the Far North, North, and Adamawa regions. Economic inequity is exacerbated by the insecurity caused by Boko Haram, an extremist group that operates in the area. These regions and the East region shoulder the highest burden of RMNCAH-N problems. For example, regional disparities for adolescent fertility are skewed higher in the East and Far North, with 44.2 percent and 23.4 percent of young women aged 15 to 19 having delivered a child in 2014, respectively, compared to 7.6 percent in the capital Yaoundé. Similarly, these four regions are affected by high rates of stunting, with 44 percent in the Far North to 40 percent in both the North and Adamawa, and 38 percent in the East.

To help sharpen this geographic focus and further understand the magnitude of existing disparities, UNICEF contributed to the investment case process by using the EQUIST tool—a web-based analytical platform that highlighted the regional disparities and supported the prioritization process.

As a result, the Cameroon investment case directs funding for the improvement of health service coverage and quality to the regions in most need and emphasizes investments to scale up financial mechanisms that improve access to essential health and nutrition services for poor and vulnerable households at both the community and health facility levels, including both vouchers to enable women and children to access care affordably and cash transfers targeted at adolescent girls.



LIBERIA

In Liberia, the evidence informed a geographic focus on the six counties which are experiencing the worst RMNCAH-N outcomes and have historically been underfunded—Grand Bassa, Gbarpolu, Grand Kru, River Cress, River Gee, and Sinoe. The data also highlighted the importance of adopting a demographic perspective to address the needs of a particularly underserved population group: adolescents.

The evidence gathered during the GFF design process highlighted the gaps in services for adolescents. Nearly 6 out of 10 girls have begun to have sex by the age of 18, and nearly 30 percent of adolescent pregnancies end up in unsafe abortions. With 177 out of 1,000 live births the result of unplanned or unwanted pregnancies, the heightened risk of sickness and death from these pregnancies is a major factor in Liberia's high maternal and neonatal mortality rate (more than 55 percent of neonatal deaths occur among mothers delivering before the age of 15). Further, the use of adolescent health services is hampered by a variety of barriers, including the costs of care and transportation; negative provider attitudes; lack of privacy and confidentiality, fear of stigma and discrimination; and an inadequate knowledge of healthy behaviors. These barriers have collectively contributed to the marginalization of adolescents, and particularly affect those who are poor. The investment case explicitly targets adolescents with a specific emphasis on the integration of adolescent-responsive sexual and reproductive health and family planning services in public health facilities. It also focuses on training health workers, paying particular attention to improved service delivery. Further, the investment case prioritizes a multisectoral approach to prevent teenage pregnancies—for instance, by leveraging the education sector to provide sexual and reproductive health education and contribute to the prevention of teen pregnancies.



BANGLADESH

In Bangladesh, 50 percent of girls are getting married before the age of 18 and one-third are beginning childbearing as teenagers. Bangladesh is working with partners and across sectors to stem early marriage and early pregnancies and, in turn, reduce maternal and neonatal sickness and death. As a result, the GFF process in Bangladesh is directing investments toward the education sector, where girls make up approximately 55 percent of secondary school enrollments. These investments are geared toward delaying the age of marriage for girls and, subsequently, toward postponing the timing of their first birth to increase the chances that both mother and child will be healthy and will thrive.



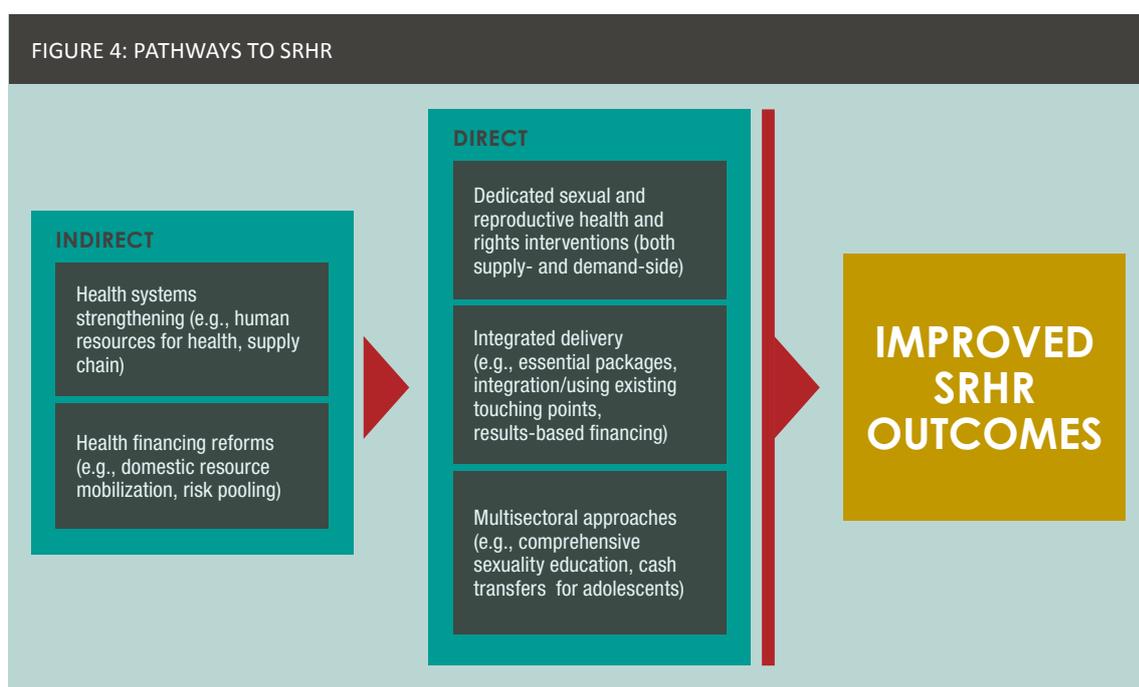
50%

of girls are getting married before the age of 18 and one-third are beginning childbearing as teenagers.



GFF PATHWAYS TO IMPACT: SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

■ The GFF contributes to efforts to end preventable deaths among women, children, and adolescents by combining direct, high-impact interventions with broader approaches to improving RMNCAH-N outcomes. These broader efforts tackle health systems bottlenecks, since a functioning primary health care system—including human resources, infrastructure, supply chains, and information systems—is critical for sustainable improvement of health outcomes for women, children, and adolescents, and the social determinants of RMNCAH-N outcomes.



This approach applies to all health outcomes, and can be illustrated by how the GFF improves comprehensive sexual and reproductive health outcomes. This begins by ensuring that priorities are identified based on available evidence of cost-effectiveness, feasibility, appropriateness and equity, through the investment case process in countries. This has resulted in sexual and reproductive health and rights (SRHR) being prioritized in all of the investment cases developed so far. Nearly 30 percent of IDA/IBRD and GFF Trust Fund financing for investment cases is directed toward SRHR.

Then, the GFF improves SRHR outcomes through a combination of indirect and direct pathways (as shown in the Figure 4).

The GFF supports the delivery of dedicated SRH interventions (for example, procuring contraceptives, aligning the

efforts of family planning providers, and supporting demand-side efforts to raise awareness for a range of contraceptive options), but does not stop there.

Direct pathways also include integrated delivery of sexual reproductive health and rights services through the development and delivery of essential health packages, performance-based financing, and delivery through existing touch points (for example, post-partum family planning, post-abortion care, and integration with HIV-focused interventions, and so on). In addition to these direct pathways, the GFF leverages its comparative advantage to improve SRHR outcomes through two indirect pathways. The first is to support the creation of stronger, more resilient health systems needed to deliver comprehensive SRH services and help prepare fragile health systems to withstand stress. These horizontal

investments include supply chain, health management information systems, human resources for health, as well as improving governance and public financial management. The second indirect pathway is the focus on health financing reforms. These reforms are planned and implemented by participating countries as part of an effort to promote domestic resource mobilization and financial sustainability to accelerate progress on RMNCAH-N and universal health coverage, and although they are not specific to SRHR, steps such as increasing the share of total government expenditure going to the health sector have important indirect benefits for SRHR. Finally, investment cases are making non-health sector investments in areas such as education and social protection address non-health determinants of comprehensive SRHR outcomes.

CIVIL REGISTRATION AND VITAL STATISTIC AND PROTECTING HUMAN RIGHTS

The GFF emphasizes the importance of national civil registration and vital statistic (CRVS) systems to record life events and provide “real-time” data to guide evidence-based decision-making.

CRVS PRIORITIES ARE INTEGRATED INTO INVESTMENT CASES IN MANY COUNTRIES,

Birth registration is stressed in GFF-supported countries as an important tool to protect against early marriage, which is often correlated with early pregnancies and childbearing, resulting in adverse health outcomes and limited future socioeconomic prospects for adolescents and their children.

THE STRENGTHENING OF DEATH REGISTRATION AND DOCUMENTATION OF THE CAUSE OF DEATH

is increasingly featuring in investment cases, such as in Kenya, Liberia, Mozambique, and Uganda. At the individual level, death registration provides access to property and inheritance rights and social services for vulnerable groups, such as orphans and widows. At the health system level, registering deaths and causes of death is instrumental in providing comprehensive real-time data. When disaggregated by gender and other socioeconomic variables, this information helps identify and prioritize the most pressing health issues, and highlights inequalities and discrimination, especially as experienced by women, adolescents, and children.

THE EMPHASIS THAT THE GFF PLACES ON STRENGTHENING DATA SYSTEMS TO MONITOR AND IMPROVE RMNCAH-N OUTCOMES

has led to support of Ethiopia’s Federal Vital Events Registration Agency in building a CRVS system through technical assistance, capacity building, and procurement of equipment. This will greatly strengthen the country’s data revolution agenda by making the CRVS system more robust and able to provide the necessary data on births, maternal and child deaths (including causes of death), and age at marriage, which are critical to monitor and improve RMNCAH-N outcomes.

PRIORITIZING CRITICAL HEALTH FINANCING REFORMS



NIGERIA

For example, the Government of Nigeria has launched a major initiative to improve primary health care delivery and is applying domestically generated funds to this end. It enacted the National Health Act in 2014, which will provide a Basic Minimum Package of Health Services for all citizens. To fund the Basic Minimum Package, the government is setting up a Basic Health Care Provision Fund (BHCPF) to be supported by the Nigerian federal government, grants from donors and other sources. The services will be delivered through a combination of public and private providers to the poor and vulnerable. As a first step following the establishment of the BHCPF, the government has requested support from the GFF Trust Fund to pilot the administrative functions of the fund in three states. GFF Trust Fund resources have the potential to be highly catalytic in the execution of the proof of concept for the BHCPF and the subsequent scale-up of the project.

Of the nine interventions in the Basic Minimum Package, six are focused on maternal and child health, and the seventh is for malaria, so the Basic Minimum Package is very much oriented to the areas that the GFF seeks to prioritize.

NIGERIA

Health financing systems are complex: most countries grapple with resources coming in from a range of sources (for example, tax revenue, donor financing, spending directly by patients, employer contributions) being pooled in multiple ways (for instance, different types of health insurance schemes, such as community-based health insurance or social health insurance) and with multiple actors involved in purchasing health services. Improving these systems is complicated, as there is typically a range of vested interests involved and multiple constituencies that need to be included in any reform effort (even within a government, as both ministries of finance and of health play key roles in health financing, and parliaments often want to engage when it comes to major reforms).

The GFF takes a flexible approach to supporting countries in identifying the priorities for health financing reform. Some investment cases contain key reforms, but in many countries this takes the form of developing either a

full-fledged health financing strategy or an implementation plan for an existing strategy. These processes and documents take a long-term perspective across the entire health sector in support of universal health coverage.

Making progress in this area requires a combination of rigorous analysis of the financing system and sensitivity to political economy considerations and opportunities for reform, so the GFF supports countries in conducting a range of analytical work (for example, public expenditure reviews, fiscal space analyses, political economy assessments) as a key first step in many countries, as they provide an evidence base for determining the most appropriate targets for reform. Translating this analytical work into concrete changes that improve the lives of women, children, and adolescents is often a lengthy process that unfolds over the course of several years, but the establishment of the GFF has accelerated this in a number of countries.



THE GOVERNMENT OF NIGERIA

enacted the National Health Act in 2014, which provided for the funding of a Basic Minimum Package of Health Services for all citizens.



GUINEA



COUNTRY SPOTLIGHT: BUILDING RESILIENCE IN LIBERIA

■ Having emerged from years of civil war and a devastating Ebola virus epidemic, Liberia is determined to rebuild its health system and intensify efforts to improve health outcomes

The challenges are formidable: average per capita income is only \$380 (2015), which severely constrains domestic resources for health; 64 percent of Liberia's 4.5 million people live in poverty; and costs and distance are major barriers to accessing health care for at least 40 percent of the population.

Although Liberia achieved the Millennium Development Goal for child mortality, the rate is still distressingly high at 94 per 1,000 live births, as is infant mortality (54 per 1,000 live births). Liberia's maternal mortality ratio is among the highest in the world at 1,072 maternal deaths per 100,000 live births. Many of Liberia's maternal and newborn deaths are caused by preventable and treatable conditions, which are not addressed because of critical shortages of skilled health workers, broken infrastructure, shortages of key equipment, and frequent stock-outs of essential drugs and medical supplies. Adolescents are a large part of the country's population, and the high teenage pregnancy rate (31%)—an estimated 30% of which end in an abortion—is a deep concern.



LIBERIA

PARTICIPANTS, THE GFF PROCESS, AND PRIORITIES:

With so many urgent needs, and its strong commitment to improving RMNCAH outcomes,

Liberia's Ministry of Health welcomed the pragmatic, results-focused process championed by the GFF. With the GFF's support, the government of Liberia selected a manageable number of feasible, high-return areas and actions. The "Liberia Investment Plan to Build a Resilient Health System 2015-2021" was used as a starting point to develop the RMNCAH investment case as a subset of the overall plan. The investment case is also an update of the "Accelerated Action Plan to Reduce Maternal and Neonatal Mortality" (2012). The GFF team included the Ministry of Health, Ministry of Finance and Development Planning, United Nations agencies (the World Health Organization (WHO), UNICEF and UNFPA, the World Bank, bilaterals (USAID), nongovernmental organizations, (Clinton Health Access Initiative, Last Mile Health, and others), and consultations were held with civil society and multisector stakeholders, including local governments.

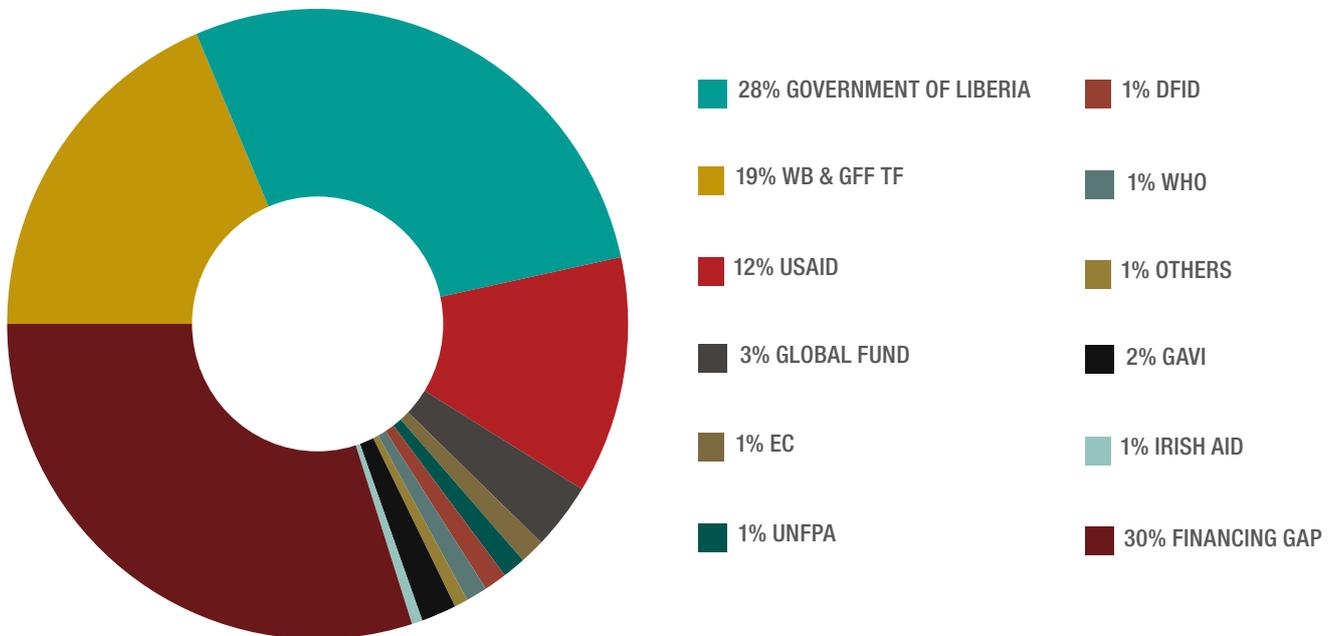
THE INVESTMENT CASE

was developed in an inclusive 13-month process led by the government and national experts, who are part of existing technical working groups, and a small core team that guided the process. Additional expertise was brought in only as needed to fill specific gaps (for example, in best practice adolescent health programs). The situation analysis entailed rigorous scrutiny and bold prioritization for smart investments across the life cycle, considering the status of current programs and causal chains, bottlenecks, and opportunities for improving the selected outcomes. A careful costing of inputs for each activity ("activity-based budgeting") and a "marginal budgeting for bottlenecks" analysis, alongside the resource mapping, made clear the need for rigorous, cost-effective choices. Health already receives 12 percent of the national budget and with a tough economic situation, there is little scope for short term increases. The resource mapping made clear the scope for better alignment of external funding (which historically has averaged approximately 40-50 percent of total health expenditures) to the country's priorities. A financing gap of 30 percent of the overall financing of the investment case still remains.

PRIORITIZATION

was done in two ways: in the six counties with the worst health outcomes, health service coverage levels, and poverty levels were identified, and six program action areas (improvements to emergency obstetric and neonatal care; adolescent health; sustainable community engagement; registration of births and deaths; maternal and neonatal death surveillance and response; and monitoring, evaluation, and learning) were selected, aiming to improve maternal and neonatal health outcomes and adolescent health. Geographic selectivity and focus aims to improve equity in access to health services and in outcomes and will enable investments to be undertaken at sufficient levels. Liberia avoided political minefields and wrangling by getting agreement first on the criteria, then applying them transparently and objectively.

FIGURE 5: CONTRIBUTORS AND SOURCES OF FUNDING FOR LIBERIA’S HEALTH BUDGET



FINANCING:

the Government of Liberia’s funding for health has historically averaged approximately 20-30 percent of the national budget, with 40-50 percent of funding for health from external sources.

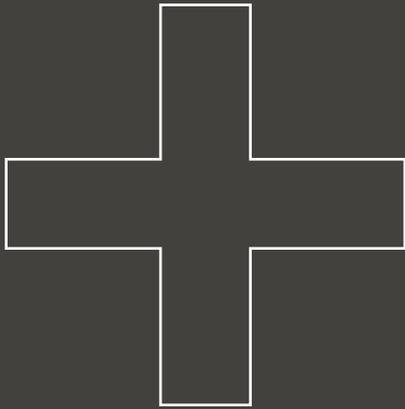
The total financing required for the RMNCAH investment case is \$719 million over the next five years. Domestic resources are estimated to be about \$201 million (with 40 percent committed), making up 28 percent of total budget requirement. Based on the mapping as of May 2017, there is a remaining 30 percent overall financing gap, as shown in Figure 5. The financing gap has been reduced as a result of some initial alignment with and coordination between the World Bank, GFF Trust Fund, USAID, GAVI, and the Global Fund in support of the priorities in the investment case. Strengthening coordination of the 94 nongovernmental organizations working in health in Liberia will help to prevent any duplications and ensure efficiency gains.

VALUE ADD— LOOKING AHEAD:

An added value of the GFF is the ongoing work on mutual accountability and transparency between the government and donors, and consolidated implementation.

The proposed performance-based financing is a good concrete example: while working to develop a contributory insurance scheme, providing small funds linked to performance can help build the capacity of public facilities to handle cash to finance outreach or other minor operational costs. The GFF process has helped Liberia toward completing its International Health Partnership (IHP+) country compact that describes how the government and development partners will work together to improve health outcomes. The development partners and 94 implementing organizations (besides government) that work in health in Liberia bring needed resources, but present a huge challenge for coordination and alignment. The GFF process is helping the ministry of health better coordinate, communicate and collaborate with them toward shared critical goals to improve the lives of Liberian families.





ADDING VALUE THROUGH IMPROVED EFFICIENCY

- Numerous estimates of the extent of losses in the health sector due to waste and inefficiency exist and they all show that the magnitude of the problem is large. For example, WHO has estimated that between 20 and 40 percent of health resources potentially are wasted through major forms of inefficiency.

GFF SUPPORT TO ADDRESS INEFFICIENCY HAS THREE KEY COMPONENTS



IDENTIFICATION

of the major sources of inefficiency in each individual country context as part of the development and review process of the investment case and health financing strategy;



COLLECTION & USE OF DATA

to help in the identification process and subsequent monitoring of inefficiencies as they are addressed (which, in turn, may require a plan for developing the systems for routinely collecting the desired data).



DEVELOPMENT & IMPLEMENTATION

of strategies to improve efficiency as the investment case and health financing strategy are implemented.

Since each country is confronted with different types of inefficiency, the GFF approach is tailored to each setting. The following examples describe the range of issues that countries are addressing to improve efficiency and free up resources for RMNCAH-N.



KENYA

Since 2010, the Government of Kenya has started to devolve power to deliver health care to the 47 county governments. Such devolution has the potential to lead to substantial efficiency gains by having more locally relevant solutions applied to context-specific problems, but also poses severe challenges as the counties' financial management capacities are highly variable. The recent national public expenditure review highlighted severe problems of low budget execution rates, inefficient allocation of resources, high levels of absenteeism and unavailability of drugs and equipment. The devolved context of the health care system, however, calls for a county-specific approach for both diagnosing and addressing the major causes of inefficiencies in the health care system. The GFF is supporting the Government of Kenya with such a county-level approach to ensure the devolution leads to efficiency gains without increasing regional inequities. This is done by strengthening the monitoring and evaluation framework so that problems of inefficiencies in budget allocations, expenditures, and provider payment mechanisms can be tracked across counties. Next, the GFF is supporting the government in conducting in-depth assessments of the health care system in several high- and low-performing counties as identified by this monitoring framework. These studies will lead to concrete recommendations for ways to address the key bottlenecks to efficiently organize health care at the county level, which, in turn, will feed into the development of county-level implementation plans for improving efficiency.



DEMOCRATIC REPUBLIC OF CONGO

Efficiency is at the core of the investment case in the Democratic Republic of Congo, which focuses on resource pooling at the provincial level by expanding the Democratic Republic of Congo experience with the Contrat Unique (single contract). The objective of this reform is to have one budgeted plan of activities at the provincial health administration that is financed through domestic and external funds available at the provincial level with a single fiduciary arrangement and a single monitoring and evaluation and reporting system.

The single contract reform addresses fragmentation in funding and service delivery—a major driver of inefficiencies in the Democratic Republic of Congo—with the aim of strengthening planning and reducing administrative and management costs. The single contract puts in place a performance framework for all funders. Along with this single contract, a number of reforms, such as the creation of a steering committee at the national level, reform of the drug procurement and supply systems aimed at reducing the number of parallel supply chains delivering drugs to the same facility, and the decentralization of human resource management, are under implementation.



TANZANIA

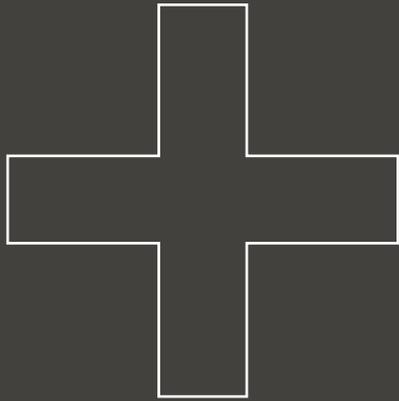
Two main causes of inefficiencies in the health care system are the limited resources directed at the primary care level—where the most cost-effective and affordable services can be provided—and the weak link between health care providers' performance and the way they are paid. Results-based financing mechanisms that explicitly link funding to the coverage of essential primary care services for women and children therefore hold great potential to improve efficiency in the health care system and are supported by the GFF in a considerable number of countries.

In Tanzania, the GFF is contributing to the efficiency agenda by supporting such results-based financing approaches at different levels of the health care system. The health basket fund for primary care that is supported by multiple donors (Canada, Denmark, Ireland, Republic of Korea, Switzerland, UNICEF, UNFPA, and the World Bank) has incorporated a performance component using disbursement-linked indicators, which release funding to local government authorities based on coverage of essential services for women and children, the quality of care, and conditions to provide quality care. This approach has led to substantial improvements in service delivery in the first year.

The GFF also supports the use of performance incentives at the level of the health care provider. The current World Bank primary care project (supported by the GFF Trust Fund, IDA, USAID, and Power of Nutrition) links funding going to regional and national authorities to results, and channels a third of the funding to health care facilities through a performance-based-financing approach that rewards facilities for both the quantity and the quality of services delivered, including several key RMNCAH-N indicators. Building on experiences from other countries, this project is expected to lead to substantial increases in coverage of essential primary care services in an efficient way.







ADDING VALUE BY MOBILIZING DOMESTIC RESOURCES

Improving efficiency is essential but insufficient to close the \$33 billion annual financing gap.

The largest volume of financing to close this gap over the long term must come from domestic resources: modeling done for the GFF Business Plan suggests that the combination of economic growth resulting in increases to tax bases and increasing the prioritization of health within national budgets would together close more than half of the financing gap in 2030 that remains after efficiency gains are included.

There are two main routes of mobilizing more domestic resources for health: increasing overall government

expenditures while holding the share for health constant (i.e. growing the pie) and increasing the share of government expenditures that is going to health (i.e. increasing the slice of the pie). The approach to supporting countries around domestic resource mobilization varies by country context, as the potential gains from these two routes differ significantly across the GFF countries. In countries that focus on “growing the pie” that emphasis is generally on strengthening systems for revenue collection, whereas those countries focused on “increasing the slice of the pie” emphasize increasing the priority accorded to health within the overall government budget. These are not mutually exclusive and most countries work on both.



MOZAMBIQUE

The Ministry of Health in Mozambique is committed to incorporating the priorities of the investment case into its Economic and Social Plan, which is the government's main annual planning and budget mechanism. Annual budgeting is a bottom-up process, with health activities planned by districts and provinces, but there is also a parallel planning mechanism led by the Ministry of Health to coordinate the budget with overall sector strategies. To ensure that investment case priorities are a part of this process, the Ministry of Health is planning to take a proactive role in promoting the priorities included in the investment case at the provincial level, where important budget decisions are being made. The inclusion of investment case priorities in the Economic and Social Plan is important, not just to shift public expenditures toward those investment case priorities, but also to align external financing around the investment case for greater impact. As part of the annual planning process, the priorities in the Economic and Social Plan are also presented to development partners, and the Ministry of Health requests all donors to contribute in line with the government's priorities in the Economic and Social Plan.

IN MOZAMBIQUE, WHERE ONCE FRAGMENTATION WAS THE OPERATIVE WORD, PARTNERS AND FINANCIERS ARE NOW JOINING FORCES UNDER THE STRONG AND REAFFIRMED LEADERSHIP OF THE GOVERNMENT. THE GFF IS HELPING CREATE MOMENTUM.



GUATEMALA

The GFF is catalyzing innovative approaches to domestic resource mobilization in Guatemala, where a \$9 million grant from the GFF Trust Fund is enabling the government to improve nutrition outcomes by accessing financing from the IBRD at lower interest rates through a performance-based "buy-down". The Government of Guatemala has committed to using the resources that are freed up from debt payments and matching them with domestic resources. They will reinvest the combined amount of \$18 million into a program that aims to improve the health and nutrition status of families in areas with large indigenous populations. Successful achievement of disbursement-linked indicators (DLIs) in years two and four trigger the release of the GFF Trust Fund resources for the buy-down of the IBRD loan to more concessional terms. The DLIs address two of the key aspects of under-nutrition in Guatemala (child feeding practices and access to health and nutrition services): (i) Increased percentage of children six months old exclusively breastfed; and (ii) Increased percentage of children under two years old who are beneficiaries of the conditional cash transfer program (parents receive transfers based on compliance with the full cycle of health co-responsibilities in the intervention areas).

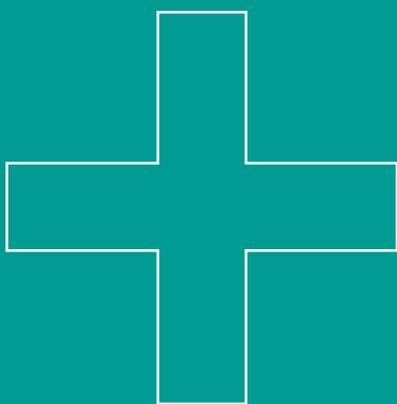
The GFF's engagement with Guatemala shows that the GFF can bring value and resources to improving and closing the RMNCAH-N equity gap within countries that are not eligible for IDA funding due to their national income level, but where there are significant inequities in RMNCAH-N outcomes.



KENYA

The GFF, linked with the Transforming Health Systems for Universal Care Project, is supporting a mechanism to incentivize county governments to increase their allocations to the health sector in Kenya. In the first year, all 47 counties will be eligible to receive seed funding to jump-start implementation based on need once they meet the required conditions, such as signing a performance agreement, opening a bank account, assigning responsible staff, and so on. Needs will be measured by: (a) the proportion of births not attended by skilled birth personnel; and (b) the county revenue allocation ratio (which is a resource allocation formula from the national to county level that combines population size, poverty level, land area, fiscal responsibility, and a basic equal share to allocate resources).

In years two to five, annual performance-based allocations will be shared among all eligible counties based on improved results. First, performance will be measured based on how much counties increased their allocation to health in their budgets against the previous year (in year two) and in their expenditures against the previous year (in years three to five). Second, improvements in health results will be incentivized, namely improvements in: (a) the proportion of women attending four or more ante-natal consultations; (b) the proportion of births attended by a skilled birth attendant; (c) the proportion of children fully immunized; (d) the contraceptive prevalence rate; (e) the quality of care in health facilities; and (f) the completeness and data quality of the health management information system.



ADDING VALUE
THROUGH
BETTER ALIGNED
EXTERNAL
ASSISTANCE

- Although domestic resources are the primary means of closing the financing gap globally over time, external assistance is still important. It is critical in the short term for almost all GFF-eligible countries and will remain important in the long term for many of them.

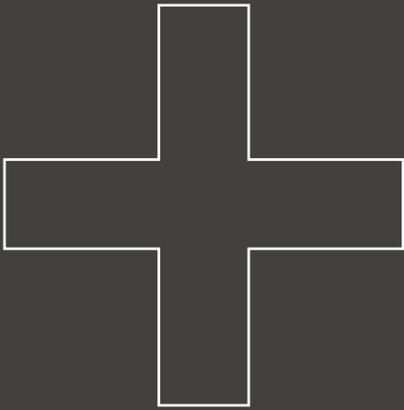
However, too often financing for RMNCAH-N is fragmented and characterized by both duplications and gaps, with key areas under-financed.

The GFF works both to increase the total volume of external assistance and to improve the use of existing financing by strengthening the alignment of donor resources behind nationally owned priorities. The investment case helps address this by creating a process that brings together key financiers behind a common set of priorities. Financiers are engaged from the early stages of designing an investment case so that they are involved in the process of identifying priorities and then commit to orienting their financing to support them. Additionally, in many countries, the GFF supports resource mapping processes to catalogue the financing available for an investment case, thereby contributing to reducing duplication and calling out gaps in the financing for key priorities.

The GFF approach to complementary financing has been enthusiastically embraced, with at least three financiers committing to supporting the priorities identified in every country that has completed an investment case. This has resulted in additional resources for RMNCAH-N as well as improvements in efficiency.

For example, in Cameroon, the investment case is being financed by a wide range of partners, including the Agence Française de Développement, BMZ and GIZ (the German government), Gavi, the Global Fund, the Islamic Development Bank, UNFPA, UNICEF, WHO, and the World Bank, in addition to the Government of Cameroon. Similarly, in Liberia, financing is being provided by the United Kingdom's Department for International Development (DFID), the European Commission, Gavi, the Global Fund, Irish Aid, UNFPA, WHO, and the World Bank, as well as the Government of Liberia. The Democratic Republic of Congo has a similar list and has introduced a promising approach to coordinating implementation with such a large number of partners, the "contrat unique," which was described on page 35.

To complement the alignment of their financing, some partners are also taking steps to strengthen the provision of coordinated technical assistance. For example, in Kenya, a fund to support technical assistance has been established with resources from DFID and USAID while in Ethiopia, the Bill & Melinda Gates Foundation is providing dedicated resources to support coordinated technical assistance around health financing.



ADDING VALUE BY LEVERAGING PRIVATE RESOURCES

- Private capital flows now dwarf official development assistance, so there is enormous potential to tap private sector resources to improve RMNCAH-N outcomes. A critical element of financing for the development agenda, therefore, is catalyzing greater private investment with measurable outcomes, and developing private sector solutions for country priorities that complement public capacity, including through public-private partnerships and innovative financing.

THE GFF PRIVATE SECTOR STRATEGY SEEKS TO LEVERAGE PRIVATE RESOURCES, CAPACITY, AND EXPERTISE TO IMPROVE THE HEALTH OF WOMEN, CHILDREN, AND ADOLESCENTS BY:



DEVELOPING

innovative financing mechanisms to catalyze private sector capital for investment case financing;



FACILITATING PARTNERSHIPS

between global private sector organizations and countries; and



LEVERAGING

private sector capabilities in countries to deliver on investment case objectives

The country examples that follow highlight the different ways that the promise of using private sector resources to achieve results is starting to come to fruition.



CAMEROON

Kangaroo mother care (KMC) is a high-impact intervention for pre-term infants but is not yet widely practiced in Cameroon, despite the fact that the country has a high neonatal mortality rate. What may become the first development impact bond in global health is being developed in Cameroon to inject a considerable amount of private capital into the country to scale up KMC. This development impact bond is the result of a partnership between the Cameroon Ministry of Public Health, Grand Challenges Canada, the MaRS Centre for Impact Investing, Social Finance UK, Nutrition International, the World Bank, and the GFF Trust Fund. In a development impact bond, investors provide the upfront and ongoing capital for an intervention to achieve agreed results and outcomes; funders (typically donors and governments) commit to making payments to investors only if the interventions succeed. Investors' financial returns are directly linked to independently verified outcomes and performance risk of the projects is shifted to or shared with investors, rather than resting solely on government or donors as in traditional program financing. Development impact bonds also enable crowding in capital from non-traditional sources of development financing, such as impact investors.

The expansion of KMC being enabled by the DIB is expected to improve health outcomes for roughly 3,000 to 4,000 pre-term and low-birth-weight newborns annually. Through supporting the implementation of this innovative financing mechanism, the GFF and other partners are bringing additional private sector capital to bear to solve the problem of pre-term and low-birth-weight babies surviving and thriving in Cameroon.



NIGERIA

The Federal Ministry of Health in Nigeria seeks to integrate innovative approaches to health service delivery by partnering with the private sector to increase the quality of services and coverage of RMNCAH-N interventions within underserved populations. In response to the specific challenges of delivering quality health care to the conflict-affected areas of northeast Nigeria, the Nigeria Service Delivery Innovation Challenge (NSDIC) was conceived as a competitive process to identify, showcase, and spur innovations in primary health care service delivery in fragile settings.

A partnership was established in December 2016 between the Federal Ministry of Health, the Private Sector Health Alliance of Nigeria, the Health care Federation of Nigeria, the International Finance Corporation, and the GFF to oversee the call for concept notes and the implementation of the competition process. The public-private partnership combines public sector definition of the problem with the private sector's creation of a platform for innovators and non-state actors to collaborate on solutions to address priority health system challenges. Four areas are prioritized: i) increasing coverage of RMNCAH-N interventions; ii) improving the quality of care; iii) increasing the availability of life-saving commodities; and iv) strengthening the availability, timeliness, and quality of the CRVS system.

The added value of the NSDIC includes access to a combination of technical and managerial expertise, infrastructure, and technology represented by the private for-profit and not-for-profit NSDIC competitors; increased efficiency of economies of scale for

market-based solutions; facilitation of financial capital injections into the health sector; fostering economic growth through new investment opportunities alongside the increased provision of public goods and services, and strengthening a complementary relationship between the public and private sectors in the health system.

Sixty-five submissions were reviewed in a rigorous and transparent selection process against promising innovative service delivery model criteria and a shortlist of nine submissions moved to the second round. Of these, three have emerged with the highest scores across the board. These three private sector service delivery innovations will be incorporated into Nigeria's investment case and will receive support to scale up their interventions. This illustrates how the GFF is supporting governments to leverage private sector innovation and capabilities for improved RMNCAH-N health service delivery in fragile settings.

THE GFF'S LEARNING AGENDA

- The GFF's learning agenda aims to help countries drive GFF results and maximize outcomes: to strengthen learning systems that track progress; draw lessons and enable course corrections; and promote joint learning mechanisms focused on continuous and collaborative learning.



PARTICIPANTS AT THE GFF COUNTRY LEARNING WORKSHOP

GFF joint learning opportunities are typically designed to address the evolving needs and priorities, as identified by countries.

The 2015 GFF Country Workshop was instrumental in tailoring the GFF's approach to learning. Participant feedback not only stressed its critical role in engaging and energizing country platforms around a common vision, but also emphasized the importance of strengthening continuous and sustainable learning through further joint learning opportunities across countries.

Participants representing governments, development partners, and civil society organizations listed three joint opportunities to support the operationalization of the GFF at the country level, namely the development of a community of practice; the organization of online seminars; and the development of another GFF Country Learning workshop.

The GFF developed peer-to-peer exchanges, using online platforms to enable countries to learn directly from each other on a wide variety of topics, including prioritization, country platform and private sector engagement, complementary financing, health financing, adolescent health, CRVS, and complementary financing for the investment case. The ingenuity of these exchanges derives from their accessibility: the use of online platforms ensures GFF knowledge is accessible to participants from all 16 countries in real time. These south-south exchanges also promote countries benefiting from each other's expertise to jointly optimize GFF-related processes and strengthen the way they are operationalized.

A follow-up GFF Country Learning Workshop was organized in April 2017 in Washington, D.C., to further help countries drive GFF results and advance the operationalization of the GFF approach. This learning event brought together 150 participants from 16 GFF-supported countries to elaborate on the GFF's vision,

discuss experiences, identify challenges and share lessons learned.

Interactive in nature, the workshop provided an opportunity to strengthen understanding and opportunities for improved design, implementation, and monitoring of operationalizing the GFF at the country level. These workshops and web-based collaborative exchanges jointly contribute to strengthening the GFF community of practice by connecting GFF stakeholders and focusing on sharing best practices and distilling new knowledge to advance the GFF at the country and global levels.

THE USE OF ONLINE PLATFORMS ENSURES GFF KNOWLEDGE IS ACCESSIBLE TO PARTICIPANTS FROM ALL 16 COUNTRIES IN REAL TIME.



IT SEEKS TO STRENGTHEN LEARNING SYSTEMS THAT TRACK PROGRESS



DRAW LESSONS AND ENABLE COURSE CORRECTIONS



PROMOTE JOINT LEARNING MECHANISMS FOCUSED ON CONTINUOUS AND COLLABORATIVE LEARNING.

RESULTS MEASUREMENT



KENYA

The GFF is still in its early stages, and it is not yet possible to show improvements across countries in mortality trends or coverage of high-impact interventions (see programmatic indicators below) in this annual report, although efforts are underway at the country and global levels to track progress on outcomes and impact. The results agenda is very much at the heart of the GFF approach, as can already be seen at both the country and global levels. See early results in the Tanzania example, page 16. Similar results are being monitored in most GFF countries.

At the country level, investment cases contain results frameworks that set out baselines and targets. For example, to track progress on stunting, many countries include under-five stunting prevalence as shown in Table 2.

Investment cases also include the priority investments needed to strengthen monitoring and evaluation systems, including in health management information systems, household surveys, and civil registration and vital statistics systems.

The focus on results is strengthened by the fact that many of the financiers providing resources for investment cases do so in results-based ways. For example, many of the World Bank Group projects are scaling up results-based financing efforts that tie the release of funds to performance. This both heightens the emphasis on results from the beginning of a project and creates a powerful incentive to strengthen the monitoring systems that track progress.

In other countries, the financing from World Bank Group and the GFF Trust Fund is tied at the national level to changes in indicators for RMNCAH-N. For example, in Ethiopia, disbursements are linked to progress in indicators such as antenatal coverage, the percentage of women whose births are attended by skilled personnel, and modern contraceptive prevalence rates.

TABLE 2: BASELINES AND TARGETS FOR UNDER-FIVE STUNTING PREVALENCE CONTAINED IN INITIAL INVESTMENT CASES

COUNTRY	BASELINE (VARIES BY DATE OF MOST RECENT SURVEY)	TARGET (TYPICALLY FOR END OF THE INVESTMENT CASE PERIOD, SUCH AS 2020)
Ethiopia	40%	26%
Kenya	26%	19%
Liberia	35%	30%
Tanzania	42%	22%

CORE INDICATORS FOR USE IN GFF COUNTRIES

To complement this work at the country level, a set of core indicators are currently being finalized for use in GFF countries, building on processes for indicators for the Sustainable Development Goals and the Every Woman Every Child movement. This includes indicators for monitoring and tracking at multiple levels—progressing from inputs/process, to outputs, outcomes, and for evaluation of impacts. The full set of indicators is too extensive to include here. The following is a core set indicators for tracking both programmatic and health financing progress:

PROGRAMMATIC	HEALTH FINANCING
<ul style="list-style-type: none">• Maternal mortality ratio• Under-5 mortality rate• Neonatal mortality rate• Adolescent birth rate• Percentage of the most recent children age 0-23 months who were born at least 24 months after preceding birth• Prevalence of stunting among children under 5• Socio-emotional health of children under 5• Cognitive function of children under 5	<ul style="list-style-type: none">• Current country health expenditure per capita financed from domestic public sources• Ratio of government health expenditure to total government expenditures• Growth rate in domestically sourced current total health expenditures since baseline, divided by the growth rate of GDP• Percent of current health expenditures on spent primary care• Improvements in nationally agreed indicators of efficiency• Composite indicator on efficiency• Incidence of financial catastrophe due to out-of-pocket payments• Incidence of impoverishment due to out-of-pocket payments

Changes in these indicators is typically the result of the combined action of many different factors which the investment cases influence and it often takes a number of years to see meaningful progress. GFF countries will therefore also measure a series of proxy indicators that can monitor change more rapidly, which will be tailored to the specific areas of work in each country, and be reported on in future annual reports.

The following table highlights the progress of countries in completing key initial elements of the GFF process. As described earlier, these processes and inputs are the first stage of results monitoring and will be complemented by quantitative data on outputs, outcomes, and impacts in forthcoming reports.

TABLE 3: CURRENT STATUS GFF COUNTRIES – APRIL 2017				
COUNTRY	INVESTMENT CASE RMNCAH PRIORITIES	COMPLEMENTARY FINANCING FOR THE INVESTMENT CASE		HEALTH FINANCING
		PARTNERS FINANCING THE INVESTMENT CASE	CURRENT STATUS OF IDA/IBRD-GFF TRUST FUND PROJECT	
Bangladesh	Using national plan (SWAp)	SWAp supported by pooled parallel and project financiers	Health and education projects under preparation	Strategy being implemented
Cameroon	Beginning implementation	France, Gavi, Germany, Global Fund, Islamic Development Bank, U.S. government (Centers for Disease Control and USAID)	Implementation	Strategy being prepared
Congo, Dem. Rep.	Beginning implementation	Canada, Global Fund, Gavi, U.S., UK	CRVS and health projects approved	Strategy being prepared
Ethiopia	Using national plan	Financiers of SDG Performance Fund	Approved; financing through the project from the Power of Nutrition	Focus on implementation plan
Guatemala	Using National Strategy to Prevent Chronic Malnutrition 2016-2020		Approved	Process recently begun
Guinea	Process recently begun	Discussions with partners underway	Early stages	Process recently begun
Kenya	Implementation	Denmark, Gavi, Global Fund, Japan, UK, U.S.	Implementation; financing through the project from Japan	Strategy exists; focus on implementation plan
Liberia	Beginning implementation	Gavi, Germany, Global Fund, European Commission, Japan, UK, U.S.	Standalone grant approved	Strategy being prepared
Mozambique	Draft available	Discussions with partners underway	Preparation	Draft strategy prepared
Myanmar	Process recently begun	Discussions with partners underway	Preparation	Process recently begun

The following table highlights the progress of countries in completing key initial elements of the GFF process. As described earlier, these processes and inputs are the first stage of results monitoring and will be complemented by quantitative data on outputs, outcomes, and impacts in forthcoming reports. (Table continuation from previous page)

TABLE 3: CURRENT STATUS GFF COUNTRIES – APRIL 2017

COUNTRY	INVESTMENT CASE RMNCAH PRIORITIES	COMPLEMENTARY FINANCING FOR THE INVESTMENT CASE		HEALTH FINANCING
		PARTNERS FINANCING THE INVESTMENT CASE	CURRENT STATUS OF IDA/IBRD-GFF TRUST FUND PROJECT	
Nigeria	Draft available	Discussions with partners underway	North-Eastern Nigeria Emergency Project under implementation; other project early stage	Strategy being prepared
Senegal	Process underway	Discussions with partners underway	Early stage	Draft available
Sierra Leone	Process recently begun	Discussions with partners underway	Early stage	Process recently begun
Tanzania	Implementation	U.S., financiers of the Health Basket Fund	Implementation; financing through the project from U.S. and Power of Nutrition	Strategy exists; focus on implementation plan
Uganda	Draft available but limited progress finalizing	Gavi, UK, U.S.	Approved; financing through the project from Sweden	Strategy exists; focus on implementation plan
Vietnam	Determining approach	Discussions with partners underway	Early stage	Determining approach



2015-2017

GLOBAL FINANCING FACILITY

INVESTORS GROUP MEMBERS:

The Investors Group was comprised of representatives of the following countries and organizations:

Canada	African Health Budget Network (2017)
Ethiopia	Jhpiego (2017)
Japan	Plan Canada (2017)
Kenya	Population Council (2017)
Liberia	RESULTS
Norway	World Vision International
Senegal	Grand Challenges Canada
United Kingdom	MSD for Mothers (2017)
United States	Safaricom
Bill & Melinda Gates Foundation	UNFPA
Gavi, the Vaccine Alliance	UNICEF
The Global Fund to Fight AIDS, Tuberculosis and Malaria	Office of the UN Secretary-General
Partnership for Maternal, Newborn and Child Health	World Bank Group
Advance Family Planning (2017)	World Health Organization

THANK YOU

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